The New Outlook

United Ostomy Association of Chicago

United Ostomy Associations of America, Inc.

March 2013
Meeting—Wednesday, March 20 at 7:30 PM

Lutheran General Hospital
Special Functions Room, 10th floor
1775 Dempster Street, Park Ridge, IL

Board Meeting at 6:30 PM

Fourth UOAA National Conference
August 7-10, 2013
Hyatt Regency, Jacksonville, Florida

Welcome to the history and charm of downtown Jacksonville, Florida, situated on a four-mile riverfront boardwalk close to area attractions in the center of Florida life. Plan to arrive by Tuesday, August 6. Registration begins at noon on Tuesday, August 6. Programming begins Wednesday morning August 7 and continues through Saturday, August 10. Come join us as we build the "Bridge to Acceptance!"

Contact UOAA at www.ostomy.org for more information and to register for the conference.

If you have a talent that you would like to share by participating in one of our many diverse committees, please let an officer know. Our offices and committees are listed in our bylaws, which may be viewed at www.uoachicago.org. Then follow the link to OAGC.

We do not have any storage space at Lutheran General. When you come to a meeting, you may want to volunteer to carry some of our supplies with you to each of our meetings. This is an easy way to become more active in our group.

Make sure you do not miss an important announcement by updating your e-mail address with us at **uoachicago@comcast.net**. To ensure delivery, make sure we are in your address book or safe sender list. Our e-mail list is private and never shared or sold. We occasionally receive requests from public relations firms and the like for our members to participate in focus groups about ostomy surgery. You will usually be paid for your time, but sometimes it is on a volunteer basis. Let us know if you want to be included.

We have been informed by Lutheran General Hospital that parking in their enclosed garage is now free for our members. This means you may park in the inside garage, take a few steps to the elevators, and come to the 10th floor, where we have our meetings. It is so easy to come. Be sure to visit us for our 38th Anniversary Meeting in April featuring the President of the DuPage Ostomy Association, Bret Cromer. Last year, he inspired us with stories of people living life to the fullest.

Ostomy Association of
Greater Chicago (OAGC)
Established 1975

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Little Company of Mary Hospital
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Resurrection Home Health Services

National UOAA Virtual Networks

- *Pull Thru Network* (Parents of children with bowel and urinary dysfunctions): Bonnie McElroy 205-978-2930
- *UOAA Teen Network:* Jude Ebbinghaus 860-445-8224
- *GLO* (Gay & Lesbian Ostomates): Fred Shulak 773-286-4005
- *Young Ostomate & Diversion Allia. of Amer*: Eric En 714-904-4870
- *Thirty Plus*: Kathy DiPonio 586-219-1876
- *Continent Diversion Network:* Lynne Kramer 215-637-2409

www.uoachicago.org

Meeting Dates at Lutheran General Hospital

March 20—Lisa Osowski, dietician, and Eric Morrow, sales manager, from Shield Healthcare
April 17—Our 38th Anniversary Meeting featuring the inspirational Bret Cromer as guest speaker
May 15
June 19—The effervescent Madeline Grimm, CWOCN, will discuss skin issues; plus we are having our second annual Summer Solstice Picnic
July 17
August—No Meeting
September 18—Diane Zeek, CWOCN, along with Otto the Ostomy Mannequin
October 16
December 11—Our 2013 Gala Holiday Party

Southwest Suburban Chicago

The Southwest Suburban Chicago Ostomy Support Group is an entirely volunteer ostomy association dedicated to the mutual aid, education and moral support of people with ostomies and their families. Meetings are held at 7:30 PM on the third Monday of each month throughout the year, except July, August, December and January.

For information regarding this special ostomy group serving Chicago's greater southwest side, please call Edna Wooding, WOC nurse and association president, at 708-423-5641. All meetings are at **Little Company of Mary Hospital**, in Evergreen Park, in the Mary Potter Pavilion, L Level, 2850 W. 95th St.

Northwest Community Hospital

The Northwest Community Hospital Ostomy Support Group meets at 800 W. Central Road, Arlington Heights. They wish to extend an invitation to all of our readers to visit them. The WOC nurses at the hospital lead the group. For more information, please contact Diane Zeek, RN, at 847-618-3215, dzeek@nch.org.

They meet from 1:00 PM until 2:00 PM in the Busse Center, B1 level, Rooms LC7 and LC8 of the Learning Center. This building may be accessed from the garage at the west end of the Busse Center. It is easiest to enter from Central Road.

Meeting Dates for 2013

April 11
June 13 **August 8**
October 10 **December 12**

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Sherman Hospital Ostomy Group

There is a new ostomy support group in Elgin having meetings at Sherman Hospital. They now meet on the **second Wednesday** of every month.

The contact person for any information is
Heather LaCoco, BSN, Case Manager
Surgical Care Sherman Health
224-783-2458
Heather.Lacoco@ShermanHospital.org

A Reading from Genesis:

And God promised men that good and obedient wives would be found in all corners of the earth . . . then He made the earth round and He laughed and laughed

Ostomy Myth Series

By Barbara Skoglund of Maplewood, MN
(Continued from the February edition)

Ostomy Myth Six

Time! Time! Time! Whew! Is life hectic or what? My job is busy, busy, busy. My grad school class starts next week, and I need to somehow get over to the university to buy my books. Their concept of evening hours for adult students is staying open to 5 PM. I am also trying to get a different job in the same agency I currently work, but I have to obtain a teaching license first. I had to fill out paperwork, and then send it to my undergraduate school to have them to fill in their part—it is weird having to procure a license for a job where I will not be teaching, but since the job is doing professional development for teachers and they usually recruit teachers for the job, it is one of the requirements.

That reminds me, I must revise my resume. Meanwhile, winter is coming to Minnesota, and we have tons of leaves to rake up in the yard. We just moved into our first house this May and still have quite a list of house things to do yet. Boy, do houses take much work. I have to cover the roses and put the lawn furniture away . . . not to mention the laundry. My husband's in a wedding party on Saturday and his suit needs to be cleaned.

I am also working on a rewrite of our Internet pages. I recently learned how to use Microsoft's FrontPage and am excited to be able to make my homepage much nicer. Tons to do and not enough time to do them—Ah! That is life. "What does this have to do with ostomy life?" you ask. My life is busy and hectic. I am involved in many things that take up time. Dealing with my ostomy is not one of these issues. I empty my pouch when I urinate, about 12 times a day. I prefer my pouch to be empty than full so I may empty it more than absolutely necessary.

According to my WOC nurse, as my ostomy ages, I will be less self-conscious and empty my pouch less often, although I like feeling an empty pouch next to me rather than a full one. I spend far less time in the bathroom than I did when I had ulcerative colitis or especially when I had a straight ileoanal anastomosis—I was on the toilet every half-hour. I change my pouching system every three to four days. It takes me about 10 minutes. I take my time and never rush changing my pouching system.

I am not very knowledgeable about pouching systems. I use the same one I used when I originally

had surgery. My ostomy nurse suggests that I try other pouching systems on a day I will be around the house to see how I feel about it. It is considered best practice to be able to use more than one set procedure when managing one's ostomy.

A few people with lower colostomies choose to irrigate theirs so that they do not need to wear a pouching system. This is a choice few make because it takes about an hour to irrigate a lower colostomy and most people do not want to spend their time doing this. Most people with colostomies simply wear a pouching system.

There are unfortunate stories of people who need to change their pouching system every few hours. This is unacceptable. These people need to see a WOC nurse for a proper fitting and to help solve any pouching issues. Most of these people do not see a WOC nurse; otherwise, they would not have these issues. A certified WOC nurse can help a person with an ostomy find a properly fitting pouching system that lasts more than a few hours, does not leak, and lets the patient live a high-quality life.

My wear time is considered optimal at three to four days. If you are getting less than one day, then see a WOC nurse. Odds are you are not using a properly fitted pouching system. Managing an ostomy (emptying it and changing it) does not cut into my personal time. Actually, since I spend so much less time in the bathroom doubled over in pain, my ostomy has expanded my available free time.

Ostomy Myth Seven—Misconceptions

This one is more of a misconception than a myth;
Nurse: "How long have you had a colostomy?"
Barbara: "I don't have a colostomy. I have an ileostomy."
Nurse: "What's that?"

There are many different types of ostomies, continent procedures, internal pouches and alternative procedures. Yet some people seem to call them all colostomies. Doctors, nurses and even people with ostomies themselves seem to lump all different types of diversionary surgery together. One type of ostomy is not inherently any better than another, except a loop ileostomy, but they are all a bit different. Colostomy, ileostomy, loop ileostomy, urostomy, continent ileostomy, Koch pouch, BCIR, Indiana pouch, J-pouch, S-pouch, W-pouch, kangaroo pouch—What are the differences?

Ostomy—the word ostomy signifies a type of surgery required when a person has lost the normal function of the bladder or bowel due to birth defects, disease, injury or other disorders. Such operations include the colostomy, ileostomy and urostomy. The surgery allows for normal bodily wastes to be expelled through a new surgical opening (stoma) in the abdominal wall. Most persons with ostomies must wear a pouching system over the stoma.

The most common type of ostomy is the colostomy. Depending on the location and nature of the individual's problem, a stoma may be constructed in any of the parts of the colon. While there was a time when most colon cancer patients ended up with a colostomy, today there are alternate procedures that preserve natural elimination. The key is location. If the cancer is in the anus or rectum, then a colostomy is probably part of the treatment.

Other diseases often resulting in colostomy are diverticulitis, that is, inflammation of small pockets in the wall of the colon. These may become inflamed, causing obstruction, bleeding or perforation. There are also accident and gunshot victims who have temporary or permanent colostomies. Birth defects may also require a colostomy.

An ileostomy is a surgically created opening in the ileum (part of the small bowel). The ileum is surgically cut into two pieces, usually as close to the end of the ileum as possible. The proximal (upper) portion of the ileum is brought to the surface of the abdomen and a stoma is created. In most cases, the distal (lower) ileum and the entire colon are then removed. The greater the length of small intestine removed, the greater the loss of nutrient absorption. Since water is no longer being absorbed by the colon, the remaining ileum takes over this function. One cannot irrigate an ileostomy in to achieve continence. The flow of effluent cannot be completely controlled. We must always wear a pouching system.

Loop ileostomies are temporary ileostomies in which a loop of small intestine is pulled through the abdominal wall to create a stoma. From my experience it can be very difficult to find a properly fitting pouching system for a loop ileostomy.

In a continent ileostomy, a reservoir pouch is created inside the abdomen by using a portion of the terminal ileum. A valve is constructed in the pouch and is brought through the abdominal wall. Several times a day a catheter or tube is inserted through the valve into the internal pouch to drain feces from the reservoir. Koch pouches and BCIRs are the most commonly performed continent ileostomies. They

are named after the doctors who designed them. The BCIR is a revision of the Koch pouch and is performed in few facilities in the US. Continent folks do not need to wear a pouching system. Most simply wear a bandage over the opening.

Urostomies result when the bladder is removed or the normal structures are being bypassed and an opening is made in the urinary system to eliminate urine. Usually, a piece of ileum is used to create a urostomy stoma. Birth defects may require a urostomy. Urostomies cannot be irrigated and the flow of urine cannot be controlled. People with ileo conduits, as they are sometimes called, must always wear a pouching system.

There are two main continent alternatives to the ileal conduit. In both the Indiana and Kock pouch, a reservoir is created inside the abdomen by using a portion of either the small or large bowel. A valve is constructed in the pouch and part of the bowel is brought through the abdominal wall to form a stoma. A catheter or tube is inserted several times daily to drain urine from the reservoir.

With an Indiana pouch, the ileo-cecal valve (between the large and small intestines) is moved and used to control the pouch, which is made from the large bowel. With a Kock pouch, the pouch and a special nipple valve are both made from the small bowel. In both procedures, the valve is located at the pouch outlet to close the pouch and contain urine until the catheter is inserted. Continent folks do not wear a pouching system.

J-pouches are internal pouches formed from the terminal ileum and connected to the anus. The J-pouch has become the surgery of choice for people with severe ulcerative colitis or familial polyposis. It is the procedure most gastroenterologists recommend for their patients who need an ostomy. J-pouches are not done on people with Crohn's disease, since Crohn's disease can pop up anywhere, even in the new J-pouch, thereby ruining it.

J-pouch surgery is performed in one, two or three separate operations. People who have the two- or three-step surgery have a temporary loop ileostomy while their internal stitches heal. The J-pouch is named for its shape. It is also called the ileo-anal pouch anastomosis, the pull through, the endo-rectal pull through, the pelvic pouch, or a combination of these. I lived for three years with a straight ileo-anal anastomosis, also called the straight shot. Straight shots are rarely performed because they never work. They are done so that the patient may have normal elimination. It is too high a price to pay!

The kangaroo pouch is the place where baby kangaroos nourish and grow.

Thank you to UOAA and ConvaTec for some of the more technical definitions.

Ostomy Myth Eight

"I have never met anyone with an ostomy." That is what you think. There are only two ways you can tell if someone has an ostomy: (1) They tell you. (2) You see them in the nude.

Believe it or not you have met many people with ostomies in your lifetime. You just do not know it because they have not told you. I used to think I would never meet any person who has an ostomy. The week before my surgery to install my permanent ileostomy, I was in a union meeting at work. I was sitting next to the president, who was also taking leave during Christmas for surgery. She was having glaucoma surgery and asked me what I was going in for. Although I had made up my mind to have the surgery, I was not going to tell anyone. So, I mumbled something about intestinal surgery.

She said, "Oh! Do you have Crohn's disease?" I said, "No, uncreative colitis." "Are you having an ileostomy?" asked Susan. "Umm, yes," uttered honest Barb. "Rob (her partner) has Crohn's disease. He has had an ileostomy for years." Oh, my! I had outed myself for the first time; lo and behold it was to a woman whose partner had an ileostomy. I still was not going to tell anyone.

Well, I told folks on the Internet, but it is much easier to tell people via a computer than in person. It was nice that Susan understood, but I sure was not going to say anything to anyone else. Then my health insurance company told me that my ostomy supplies were unnecessary luxury items. Mind you, if I was a man who needed a penile implant, or if I wanted a bed pan they would pay for it.

So out I came in full force. I told everyone—my legislators, all of the state employee unions (I am a state employee), the newspapers, any and everyone who might be able to put pressure on the State of Minnesota to pay my insurance company for this benefit. It worked, and after five months, I won ostomy supply coverage for all state employees, a coverage the state would pay for regardless of the insurance plan chosen. Four of our six plans previously covered ostomy supplies. The one I chose did not. I am now very out about my

ileostomy. No, I do not walk up to strangers and say, "Hi, I'm Barbara and I have an ileostomy."

But I do not hide it either. I mentioned it in my annual holiday letter when I had my surgery. When a coworker lost her dad to colon cancer, I offered my condolences. I noted that I understood a bit how difficult it was since I had started developing colon cancer and had to have my colon removed. "Oh, how can you live without your colon?" I said, "I have an ileostomy." When it is appropriate I discuss it. I am open to share my experiences with others and share how much better my life is now.

I would speculate that I am much more "out" than many of my fellow individuals with ostomies. I felt forced into that situation when I had to fight the State of Minnesota, and I am also a very self-disclosing person to begin with. Some people with ostomies tell only intimate family members. Others are out like me. Most probably fall somewhere in between. I am sure they have met a person with an ostomy but never even knew it. We are everywhere.

Ostomy Myth Nine

When people think of those who have an ostomy they think only old people have ostomies. I am going to be 36 in November. I am not that old despite what the teenagers think. I was 30 and living in Fargo, ND, working as the student organization and Greek advisor at NDSU, when my ulcerative colitis became so bad that my colon had to go. My WOC nurse arranged for four friendly visitors to see me before my surgery. I was going in for a J-pouch and temporary ileostomy, but as we know, came out with a straight shot.

Anyway, there I was lying in my hospital bed depressed and feeling sorry for myself. In walks one of the most beautiful young women I have ever seen. Even though it was late September, she still had a tan and sun-bleached hair. Young and perky, she wore tight jeans and strutted into the room as if she owned the world. She was carrying a lovely plant and said she was looking for Barbara. "That's me!" I said. She sat down and asked, "How are you doing?" "Been better," I said. I thought she was delivering the plant as a gift from one of the sororities or student groups I worked with at NDSU.

I was shocked when she said, "Your nurse Jill asked me to stop by to chat with you." "Huh?" I gasped. She said "Well, I was born without a bladder and I have had a urostomy since I was an infant. I am 23 now. What kinds of questions do you have?"

My expectation of an elderly, grandmother type of person with an ostomy was blown right away. Two of my other visitors were in their 30s and the fourth was in her early 40s. Two of them had their ostomies for years. Just as ostomies are needed to deal with a variety of medical problems, people with ostomies are represented in all age groups.

Granted, UOAA (United Ostomy Associations of America) studies have shown the average age of people with ostomies is increasing. The J-pouch and better cancer treatments have reduced the number of ostomy surgeries. But our population is still growing. There are still many of us, of all ages, who live with ostomies. I was surprised to learn about kids who have ostomies in childhood, but who are able to have reconstructive surgery or for other reasons are able to be reconnected later. When one of my former coworkers learned I had an ileostomy she said, "One of my sons had an ostomy when he was a little boy." Some people, like my friendly visitor in Fargo, spend their entire lives with an ostomy.

(To be continued in April)

Ostomy—The New Normal

Medications and an Ostomy

By Jill Conwill, MSN, CWOCN

There are a variety of forms in which medications are dispensed. Many of the medications are prescribed by a physician with the knowledge that their patient is a person with an ostomy. With the many specialists in the medical field, it is a good practice to remind your physician that you have an ostomy just in case the medication needs to be dispensed in a more digestible form. The following list of terms discusses some of the forms in which medications are dispensed and how they affect a person with an ostomy.

Chewable means the medication should be completely chewed. Any fragments left may be found in the effluent—stomal output. If you routinely chew all of your tablets or separate capsules, you may be looking for trouble. Many medications are not meant to be chewed.

Enteric coated tablets have delayed dissolution. These tablets have diminished or minimal effectiveness for someone with an ileostomy.

Gelatin coated medications are less effective than liquids if the person with an ostomy has short bowel syndrome.

Liquids are more rapidly absorbed. If you have difficulty swallowing pills, ask for the medication in a liquid form.

Sustained release medications take 8 to 12 hours to absorb. These capsules should not be chewed or opened—unless approved by your pharmacist. These capsules are designed to release slowly after they pass through the stomach, not before. Side effects may be exacerbated if directions are not followed.

Sugar coated tablets do not dissolve completely until the tablet reaches the ileum. Watch for traces of the tablet in the effluent.

Uncoated tablets begin to dissolve in the stomach. But, the complete time taken to dissolve may vary among different products. Always ask your pharmacists to be on the safe side.

Here are some special notes regarding certain medication groups.

Antacids use basic compounds, alkalines, which are used to reduce acidity of the gastric contents. Sodium bicarbonate–based antacids are high in salt. Magnesium-based antacids have a laxative effect, which means do not take them if you have an ileostomy, you irrigate, or you have renal failure. Aluminum-based antacids lengthen the emptying time of the stomach, inhibit the absorption of iron, are constipating, and increase the excretion of aspirin and similar products in urine.

Antibiotics may often result in diarrhea. If so, then increase your fluid intake. Antibiotics alter the normal bacteria found in the large intestine and may result in a fungal (yeast or candida) infection. The large intestine has either bacteria or fungus; it is never clean. Make sure you use a micro granulated antifungal powder under your barrier whenever you are taking antibiotics to fight off fungal invaders.

Antiflatulent medications like Gas-X help disperse and prevent gas. If the flatus is caused by foods, such as beans or broccoli, try a product like Beano.

Chemotherapy may cause gastrointestinal tract disturbances. If you are currently irrigating and diarrhea begins, stop until the stool regains consistency. Make sure you inform your doctor about all side effects, as well as any vitamins, supplements or medications you are taking. Many supplements react to chemotherapy.

Diuretics may cause fluid and electrolyte imbalances. People with ileostomies should not take these unless seriously researched by your doctor. If you have a lower colostomy and you irrigate, you may obtain poor results because your colon is dehydrated.

Laxatives should never be taken by a person with an ileostomy. Mineral oil should not be taken with a meal because it lengthens the emptying time of the stomach. Bulk-forming products like Metamucil must be taken with sufficient water or they cause constipation. The best way to control output is through diet. Natural laxatives like warm prune juice or adding fruits, vegetables and fluids to your diet are best.

Odor control can be obtained by medications that have a bismuth subgallate base, such as Deveron tablets. Chlorophyll is abundant in parsley but may be purchased in capsule form. It will turn the stool green.

Pain medications, especially those containing a narcotic, are constipating, so be sure to drink plenty of fluids.

Salt substitutes reduce sodium and should be avoided by people with ileostomies unless recommended by your doctor for your particular body chemistry.

Vitamins are often taken without consulting your physician. Always inform your doctor if you are taking vitamins. Some prescribed medications can interact with vitamins, resulting in ineffective absorption or causing adverse reactions.

When starting a new medication, ask about side effects on your ostomy. Most pharmacies include a list of actions and side effects with each prescription. If problems arise, call your physician so that the problem does not get out of hand. Communication with your doctor and your pharmacist always pays off in the end. Most doctors and pharmacists have to call the drug manufacturer about some medications because their absorption by someone with an ostomy may not be well documented.

Who Cares for the Ostomy?

From the Journal of WOCN

Who cares for the ostomy once it is created? This question is central to WOC nursing, but the answer remains surprisingly elusive for both WOC nurses and the surgeons who create ostomies. In a recent issue of the *Journal of Urology,* Tal and coworkers reported results of a telephone questionnaire administered to 65 adults who had undergone urostomy surgery 6 to 74 months prior to the study. The average time the participants has had their urostomy was 30 months. The article was titled, *Ileal Conduit—Who takes care of the stoma?*

Slightly more than half (52%) stated that they were independent when caring for their ostomy. Women were significantly more likely to report independence in self-care than men (85% vs. 44%). Independence in self-care was associated with higher quality of life and psychological impact scores.

Not surprisingly, multivariate analysis of factors associated with achieving independence in ostomy care included early education by an ostomy nurse. While this finding is not surprising, the comparatively low proportion of males in this study who professed independence in self-management emphasizes the need for every patient to have access to early and ongoing care provided by a WOC nurse.

Editor's note: Much of the research published by universities is only to fulfill the personal ambitions of authors who are required to publish something, anything, to keep their jobs. Although they use terms such as "multivariate analysis" (in this case it refers to the identification of critical design drivers and correlations across hierarchical level) that even the most educated readers do not understand, those of us who do understand know the weakness of the article. They are making a statement about a population of about 100,000 urostomy patients in the U.S. by using a sample of 65. This would produce mathematically accurate results under certain strict conditions required by the theory behind it. The Central Limit Theorem and its corollaries are the tools used to produce statistically significant results. Plus, these results should always be reported with a probability of correctness. However, one must satisfy the requirements of the theorem, namely, that the sample be obtained randomly. A perfectly random sample is virtually impossible to obtain in real life. A remedy is to obtain a larger sample size, say a thousand. The results of this survey were obtained by using a convenient sample; i.e., it was not obtained randomly. Therefore, it has questionable mathematical significance. We understand the difficulty in finding 1,000 urostomy patients. UOAA is probably the best source that represents all ostomy patients in the entire world. However, they are seldom, if ever, utilized for mathematically significant research. We do not understand the reasons UOAA and the WOCN do not work together to complete this research. Nevertheless, these nonscientific results are nice to view, for they may lead to broader research that does produce more probable inferences. Such research might show the direction in which the medical and support community can improve the quality of life for ostomy patients.

Peristomal Hernias

By Dr. Tom Miller

It was surprising to find that about a third of our group had developed hernias on one side of the stoma. The discussion started when a person with a new ostomy was asked if she had any problems. She answered, "Yes, I'm having trouble with those snap-on type pouches popping off the skin barrier because of the side pressure of a hernia."

She was using one of the high-quality four-inch wide elasticized hernia belts manufactured by New Hope, Inc. Another member had experienced the same trouble, and he stated that when using a snap-on pouching system the skin barrier stays on better if one does not use a hernia belt. This is odd because usually the exact opposite is true.

A senior member with a colostomy stated that his experience was that it was much better to use a one-piece drainable pouching system with a New Hope brand of hernia belt. The life of his skin barrier was about 4 days even with a hernia, depending on the amount of physical activity he did. When he bent over often—as when he played golf—it shortened the life of the skin barrier.

Q What is a hernia?

A It is a tear or break in a muscle that allows another bodily organ to enter. As the other organ enters—it is usually intestine—it produces a bulge next to the stoma. It may be painful, may be as large as half a grapefruit, may require surgery, and may develop into an emergency situation if left untreated.

Q Why do people with colostomies have hernias more often than people with ileostomies or urostomies?

A Because in hernias with colostomies, the opening created for the stoma is in the rectus muscle, which is easier for the intestine to push through. The hole made during surgery must be considerably larger to accommodate the diameter of the colon—about 1¼" for a colostomy versus ½" for an ileostomy. The inside diameter of the opening through the abdomen is less than the outside diameter (which the skin barrier covers) because the intestine is turned over on itself to form a stoma.

Q How can hernias in people with colostomies be prevented or reduced?

A Lifting heavy weights is the number one reason for hernias. A heavy, soft, non-muscular body is very hard to lift. Stress is placed on the inside of the abdomen, which initiates the pushing and tearing these tender muscles. Muscles that are weak or mostly fat tissue can easily tear.

Isometric exercises can help. These exercises not only help strengthen muscles, but they help close spaces between them. Walking is an excellent low-impact, isometric exercise that gently builds stomach muscles. Doing sit-ups is not recommended for any except the most physically fit. Sit-ups build muscles but do not close the spaces between them. Hernias may form in these spaces.

Five years after her colostomy surgery, for no apparent reason, one member developed a serious hernia. Another member developed a hernia six months after surgery as a result of carrying heavy travel bags. Warnings about hernias are given to ostomy patients before they leave the hospital.

Q Can hernias around stomas be repaired?

A Yes, with surgery. If the stoma is not moved, the operation is relatively minor, but the hernia may return. There are large numbers of artificial- skin products used to repair a hernia surgically. These are commercially available or in development. Visit AlloDerm® at LifeCell Corporation for details on the newest products. Products like these have substantial relevant evidence on efficacy.

Allograft acellular dermal matrix products, derived from donated human skin tissue, are supplied by U.S. AATB-compliant tissue banks using the standards of the American Association of Tissue Banks (AATB) and U.S. Food and Drug Administration's (FDA) guidelines. The processing removes the cellular components, i.e., epidermis and all viable dermal cells that can lead to rejection and infection. Acellular dermal matrix products from human skin tissue are regarded as minimally processed and not significantly changed in structure from the natural material; the FDA classifies it as banked human tissue and therefore it does not require FDA approval.

After one member lived with a hernia for 12 years, it was completely repaired by moving the stoma to the navel. This was a major operation but a great success for the patient. The navel is in the strongest part of the rectus muscles. Even though the skin surface is very uneven at the navel, immediately after the operation the patient could use a barrier without any problem. Now a pouching system is not necessary, although it takes her about an hour a day to irrigate.

Q Do hernias interfere with irrigation?

A Yes. It is more difficult to place a catheter or cone in the correct position with a hernia. It also takes longer to instill the irrigating water and longer for the bowel to empty itself.

One experienced member who had a hernia for 10 years needed over an hour to irrigate and even then it was done with difficulty. Now, after having the hernia removed, she finds it much easier to irrigate and needs only about 45 minutes.

Love you own soul, and comfort your heart, remove sorrow from you: for sorrow has killed many, and there is not profit therein.

Water

By Prometheus T. Peabody, NNBB

Water is important. A person with an ostomy especially needs to drink enough water. It is necessary when you want to take better control of your life. Along with a balanced diet and regular exercise, water helps provide good health for your body and mind.

Water keeps us fit. We all want to stay lean and avoid adding too much body fat. Dehydration slows down our metabolism, which reduces the number of calories we burn. Did you know that sometimes when we feel hungry it might just be we are thirsty? Next time instead of snacking, drink a bottle of water. You actually train your body to be thirsty. Drink water regularly and you will be thirsty more often. Your body will know when it needs water and will begin telling you if you train it correctly by drinking enough water.

Water helps prevent headaches, dizziness and cramping caused from dehydration. You can think and remember more clearly when you drink enough water throughout the day. Water distributes the chemicals our bodies need. Enough water distributes vitamins and minerals evenly and dilutes them enough for us to use.

Water helps us normalize our body weight. Water washes fats out of our bloodstream. If we start drinking about 3 liters of water a day, our weight will increase the first few days. Then, amazingly, our weight goes down sharply. The water we drink is washing the waste out of our bodies while making our metabolism more efficient. Fashion models that need to maintain extremely thin figures drink water so their tissues do not store it. Of course, just as important, we need strenuous exercise to move our blood through our veins to obtain these excellent results.

Water reduces itchy skin. It you have ever had itching around your pouching system—and we all do on occasion—try drinking a glass of water. People with ostomies are notoriously dehydrated. Our skin will become dry and itchy when this happens. People with new ostomies have the most trouble with itchy skin while their bodies adapt to their new life. Drink water to reduce itching and dry skin.

Water helps lubricate the joints in our bodies. Our skin will feel softer and smoother. Drinking water removes wrinkles and creases in skin. You will look better. The water we drink combines with nutrients in our body to create the oils and lubricants necessary for a healthy and good-looking body.

Water is especially helpful for people with ostomies in preventing kidney stones and promoting a healthy liver. When the kidneys are overworked because of inadequate water, the liver must assume some of the tasks of the kidneys. This is not good. Because minerals may not be removed from the kidneys, stones may form more easily. Simply drinking enough water helps prevent this condition. In addition, excess bile salts are metabolized and disposed of more easily. This assists many organs and body units to operate efficiently.

Water is an excellent remedy for a hangover, which develops partly because of dehydration. Drinking caffeinated beverages like coffee, alcoholic beverages, sodas and the like actually dehydrate some parts of the body. Drink more water after enjoying these drinks. You do not need to remove them from your diet; you just need to drink more water when you drink caffeine. Many beverages do add some liquid to our bodies, although much less than drinking pure water does.

Water fights fatigue. Many people have tiring schedules and by the day's end are exhausted. One cause of fatigue might be that we fail to drink enough water during the day. Make sure you always bring along a bottle of water. Drink water on the way to work, at work, at home, away from home, all the time. You will feel much more energized.

Water should be obtained from a high-quality source. Tap water should be used only in moderation. It contains toxic chemicals that in large quantities are poisonous to our bodies. Bottled water should not contain these toxins. Reputable water vendors sell high-quality water containing beneficial minerals, especially when drunk from a glass bottle. One of the easiest ways to be healthier quickly is to start drinking 3 liters (about seven 12-ounce glasses) of water throughout every day. We value each of our local ostomy support group members, and we value the good health of each one of you too.

Love is the root of all virtues

For our liability disclaimer and privacy policy visit
http://uoachicago.org/liability.htm

Ostomy Association of Greater Chicago

Confidential Membership Application

We invite you to join our association. You are especially welcome if you have an ostomy, are preparing for surgery, are a healthcare professional or have a loved one who has had surgery. We are a completely volunteer-operated ostomy support group. Our mission is to support, educate and advocate for people with ostomies.

Name _____

Address _____

City _____ State _____ Zip _____

E-mail _____ Phone _____

Type of Ostomy Colostomy Ileostomy Urostomy Continent Procedure

Date of surgery _____ Age group Under 21 22–36 37–50 51–65 66–80 Over 80

Attend one of our general meetings. There are always friendly people to talk with you. You may even want to participate in our association's leadership. We always need talented people to share in our good work. Membership is free (our funds come primarily through donations). Please mail this application to

Judy Svoboda, President
605 Chatham Circle, Algonquin, IL 60102
or e-mail information to uoachicago@comcast.net.

Bacteria in the Small Intestine

--Great Smokies Diagnostic Laboratory

Bacterial overgrowth of the small intestine can be a hidden, unsuspected cause of chronic bowel problems such as indigestion, bloating, abdominal pain, gas, and irregularity. Normally, far fewer bacteria inhabit the small intestine than the ample growth found in the colon. The secretion of gastric acids and the rapid movement of digested foodstuffs through the intestine (called "intestinal motility") normally keep the small intestine relatively free of bacteria.

A wide range of abnormalities and malfunctions, however, can encourage bacteria to multiply in the small intestine. There, the bacteria ferment carbohydrates, producing gases such as hydrogen and methane. These gases cause the gas and bloating seen in individuals with carbohydrate intolerance and, over time, can irritate the intestinal lining.

The most common cause of bacterial overgrowth of the small intestine is a decrease in gastric acidity or digestive enzymes, which creates an unsterile environment for the small intestine. Other possible causes of bacterial overgrowth of the small intestine are intestinal obstructions caused by Crohn's disease, adhesions, radiation damage, and lymphoma.

Treating bacterial overgrowth of the small intestine has been shown to significantly alleviate chronic symptoms such as diarrhea and abdominal pain in patients with irritable bowel syndrome (IBS). For this reason, healthcare experts recommend that a laboratory evaluation for small bowel bacterial overgrowth be performed in patients with IBS when indicated by their history.

The breath test for bacterial overgrowth of the small intestine measures breath hydrogen and methane gases in response to a lactulose challenge. Because both gases may be produced in the intestine, testing for both hydrogen and methane is considered more sensitive for detecting small bowel bacterial overgrowth than testing for hydrogen only.

Without proper detection and treatment, bacterial overgrowth of the small intestine can eventually cause health problems more serious than chronic indigestion. By inhibiting proper nutrient absorption, bacterial overgrowth of the small intestine can lead to systemic disorders such as altered permeability, anemia and weight loss, osteomalacia and vitamin deficiency.

The incidence of bacterial overgrowth of the small intestine increases with age, particularly in people aged 80 and older. Elderly patients may develop malabsorption secondary to bacterial overgrowth. Bacterial overgrowth has been suggested as the major cause of clinically significant malabsorption in the elderly and has been linked to the "failure to thrive syndrome" seen in older patients.

Editor's Note: Normally, there are 300–400 types of bacteria in the colon, at a concentration of roughly one trillion bacteria for every milliliter of stool. However, the small intestine should have less than 1,000 bacteria per milliliter of stool.

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514 Knox St.
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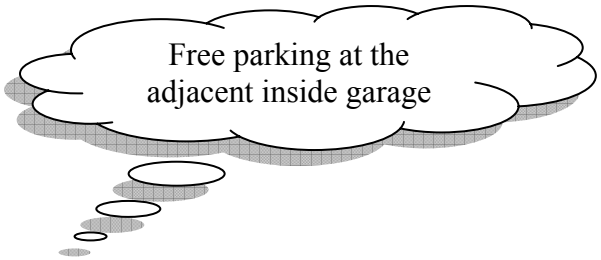

We invite you to attend our general meetings. Relatives, friends, doctors, and nurses, as well as our members—any interested people—are invited and welcome. Our association has a team of trained volunteer listeners available to discuss the concerns of patients. Healthcare professionals and families are urged to use this free benefit. When you know of a patient who would like to talk to a person who has been there and done that, please call the visiting chairperson (see page 2).