The Mail Pouch

March, 2010 Newsletter

Ostomy Support Group EastValley/Arizona

Our next meeting: Sunday, March 21st – 2:00PM

Centennial Village 130 West Brown Road, Mesa, AZ 85201

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WELCOME NEWCOMERS:

Linda Ferguson ***(sorry about the acknowledgement delay, Linda)***

Janeen Hainrich, Billie Topping

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The February Meeting was well attended....69 people signed in and there are always some of us who forget to sign in! Bob Huber's Traveling with an Ostomy presentation is tops! The information is up-to-date and thought provoking. His hand-outs are useful. If you missed this program you missed a lot!

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Today's program will be interesting for those of us with diet issues and/or diabetic issues. Dr. Kim Olson-Gibbs is Certified in Bariatrics.

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Clip & Save: Meeting Dates Sundays at 2:00PM
Centennial Village 130 West Brown Road - Mesa, AZ 85201
April 25, 2010 May 23, 2010
Summer Break: No meeting in June and no meeting in July.

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50/50 Project: *At every meeting Ward (our friendly Greeter!) sells raffle tickets for 2 for $1.00 at the sign-up table. Half of the money collected is given to the Youth Rally. If your number is drawn you have the option to collect half of the winnings or donate your winnings to the Youth Rally. The lucky winner last month was Janis Hahn!*

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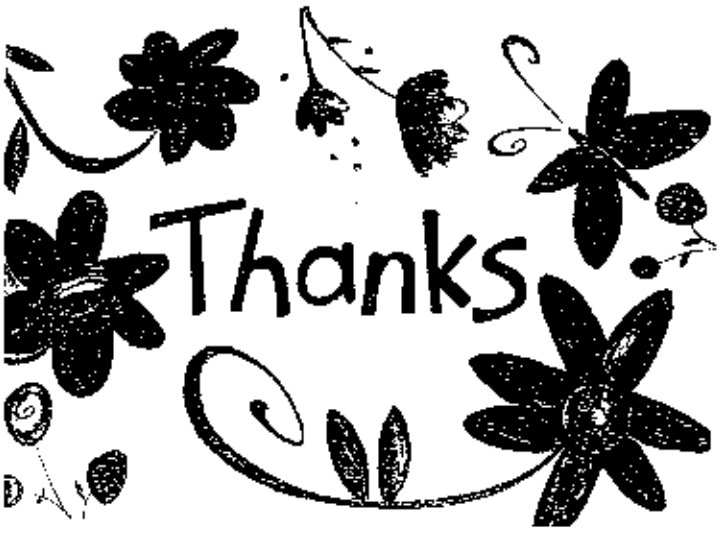
Members are invited to attend the monthly Board Meetings. The next meeting will be Saturday, April 10th at 1:00PM....the Board Meetings are held in the same place as our regular monthly meeting. Come to the meeting and let us know what you would like to see happen in our group....or volunteer to help us! We appreciate any constructive suggestions....."it takes a village to be a support group" !

A WORD OR TWO FROM YOUR PRESIDENT

We must be doing something right!! It was so good to see another great turnout to our February meeting. Happy to see our regular attendees as well as new faces. Sandy Clark distributed signup sheets for refreshments and we got a great response. Thank you one and all. It was embarrassing to run out of food in January and I think you all felt the same because this month we had more than enough. In case you don't know any member of our group is welcome to attend our Board Meetings. Perhaps if you did you could see how we function and realize what a great team we are therefore feel comfortable in joining our Board in various needed capacities. FYI the next Board Meeting will be Sat. April 10th at 1 pm at Centennial Village. I thank Bob Miller for joining us and working so efficiently on getting a website going for us. As I mentioned at the meeting, elections are coming up. There are some vacancies that have to be filled and so I ask that you please contact me or any of our Board members to serve with us. I will have duties of each committee program printed and available at the next meeting. I know there are many of you out there with special talents that we sorely need. Please help to keep us the exciting, caring group we are. As always we thank Ostomy Nurses, this time Angela Reboterra and Sandy Hall who were ready willing and able to answer your ostomy questions. We were fortunate to have had Bob Huber as our speaker on Traveling with An Ostomy. His concise organized presentation gave us hints on making travel easier. Many of these hints can be implemented in everyday use. We thank Bob for his passion in making ostomy life so much easier. A reminder, Centennial Village is a smoke free facility,-- smoking is not allowed anywhere on the premises. I look forward to seeing you at our next meeting where our speaker will be on Diabetes and Diet. Should be a good one! Please keep Florence Park's daughter Patty Coy in your prayers who once again is dealing with cancer flair up. Note that the meeting is early this month on MAR 21 so please mark your calendars accordingly. Until then, stay happy, healthy and enjoy the heck out of each day.

Love

Sheila



All our members appreciate the donations of Ostomy supplies...those we don't use are donated to a Mexican hospital. This month we thank Marcia Goldberg for thinking of us.

All the ostomy supplies on the stage are free to all members.
Take what you can use.

Ostomy Terms and Procedures

Learning the Lingo

UOAA UPDATE 2009

If you are reading this newsletter, chances are you or someone close to you has had an **intestinal** or **urinary diversion.** This is the broadest terminology for the types of surgeries we are all dealing with at various stages– whether just starting out or successfully managing for a number of years. Quite simply, our body's waste management system has been diverted or changed from its normal course. If you have an intestinal diversion, the way your body **excretes** (or passes) solid waste has been changed. If you have a urinary diversion, the normal flow of urine from the kidneys to the bladder has been interrupted. These two types of diversions can be further divided into two more subdivisions: **continent** and **incontinent diversions.**

Continent Diversion – a continent diversion is one where the elimination of solid waste or urine is controlled. The control is made possible through the creation of an internal **reservoir** (a man-made pouch inside your body) to hold the feces or urine. Elimination is then done through manually inserting tubing to drain the reservoir (**catheterization**). In the case of "pull-throughs" where the reservoir has been attached to the anus, elimination is through normal means.

You may have a Kock (or K) pouch; an Indiana pouch; a Barnett Continent Ileal Reservoir; or a pull-through such as J, S, or W pouch; an ileoanal (or pelvic) **reservoir**, or similar procedure. These are all considered continent (controlled) Diversions.

Incontinent Diversion – the elimination of either fecal waste or urine is not controlled in this type of diversion and requires the patient to wear a pouching system. Usually an **ostomy** is considered to be an incontinent procedure.

Ostomy – an ostomy refers to a surgically created opening in the body for the discharge of body wastes and allows for the formation of a **stoma.**

Stoma—the actual end of the small intestine (**ileum**) or large intestine (**colon**) that can be seen protruding through the abdominal wall and through which the feces or urine is discharged. The ideal stoma is round, dark pink and moist. The skin around the stoma (the **peristomal** skin) is intact with no breaks or cuts and no irritation. Not every stoma is ideal, though. Your own stoma may be **retracted, flush** or **prolapsed** and may require additional attention to manage properly.

Retracted Stoma—your intestine is pulling in and creating a concave effect, so that your stoma is below the surface of your skin. This may result in increased skin irritation.

Flush Stoma—the stoma is at the same height, or flush, with the surface of the skin. This also may result in increased skin irritation.

Prolapsed Stoma—the intestine is being pulled out of the abdominal opening, so that the stoma sticks out further than desirable. This can be uncomfortable and may cause the stoma to not work as efficiently.

Article continued

Article continued

Ostomy Terms and Procedures

There are basically three types of ostomies that result in the formation of a stoma: **colostomy, ileostomy** and **urostomy**.

Colostomy—A colostomy is created when a portion of the **colon** (large intestine) or the **rectum** (the portion just above the anal opening) is surgically removed and the remaining colon is brought to the abdominal wall. It may further be defined by the portion of the colon involved and/or its permanence

Sigmoid or Descending Colostomy—the most common type of ostomy surgery, in which the end of the descending or sigmoid colon (the portion that goes down the left side of your body) is brought to the surface of the abdomen. It is usually located on the lower left side of the abdomen

Transverse Colostomy—a surgical opening created in the transverse colon (the portion that goes across your body) resulting in one or two openings. It is located in the upper abdomen, middle or right side.

Ascending Colostomy—an opening in the ascending portion of the colon (the portion that goes up the right side of your body). It is located on the right side of the abdomen.

Loop Colostomy—usually created in the transverse colon. This is one stoma with two openings; one discharges stool, the second mucus.

Temporary Colostomy—it may have one or two openings (if two, one will discharge only mucus). Allows the lower portion of the colon to rest or heal. A temporary colostomy will be evaluated at some time to determine if the colon can be reattached (called a resection or reversal) or if the colostomy should become permanent.

Permanent Colostomy—usually involves the loss of part of the colon, most commonly the rectum. The end of the remaining portion of the colon is brought out to the abdominal wall to form the stoma.

Ileostomy—An ileostomy is created when a lower portion of the small intestine, the **ileum,** is surgically brought through the abdominal wall to form a stoma. Ileostomies may be temporary or permanent and may involve removal of all or part of the entire colon.

Urostomy—This is a general term for a surgical procedure which diverts urine away from a diseased or defective bladder. The most common urostomies are the **ileal** or **cecal conduit** procedures.

Ileal Conduit—in this procedure a section at the end of the small bowel (the **ileum**) is surgically removed and relocated as a passageway (conduit) for urine to pass from the kidneys to the outside of the body through a stoma. It may include removal of the diseased bladder. Another common name is the ileal loop.

Cecal Conduit—in this procedure a section at the beginning of the large intestine (the **cecum**) is surgically removed and relocated as a passageway (conduit) for urine to pass from the kidneys to the outside of the body through a stoma. It may include removal of the diseased bladder. Another common name is the colon conduit.

A word about the perineal wound:

If you had your rectum and anus removed as part of your ostomy surgery, you have what is called a perineal wound, a gap in your perineum. This wound is often neglected in the care and management of patients with colostomies and ileostomies, since most of the attention is devoted to the stoma. As a result, many ostomates are not prepared to deal with the perineal wound. Doctors and nurses tend to explain the ostomy and the need to remove the rectum, but rarely mention the "hole" left after the rectum and anus have been removed, and what to do with it and how to take care of it.

The perineal wound is bounded by the pelvic bones. It is different from other wounds which just simply grow together (often after having been stitched), since it is important that the wound heal from the inside out and thus be filled with tissue. Healing may thus take considerably longer than 'normal', the healing time ranging from two months to even a year.

While you are waiting for the wound to heal, it may be more comfortable to sit on a soft cushion. But do not use a donut cushion! It has the tendency to pull the skin outward, putting more strain on the area, causing pain and slowing down the healing.

Sitz bath can be both soothing and helpful, stimulating the blood circulation in the area.

Ostomates may experience a need to evacuate the rectum, even though it has been removed. Some ostomates experience such urges while irrigating. Such phantom sensations are the result of nerves, that have enervated the rectum and were responsible for rectal continence, continuing to function, even after removal of the rectum. Often changing position, or sitting on the toilet for a short period of time may relieve the symptom temporarily.

Pain in the perineal wound area during the first year after surgery may be significant. It could indicate an infection of the wound. There may be healing at the skin level, but abscesses may be forming below. Ostomates with persistent pain should see their physician.

Thank You, San Gabriel Valley, CA, Laguna Hills, CA, Hemet-San Jacinto, CA The Right Connection, CA newsletters

TYPES OF UROSTOMIES

Urostomy is the general word for any type of urinary ostomy. There are, however, several types of urostomies. Some people have ileal conduits. In those cases, a piece of ileum (the third portion of the small intestine) is removed from the intestinal tract and the two ureters (tubes that carry urine from the kidneys to the bladder) are attached to the portion of the ileum. One end of the ileum is stitched closed and the other end is brought out into the abdomen as a stoma. Very often, people who have ileal conduits think that they have an "ileostomy" because health-care personnel often incorrectly call this surgery an ileostomy. Remember that if the urine is coming through your stoma, you do not have an ileostomy.

Sometimes the ileum is not used, and instead, a piece of the large intestine is used, usually from the sigmoid colon. In this case, the surgery is called a colon conduit.

Urostomies are formed for many reasons In adults, the surgery is most often done to remove a cancerous bladder. For people with spinal cord problems, a urostomy of one sort or another may save someone from irreparable kidney damage. Sometimes after urostomy surgery, a bladder may be left in place, but if the bladder is diseased, it is usually removed.

Drinking fluids is essential for urostomates. Kidneys are happy when they have lots of work to do. Show me someone who does not produce much urine and I'll show you two unhappy kidneys! Drinking water may be the single most important thing that a person with a urostomy can do.

Urostomies are the most complex of the three major types of ostomies. They can be found in all age groups. They are performed for more varied reasons than the other two categories, and they can present incredibly complex problems, but when they work right, they are winners!

Remember, an ostomy is a cure, not a disease!

ATTENTION NEW OSTOMATES: 3 issues of our newsletter will be mailed to new ostomates whose names we receive. If, after that time you have not indicated your desire to join our chapter, and thereby receive the newsletter as a benefit of membership, the complimentary subscription will lapse. We will assume you are not interested in our support group but sincerely hope you will join one of the many support groups in the valley. Every ostomate needs as much information on their ostomy as they can get! A membership application form is located in every newsletter.

Visitation Report:
1 referral:
Ileostomy - Female

Referred by: Bobby King
Visitor: Kaye Shemorry

For Visitors or Phone Contacts please contact Bobby King at 480-218-4658

Sunshine Report:

Nothing to report this month.

Please call Marilyn Justice at 480-982-4862 if you know someone who would appreciate a card.

Officers & Board of Directors:

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Vice President: Vella Owens 480-657-6464
Secretary: Allison McBride 480-988-9093
Past President : Gloria Rose 480-596-5661
Acting Treasurer: Paula Nelson 480-276-3436
Director: Juanita Frankenstein, 480-833-1932
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Member-at-Large: Andrea Pinsker 480-945-7322
COMMITTEE CHAIRS:
Visitation: Bobby King 480-218-4658
Programs: Vella Owens 480-657-6464
Greeter/Sign-in: Esther & Ward Beall 480-983-6584
NL Editor: Kaye Shemorry 480-699-9590
NL Circulation: Sandy Clark 480-835-1338
Sunshine Lady: Marilyn Justice 480-982-4862
Refreshments: Florence Park 480-964-8953
Publicity: Marilyn Justice 480-982-4862
Advocacy: Sheila Kollenberg 480-451-3815
Advertising: Gloria Rose 480-596-5661

To all who receive our newsletter: Please understand that some articles are repeated for the benefit of new ostomates.

ET ADVISORS:
Banner Desert Medical Center (Dobson)
Wound/Ostomy Clinic 480-512-3449
Janet Schmidbauer, RN,BSN,CWOCN
Elaine Fox, RN,BSN, CWOCN
Angela Rebottaro, RN,BSN,WOCN
Banner Baywood Medical Center (Power Road)
Wound/Ostomy Clinic 480-321-4642
Miriam Jensen, RN,COCN,CWCN
Sandra Lane, RN,COCN,CWCN
Karol Friend, RN,COCN,CWCN

?????? Got Questions ??????
Call the manufacturer directly.
Ask for the Customer Service Dept.
They will also send free samples.
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HOLLISTER... 1-888-740-8999
KEM.....1-888-562-8802
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