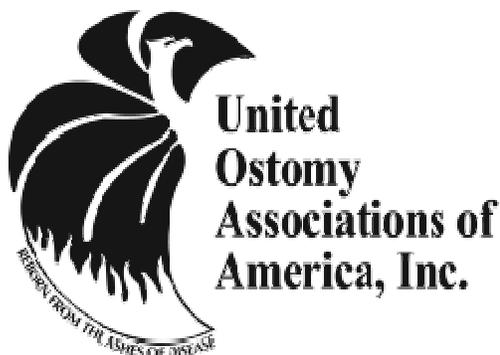


The New Outlook

United Ostomy Association of Chicago



July 2013

Meeting—Wednesday, July 17 at 7:30 PM

Lutheran General Hospital

Special Functions Room, 10th floor
1775 Dempster St., Park Ridge, IL

Board Meeting at 6:30 PM

Last Month's Meeting (our 432nd)

By Judy Svoboda

Although we were competing with the Blackhawks, many of us enjoyed our summer solstice picnic featuring a very educational and entertaining presentation by Madelene Grimm, WOCN. Madelene gave us numerous tips for traveling with an ostomy.

She told us the key is planning. We should pack at least twice as many supplies as we normally use and always pack powder, even if we do not regularly use it. High heat and humidity can affect the wear time of a skin barrier and peristomal skin issues can develop very quickly. Keep an emergency kit with you at all times. Make a list of product numbers should you need more while traveling. Plans change and emergencies happen.

Most suppliers can ship within one day. Ask your manufacturer if they have a local supplier at your destination. Whether traveling by car or plane, start your trip with a fresh, empty, pouching system. Be sure to continually hydrate and eat smaller meals more often. Good advice for everyone, not just those with ostomies. Be careful when eating new foods; try a small amount at a time. If you have not yet traveled since your surgery, you might want to try a short trip as a trial run to become accustomed to having an ostomy in unfamiliar surroundings. And yes, you can go swimming! Above all, do not be afraid; relax and enjoy.

Next month at our pizza party, we will be talking about and sampling some new products.

Our special guest will be Steve Vandevender from ConvaTec. He will highlight their extensive line of products and present many new items, including the much-anticipated new pouch. In addition, Patrick Bance from Byram Healthcare will discuss their services, including Medicare and private insurance billing. So be sure to arrive hungry—for pizza and information!

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.

We do not have storage space at Lutheran General Hospital. When you come to a meeting, you may want to volunteer to carry some of our supplies with you to each of our meetings.

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 have requests from public relations firms for our members to participate in focus groups about ostomy surgery. You will usually be paid for your time, but it may be as a volunteer. 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.

United Ostomy Association of Chicago

Established April 1975

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Nancy Chaiken 773-878-8200
Swedish Covenant Hospital

Terry Coha 773-880-8198
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Jan Colwell & Maria De Ocampo 773-702-9371 & 2851
University of Chicago

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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

Meeting Dates at Lutheran General Hospital

July 17—Steve Vandevender from ConvaTec plus Patrick Bance from Byram Healthcare

August—No Meeting (UOAA Conference)

September 18—Diane Zeek, CWOCN along with Otto the Ostomy Mannequin

October 16—A Plan for Something Special

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**, Evergreen Park, 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 LC7-8 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

August 8

October 10

December 12

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

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how easy it is to nick your gum with your toothbrush and cause it to bleed.

It is the same with your stoma. If you injure your stoma, it will bleed. If you take blood thinners or other medications, e.g., aspirin or aspirin-containing medication, your stoma may bleed more than normal.

If you have another condition, such as portal hypertension or cirrhosis of the liver or another liver condition, the stoma can bleed excessively. The rule to remember is that if you cannot stop stomal bleeding with 15 minutes or if the bleeding is excessive, you should seek medical attention immediately.

A Urostomy Experience

Forwarded by *The Magnolia Ostomy News*

I have been reading articles in the newsletter for a few years now. I had an unusual and awakening experience concerning my urostomy that I thought might be of interest to your readers.

I have had my stoma for four years now and have had no complications or problems. For the past six months, I have noticed that the skin around my stoma was white and irritated. I tried several different things to clear it up, such as changing to different brands of skin barriers, changing the skin barrier more often, drinking more water and cranberry juice, and using different powders. But nothing seemed to clear it up.

So, I just put up with it, hoping that once I had enough time at my new job, I could take time off and make an appointment.

While at work last Thursday, I went to empty my pouch, and it was full of bright red blood. I noticed two small blood clots. This got my attention, and I went directly to the phone and called the doctor who had performed my surgery four years ago. The nurse said she would leave a message for him and he would call me back. Meanwhile, I continued to work. I started dramatically increasing the amount of water I usually drink and had a couple of bottles of cranberry juice, thinking this would clear things up. After lunch, I again went in to empty my pouch and this time it was so full of huge blood clots that it would not even drain.

I became more scared than ever, and I called my doctor's nurse and told her that I had an emergency situation. I was told to go directly to the hospital where a urologist came in to look at my stoma.

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

Is Bleeding Normal for a Stoma?

By Gwen Turnbull, WOC nurse, Cleveland Clinic

It is normal to see a bit of blood on your washcloth as you cleanse around the stoma. The tissue from which the stoma is fashioned is very much like the lining inside your mouth. You know

When I took off the pouch, the blood had coagulated so thick that the doctor could not see the stoma.

He peeled off the skin barrier and blood was spurting from a severed artery next to the stoma. He said that because the skin around the stoma had such severe erosion, it caused the artery to rupture and break loose. He skillfully put in several stitches to close the artery. I had lost quite a bit of blood but not enough to keep me in the hospital.

I was told my urine would clear up later that evening, which it did. I took several days for me to become myself after the panic of what had happened. Because of this ordeal, I made an appointment with a WOC nurse. She told me that she recommends that people with urostomies wear a convex barrier or a Microskin pouching system made by Cymed. These are especially made to keep the urine from pooling around the peristomal skin area. In addition, she showed me how to use barrier seals and powders to complement my skin barrier.

I have also scheduled an appointment with my doctor to follow up on the excellent care provided by the ER urologist. The urologist told me that he rarely sees an artery burst like mine did. Obviously, he does not see many urostomy stomas.

Dealing with Skin Ulcers

Forwarded by The Evansville Indiana Ostomy Association

People with ostomies might experience some form of skin breakdown from time to time. However, skin ulcers, which are very painful, are not common.

A skin ulcer is an open wound; it can be close to the stoma or an inch or more beyond its base. Many people who have experienced skin ulcers are under the impression that the cement or glue on the skin barrier causes them. We have never found this to be true.

All cases of skin ulcers that we have seen have been due to wear.

- Belts worn either too loosely or too tightly
- Belts moving away from their original position
- A poorly fitting skin barrier

Although skin ulcers are not dangerous, they are painful. If they are neglected, they can take more than two weeks to clear up. If you are having problems with skin ulcers, see your doctor or WOC nurse to find the cause and cure as quickly as possible.

Latent Risk of Cancer

By Patricia Murphy, WOC nurse, Chicago

There have been clinical reports on adenocarcinoma of the ileostomy after surgery. This is a brief overview of an interesting case that came to my attention after researching the latent risk of cancer after colectomy for patients with ulcerative colitis and familial polyposis.

There was a person who had an ileostomy done for mucosal ulcerative colitis 29 years ago. She called and made an appointment to see me regarding some sore on her peristomal skin. When I saw the patient, the stoma looked almost like a double-barrel type instead of an ileostomy.

There was red, healthy looking mucosal tissue forming what looked like an extra stoma and smaller spots of this near the real stoma. I was surprised that she was able to use a skin barrier over all of this and that it stayed on for four days, even though this tissue was wet. I thought that perhaps leakage under the skin barrier had caused this condition; however, most of the skin looked fine.

I referred her to a surgeon who thought it might be excess granulation tissue. He treated the problem by cauterizing it with silver nitrate. The next week it looked worse and appeared to have a necrotic center. He biopsied it and it turned out to be adenocarcinoma of the ileum.

This is an extremely rare cancer. We could find only about two dozen cases that had been reported. They all had something in common: All of the patients had their stomas for a long time—an average of 24 years. They either had a history of ulcerative colitis or familial polyposis. Most of these cases were discovered in the last fifteen years. This may mean that there is a growing population of patients who have had their stomas for a long time. They may be at risk to develop cancer of the ileum.

It was suggested that the cancer develops in this way: First, the ileal mucosa changes to colonic mucosa, then to colonic dysplasia, and then to adenocarcinoma. These changes resemble those that occur when a patient who has ulcerative colitis for a number of years develops colon cancer. An annual evaluation of the stoma, looking for changes in the mucosal cells of the stoma (colonic metaplasia, inflammatory lesions consistent with ulcerative colitis, and dysplasia), is recommended.

The surgeon removed my patient's entire stoma and the involved skin. He made a new stoma on the

other side of her abdomen. This wide excision of the tumor should result in a complete cure. The patient did very well and went home after only a few days in the hospital.

A very good outcome for these cases can be expected with early detection and resection. The moral of this story is

- Do not become complacent about your stoma, even if you have had it for a long time.
- Do watch for changes in the way it looks and functions, and for changes in the peristomal skin.
- Do continue to see your WOC nurse to have him/her examine your stoma every year or two.

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Essential Tips for Ileostomies

- Do not fast. Fasting may lead to serious electrolyte imbalances, even when adequate fluid intake is maintained.
- Do not limit your fluid intake. Most people with ileostomies are slightly dehydrated due to the constant outflow of fluids, so maintaining fluid intake at all times is necessary.
- Do not completely eliminate salt from your diet. Salt is lost with the fluid outflow, about a teaspoon more a day than someone with a normal colon. Even those with high blood pressure should not eliminate salt altogether. Consult your doctor for his/her recommendation

on salt intake, especially when other physical conditions are present.

- Giving blood may not be prudent. Everyone with an ileostomy, due to the risk of dehydration, experiences an enormous stress on kidneys when giving blood. Serious damage may occur. Blood donation is a practice to be exercised with great care by anyone with an ileostomy.
- Do not put anything in your stoma without your doctor's direct supervision. Often, doctors give routine orders, i.e., for enemas, that will injure you. Question any procedure that intrudes upon the stoma, including suppositories.
- Do not take any medication unless you know it will dissolve before it would normally reach the colon. This is sometimes hard to find out even for a pharmacist. Be vigilant.
- During your annual checkup, be sure to discuss with your doctor your vitamin B-12 level and your bone density. He/she will order tests to evaluate these measurements.

Keep Mentally Healthy

Do Something for Others

Doing something for someone else is the best way to stop worrying about you. We are made to help each other. Unless you embrace this fact, you cannot achieve happiness for yourself.

Talk It Out

We tend to bottle up our feelings. Confide your worries to some mature, prudent person you can trust. The talking-out process has enormous value.

Work Off Your Anger

Let revenge wait for another day. It eats away at its possessor. Work off your pent-up energy by cleaning house, working at a hobby, taking a long walk or just doing anything you enjoy. It takes a calm head to handle a challenge in life properly.

Take One Thing at a Time

Do what is most expedient. Start with the most urgent; forget the rest until you get to it. Just remember the story about the man who could not break a bundle of sticks—until he took apart the bundle and broke them one at a time.

Escape for a While

Sometimes—if you are able—get away for a while. A change of activity, or scenery, or people helps provide some variety in your life. Getting away if only for a day is still a great boost to your attitude.

Go Easy on Yourself

Put an honest effort into the things you do. Be tolerant of your shortcomings. Nobody is an expert at everything. Nobody was given all the gifts. Be nice to yourself. You deserve it!

Internal Pouch, Continent Reservoir

By Wendy Sheridan, *Bladder Cancer Web Cafe*

A neobladder is a pouch that connects to the urethra so that natural voiding is possible. An ileal conduit is an abdominal stoma that drains into an ostomy system. Internal continent reservoirs are pouches and outlets fashioned from various sections of gastrointestinal organs, usually bowel segments. Some examples are the Kock, Indiana, Mainz, Miami, Studer and Mitrofanoff pouches. A catheter is used to drain urine from the pouch through an abdominal stoma. This is an easy and painless process. Irrigating the pouch using self-catheterization is necessary to prevent a mucus plug from forming.

Continent reservoirs are constructed in complex procedures with longer operating times as well as longer recovery times. They require intensive post-operative care and, compared with ileal conduits, are more likely to require further surgery.

Metabolic disturbances are common after continent urinary diversion. They can, however, be minimized through careful patient selection, vigilant follow up, and patient education to ensure adequate daily fluid intake and complete reservoir emptying. Patients should be aware of the potential complications, particularly at times of illness, when dehydration increases the risk. Physicians should be alert to the possibility of metabolic disturbance in this population.

The success of initial surgery and the need for follow-up surgery depends on the skill of the surgical team and the quality of the medical center. However, candidates for bladder reconstruction should be aware that complications such as scarring, obstruction of the ureters, chronic urinary tract infections and problems with self-catheterization could complicate recovery for both the continent reservoirs and the external conduit procedures.

The ileal neobladder is made from small intestine (ileum), and the outlet is the natural urethra. There is no stoma.

The Indiana pouch is made from the large intestine (ascending colon). The natural ileocecal valve is used, and the outlet is made from terminal ileum.

The Kock pouch has valves and an outlet made from terminal ileum.

The Mitrofanoff procedure (and variations) may use the bladder, large intestine, small intestine or a combination of these. The outlet is made from the appendix, a fallopian tube or a ureter.

A Bump on My Stoma

UOAA Discussion Board

Q I have had my ileostomy for about a year now. Everything is just wonderful since my surgery. However, I notice that I have developed a small bump, about 1/8 inch wide, on the side of the stoma. It does not hurt nor does it bleed, just a bump on an otherwise smooth stoma. Is this normal or do I have a problem?

A I want to take this opportunity to clarify the often repeated, albeit inaccurate, statement that stomas have no nerve endings and therefore feel no pain.

While the stoma may have diminished sensory nerve fibers, it is not true that the bowel has no nerve endings. There are different types of nerve fibers. Some of the nerve fibers scattered throughout the bowel regulate or respond to tactile stimuli and others respond to or regulate motor (motility) and hormonal functions. Normally, the stoma has diminished sensitivity to normal touch or painful stimuli across its mucosal surface. However, it still possesses other (motor) nerve endings that allow stool movement via peristalsis, and the obvious wiggling.

It is this apparent lack of sensory nerve fiber response that may allow a stoma to suffer injury without feeling the pain associated with the initial injury. A cut stoma is the classic example. However, the bowel, of which the stoma is a part, can feel pain when it is stretched, swollen or inflamed, for example, during an intestinal blockage or an acute flare of inflammatory disease. During these moments of distress, the bowel is quite uncomfortable (experiencing visceral pain) and the person will readily acknowledge painful distress.

I know I am drawing a fine point of distinction here; however, I do not want folks to continue to

repeat an inaccurate or misleading statement that the stoma feels no pain because it has no nerve endings.

Additionally, it needs to be pointed out that some folks may well experience a painful response to a stomal injury while others may not. It is not always clear to us why this is so. However, we cannot arbitrarily rule out a genuine source of the pain, be it physiological, psychological or both.

To answer your question, it depends on where the irritation on your stoma occurs. If the irritation is starting at the base of the stoma, you might have the wrong size skin barrier opening. If your stoma is still relatively new, you should re-measure it. If the size of your skin barrier opening does not fit your stoma, the effluent may irritate your skin. If the opening is too small, it may rub or cut the stoma, or create bumps.

Remember, if you gain or lose weight, the base of the stoma may change size. You may wish to use cut-to-fit skin barriers. Sometimes skin irritations are caused by pouching systems that are worn too long. The key is to observe the erosion of your skin barrier after you take it off. You may need to change the pouch more or less often.

There are other reasons for peristomal skin irritations and stoma bumps. If a rash is away from the stoma, it could be a yeast infection, contact dermatitis or an allergic reaction. You should consider making an appointment with your ostomy nurse to obtain an accurate diagnosis and find the source of the problem.

Mike D'Orazio, ET

A Message from WOCN Society

The following message is from our friends at the American Association of Nurse Practitioners (AANP). Please take action by contacting your federal representatives from the link below. Please note that you need not be a member of AANP to this take action. Nurse practitioners across the country are urging their members of Congress to protect Medicare beneficiaries' access to essential durable medical equipment (DME) by convincing the Centers for Medicare and Medicaid Services (CMS) to delay the scheduled July 1 implementation of new documentation requirements. AANP is talking with the agency and Congress about the problems caused by regulations that would require NPs, including WOC nurses, to get a physician to document that a face-to-face encounter with the patient had taken

place before commonly prescribed items including home glucose monitors, nebulizers and bed padding could be ordered.

The association is asking that enforcement of the new documentation requirement be postponed while the list of items covered by the policy can be reviewed. It is not too late to contact your members of Congress and urge them to tell CMS to delay the July 1 implementation of the DME documentation requirements. Visit the AANP Advocacy Center at <http://www.capwiz.com/aanp/issues/alert/?alertid=62722811> immediately and click on "Time To Take Action!" to urge Congress to stop restrictions on Medicare DME.

Thank you,
The WOCN National Office

Is It an Ileostomy or What?

Q I have a question that I think is self-explanatory; however, I had a discussion with a professional about this. I have an ileo-conduit loop (a urostomy) and a colostomy. Well, she kept calling the urostomy an ileostomy. I told her it is a urostomy, and she then said I should not say it is an ileo-conduit loop, that it is just called a urostomy. She said I could confuse medical staff because they would just assume I have a colostomy and an ileostomy.

I questioned her on how a person can have a colostomy and an ileostomy, and if there is even such a thing as that. Is this possible? I am just confused by all of this.

A Medical folks are not immune to using sloppy language or abbreviations to describe procedural outcomes. The term ileal loop or ileal conduit or Bricker's loop all mean the same thing surgically. They define or describe the surgical procedure in which a length of small bowel, in this case part of the ileum, is removed and the ureters—now disconnected from the bladder—are attached to one end (the closer or proximal one) of this bowel segment. This segment of small bowel conducts urine to the outside the body and into a collection pouch.

Now, here comes some technical correctness. The term *urostomy* is a somewhat sloppy generalization of any urinary diversion. The term *ileostomy* is also a bit of a sloppy catchall term. To be most accurate, one should specify what type of

ostomy they have. For example, an ileostomy, if meant to describe the classic one related to stool diversion, should be more accurately termed a fecal ileostomy. Conversely, if one uses the term *ileostomy* to mean a urinary one, then it should be described as an ileostomy for urine or a urinary ileostomy.

I believe the sloppy use of *ileostomy* to mean a urinary diversion arose among the urologists themselves. To them, any ostomy they do involving the small bowel (ileum) meant the Bricker's loop. So, blame the urologists for causing confusion.

To answer your other point, let us talk about having a functional stool ileostomy and colostomy. If the fecal stream is not completely diverted within the small bowel—whether it be in the ileum or higher up—and the patient has some fecal continuity with an ileostomy stoma and a colostomy stoma, then it is possible for stool to emerge from both.

There used to be a technique employed to decompress the bowel partially, without completely diverting the fecal stream, called a blowhole colostomy or even an ileostomy. This procedure was designed to relieve the excessive tension or pressure on the bowel, often done when the bowel was significantly distended.

Now as to why *ileum* is used to describe anatomical locations of organs, it is probably rooted in very early conventions used by the ancient practitioners of anatomy and surgery. The hipbone is anatomically defined as the ileus. The terminal small bowel is located near the hipbone. Thus, it is not much of a stretch to call that portion of the terminal small bowel the ileum. In fact, we name other bowel segments according to where they are located how they are shaped or in which direction the fecal stream travels.

The ascending colon received its name because it carries upward, on the right side of the colon. The transverse colon is the horizontal part of the colon. The sigmoid colon received its name because it is shaped like an S-curve, or, in Greek, sigmoid.

Some interesting information: removal of the rectum and anus, via abdominal and perianal surgical approaches, with formation of an end colostomy (in the descending or sigmoid colon) is typically called an abdominoperineal resection (APR) of the rectum. This is most often done for cancer of the rectum; however, any time the rectum is removed and a permanent ostomy is created, the term APR is accurate. The term for removal of the rectum is

proctectomy. Another example of surgical jargon for folks who have end ileostomies would be *pancoloproctectomy*. If one analyzes this word, "pan" means complete or total, "colo" means colon, "proct" means rectum and "ectomy" means removal. Put all these terms together and you have the total or complete removal of the colon and rectum.

A word ending in *ectomy* means the removal of an organ or body part. Hence, the removal of an ileum would be an *ileectomy*. If the jejunum were removed, then it would be a *jejunectomy*, and so forth.

When one has many resections of the small bowel, the terminology rules are complicated, so it is more appropriate to state that one has had many small bowel resections involving the [here you fill in the blank with the exact location and length of bowel segments removed].

Mike D'Orazio, ET

**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.

Adhesions

www.healthcentral.com

Definition

An adhesion is scar tissue that binds together two anatomic surfaces that are normally separated from each other.

Description

Adhesions are most commonly found in the abdomen, where they form after abdominal surgery, inflammation or injury. Lysis (destruction or dissolution) of adhesions is a surgical procedure performed to free tissues from adhesions. Although sometimes present at birth, adhesions usually form after inflammation. The most common site of adhesions is the abdomen, where they often form after peritonitis (inflammation of the abdominal lining) or following surgery, as part of the body's healing process.

Abdominal adhesions infrequently bind together loops of intestine, resulting in intestinal obstruction. The condition is characterized by abdominal pain, nausea and vomiting, distention and an increase in pulse rate without a rise in temperature. Nasogastric intubations and suction may relieve the blockage. If there is no relief, an operation is usually required to cut the fibrous tissue and free the intestinal loops.

Although scar tissue in the abdomen can form after any abdominal operation, it is more common after a ruptured appendix. Most adhesions cause no problems, but in about 2% of patients, they obstruct the intestine. These obstructions can occur several years later. Adhesions can also block the ends of the fallopian tubes, causing infertility.

Questions to Ask Your Doctor

- How do you know the problem is adhesions and not some other growth or condition?
- Is surgery recommended to remove the adhesions?
- What is the procedure?
- Will the adhesions redevelop?

Be Your Own Advocate

By Cathy Tomasik, *DuPage County Ostomy Association*

Most hospitals encourage patients to be advocates for their own health care. To help you, they offer the following suggestions.

- When you go to the hospital, bring a paper and pen to write down questions for your caregivers (doctors, nurses, etc.) as you think of them.

- Consider keeping a journal if your health care experience is extensive, involving many health care professionals over a prolonged period.
- Ask caregivers for their names and titles, and write them down.
- Ask what tests and procedures are being done and why.
- Find out when your doctor's rounds will be done and have a family member or friend there to listen to the information, to ask questions and to talk with after the team leaves.
- Before you sign any consent forms, make sure you read and understand them. Ask questions, such as what the nature of the procedure is and who will be performing it.
- Bring a list of all medications you have been taking at home. When it is time to go home, ask about and understand the normal or abnormal side effects of your procedure. (For example, how much pain to expect.)
- Ask for educational material on your condition, procedures and treatments. Ask how much you should do when you get home and what you will need help with.
- Ensure that you, your family, and your caregivers arrange for help. Ask about your home care options.
- Find out exactly what home care arrangements have been made and ask for the contact name and phone number. If something is not covered, make sure you plan for the help you need.
- Ask about your expected recovery time. Find out when you can return to work. If you or your loved ones do not feel you are ready to return home, state your concerns to your caregivers and ask for some time to discuss these concerns in detail.
- Ask about follow-up procedures. Find out what future appointments you will have and with whom. Ask if you should have a follow-up visit scheduled with your physician.
- If you need help resolving your concerns or want to give feedback to the hospital, call and ask to speak with the hospital's patient representative.

The ally of tolerance is knowledge.

Manners are minor morals.

New Documentation Requirements from Medicare

Forward By *Secure Start Newsletter*, Hollister, Inc., winter 2013

The Centers for Medicare and Medicaid Services have told us that they now estimate that they are losing billions of dollars to fraud and abuse each year. Fraud is someone billing for supplies or services that were not actually received. Abuse is doctors or suppliers who do not follow good medical practices, and it results in unnecessary costs.

As part of the ongoing effort to fight Medicare fraud and abuse and to ensure the products delivered to a beneficiary are still necessary new rules are being implemented. These rules may change the way your supplier processes your re-order for supplies.

Medicare clarified these rules in a recent communication to suppliers. Below is a summary of the main points of the communication:

- When products are supplied as refills to an original order, suppliers must contact the beneficiary within 14 days prior to dispensing the refill and it cannot be delivered more than 10 days before the current supply runs out.
- Suppliers cannot ship on a pre-determined basis, even if authorized by the beneficiary to do so. This shall be done to ensure that the refilled item remains reasonable and necessary, and that the existing supplies are approaching exhaustion.
- Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization. They must stay attuned to the unusual patterns and must verify with the physician that the changed utilization is warranted.
- The communication outlines specific reordering instructions for suppliers so there is no question what Medicare expects from them.
- If you have Medicare insurance coverage, or are angered if your supplier asks you for a count of the product you have left, they are only doing what Medicare requires of them. Medicare is only requiring this information in an effort to keep those lost billions of dollars in the trust fund for future use by the program.

It is never safe to consider individuals in groups, classes or races. To ascribe virtues or vices to all the individuals of a group is as senseless as it is unjust

Know When You Are Dehydrated

By Michael Blune, M.D.

The chemical composition of the human body is more than 50% water. Drinking adequate amounts of water is essential for maintaining adequate blood volume to flow to such vital organs as the brain and the kidneys. Also, it is important for maintaining optimal function in the cells of the body.

Dehydration can be defined as a significant decrease in the total water content of the body. It occurs when the rate of water intake, which is mostly by mouth, is lower than the rate of water loss through urination or from skin, lungs and gastrointestinal tract. When you lose a significant quantity of water, you may feel dizzy when you get up from sitting or lying down.

Why should you be concerned about becoming dehydrated? When you become dehydrated, you have less blood circulating and less blood flows to your vital organs.

Not only is reduced blood flow a major problem, but as you lose water, you also lose the essential minerals potassium and sodium.

If dehydration is mild, you might try to rehydrate yourself by drinking a salty broth, orange juice, sports drink, etc., but never alcohol or caffeine. Drinking these beverages may replace potassium and sodium electrolytes lost through perspiration, vomiting or diarrhea.

When should you seek medical attention for dehydration? If you are experiencing profuse diarrhea or protracted vomiting, if you are unable to keep down liquids, if you have a very high fever, or, most importantly, if you are unable to urinate, you must see a doctor. Immediate treatment should address the cause and replace the lost liquids and electrolytes, using intravenous liquids if necessary. If you experience any of the above symptoms, check with your doctor before complications develop.

It is most important for persons with ostomies to consume adequate amounts of water and avoid dehydration. Those with ileostomies are particularly subject to dehydration and should be most proactive in guarding against it.

and inaccurate. As a rule, the sincere understanding of another's nature precludes hostility. This holds good between nations and races, as well as between individuals.

United Ostomy Association of 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 <21 22–36 37–50 51–65 66–80 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 uochicago@comcast.net.

Pain from Effluent

Q Apologies in advance, I know this is gross to read about, but I am desperate. I am having problems with my output being so thick and paste-like that it sticks the sides of the ileostomy pouch together. It also stays up around the stoma without falling down into the pouch. This happens especially at night and wakes me up with excruciating pain every few hours.

It happens during the day when I am standing up, too, but at least then, I can keep more of a watch on it so it does not get quite as bad. I am disabled and at home all the time. The stoma cannot push the effluent down into my pouch. I have to move it manually. What am I doing wrong?

A We will assume that your stoma is not blocked, tight (stenosis) or twisted by strictures. If this is so, then you may wish to try the following techniques.

1. Leave a little air in your pouch after each emptying cycle so that the walls of the pouch are separated enough to allow the stool not to become readily trapped between the flattened walls of the pouch. However, this may not be as helpful as it sounds because of the very sticky

nature of your stool, what we professionals call an inspissated stool.

2. Have you considered using a larger capacity pouch? Some of the major manufacturers have large-capacity pouches, designed for high-output stomas, on the market now.
3. Hollister makes a combination pouch deodorant and lubricant (Adapt brand) that may allow the stool to slide down more easily.
4. Make sure your clothing and your sleeping position do not trap stool near the stoma.
5. Finally, you may want to review with your doctor, GI specialist or pharmacist whether some dietary or medication regimen might ease the passage of the stool out of the stoma.

Miké D'Orazio, ET

A sorrow shared is a sorrow halved.

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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).