February 2006 Volume 8 Issue 2

The Mailbag

Meetings are held at the Baptist Medical Center
8th Floor - Meeting Room C - 3rd Sunday of each month 3PM

Contact:
Patti Langenbach
(800)741-0110 or
(904)733-8500
patti@ostomymcp.com

Brenda Holloway
282-8181

Inside this issue

Bladder Cancer……………………….....2-3
Wound Management..…………………...3
Colostomy General……......…………..3-4
Ostomy Chat Room
Weekly Meetings……...……..….......…..5

Please plan to join us Sunday Feb. 19th starting at 3 p.m.

Medical Care Products, Inc
Toll Free 800 741-0110
WE ARE ON THE NET
www.ostomymcp.com

OSTOMY SUPPORT GROUP

In February, we will be having our meeting at BAPTIST MEDICAL CENTER. We had discussed having it at Patti's office but due to unforeseen circumstances we are unable to do so this month. Next month, (March 19, 2006), we will be having CONVATEC as our guest speaker. So I hope that we have a good turn out that month.

For our April (the 23rd) meeting I am in the process of trying to get a rep. from Coloplast. The month of May (21st), I have Hollister scheduled as our guest speaker. I just want everyone to know that out of all I do for the Support Group, this is the hardest job getting someone to speak at our meetings. So, please bear with me when I don't have anyone. I still like for people to show up for support if any new ostomate come.

We will be having a meeting on January 15, 2006 at 3:00 p.m. at Baptist Medical Center, 8th Floor, and Function Room C.

We are going to continue this year collecting the pop tabs for the Ronald McDonald House. We are going to see if we can fill a gallon jug by the end of the year again. In 2005 we filled a gallon jug up. We will collect these at every meeting or you can drop them off at Medical Care Products.

Also, please remember if you have any extra supplies that can be donated to our closet for those less fortunate and or to help individuals during the hard time or in between insurance companies. Either bring to a meeting or take them to Medical Care Products or call Brenda Holloway and she will arrange to pick them up at your home, her number is 422-8165. We appreciate all you do for our closet.

Only meetings that are changed this year due to holidays are the following:

April = April 23, 2006 due to Easter***June = June 25, 06 due to Father's Day**

I would like to dedicate this paragraph to Ronald Perry, who passed on January 7, 2006. He kept the UOA going when they were going to fold. He believed in the UOA and that it was important to him that we keep this group up and running. When I came along we worked together to keep things going. I told him that if anything every happened to him I would keep it going. He felt it very important to get the word out that there is a support group for ostomates in Jacksonville and the surrounding areas, they don't have to deal with this alone. Therefore, we will keep his wish, by keeping this group going even if for some reason one of the months no one shows up. But like he would tell me, you never know then a new ostomate will show up. Please keep his family in our prays.

Thank you for your time,
Brenda L. Holloway, Support Group Contact

BLADDER CANCER

Bladder Cancer

Cancer appears in the bladder more often than in any other organ of the urinary system. One of the more common forms of cancer among men, bladder cancer incidence is nearly four times higher in men than in women. It occurs after the age of 50 about 90 percent of the time.

Cancer of the bladder has one outstanding and readily detected sign—blood in the urine. Fortunately, this sign usually appears while the cancer is still in its early stages when it may be treated most successfully.

Most people with blood in the urine do not have cancer—urinary infections also may produce blood. But, it is an important warning sign that warrants investigation at the earliest possible moment.

Blood in the urine is not always a bright red color. If it is present in small quantities, the urine may appear to be merely "smoky" or "pink" in color. But any change from the usual appearance of urine should be investigated promptly.

Do not be misled if the bleeding occurs only once and then stops. It often appears intermittently; therefore, a single appearance warrants a visit to your doctor. Regardless of the treatment you receive, the earlier you see a doctor, the better are your chances for a cure.

Bladder cancer is diagnosed by an examination of cells in the urine and examination of the bladder wall with a cystoscope—a medical instrument with a tiny lens and a light, which enables a physician to examine the interior of the bladder. The patient is given a mild anesthetic so that he/she is comfortable and without pain during the procedure.

A small piece of tumor is taken and submitted to a pathologist for examination to confirm diagnoses. A urine test is also administered, and a microscopic examination is made.

Usually the cancer is controlled without surgery by scraping the cancer out of the bladder or by implanting radon. Radon—a gas—is a cancer-killing radioactive agent that has been extracted from radium. It is enclosed in a gold capsule and placed in the bladder.

Regardless of treatment you receive, the earlier you see a doctor, the better are your chances for cure.

____

New Test Saves Lives

Bladder cancer, a killer disease notoriously difficult to diagnose, can now be detected with 95 percent accuracy by a new test for abnormal genetic material in the urine. The test could mean early treatment for thousands of patients, say researchers. Dr. David Sidransky of Johns Hopkins University School of Medicine said, "The simple urine samples can be analyzed for the presence of abnormal DNA, a telltale sign of cancer." The DNA abnormality appears at a very early stage—a time in the disease process when there is a high likelihood of cure. Researchers report the pilot study using the new test detected 19 to 20 patients with bladder cancer. Current bladder cancer tests detected less than half the patients with the disease. Dr. Carlos Cordon-Cardo, a bladder cancer expert at Memorial Sloan Kettering Cancer Center in New York said, "The new test is very important in saving lives. Labs now find only 20-30 percent of bladder cancers in the early stages."

____

Reliable Screening For Bladder Cancer

A protein called Survivin is made in detectable quantities only by cancerous cells. Researchers measured Survivin levels in urine of 158 patients, some of whom had already been diagnosed with bladder or other type of cancer and some of whom were cancer free. Survivin was present in the urine of all the patients with bladder cancer, but not in that of healthy participants or in that of people with other types of cancer, whose cancer cells may have been making Survivin, but not releasing it into the urine. The cancer marker was also present in the urine of 4 out of 50 people with precancerous urinary disease, but 2 of them later developed bladder cancer.

____

Tumors and the Bladder

Most tumors of the urinary bladder are malignant. They are likely to develop after the age of 50, and men are more susceptible than women. At least 95 percent of these tumors are carcinomas or papillomas. These cancers are unique, especially papillomas.

When the first tumor is removed, another develops months or years later. It is a new lesion and likely to be more malignant than the first. And this type of recurrence may happen over and over again. This is why urologists insist on looking into the bladder every three to six months after the first neoplasm is removed.

Tumors are increasing. The incidence of bladder tumors is increasing among our population. In 2002, an estimated 56,500 new cases will be reported. Overall, bladder cancer incidence is about four times higher in men than in women. On the other hand, the death rate has not risen due, perhaps, to improvements in early diagnosis and treatment.

Cancers of the bladder may grow for varying periods of time without producing any symptoms. They are always suspected when the individual suddenly, and for no apparent reason, urinates blood. Should this painless, but serious, sign develop, consult your physician without delay. He may recommend a urologist who will try to find the source of the bleeding.

If nothing is done about the sudden bleeding, it may stop spontaneously. However, signs of bladder irritation and infection may soon ensue with frequency, urgency, and difficult and painful urination.

Diagnosis is made by looking into the bladder with a cystoscope and doing a biopsy. With this procedure, the surgeon determines the size, shape, and location of the tumor. In some instances, the top of the lesion has sloughed off, leaving a bleeding ulcer. A pap test of the urine may reveal cancer cells. X-rays of the kidneys and an examination of the prostate gland complete the study.

Some vesical tumors can be removed with electrocoagulation or cutting electric currents inserted through the opening in the scope. Radon seeds can be inserted in the same way. Serious lesions require abdominal surgery, which involves removal of part or all of the bladder.

(T.R. VanDellen, M.D)

———

Urine Test For Bladder Cancer

Scientists at the National Cancer Institute (NCI) have developed a relatively simple urine test that shows promise of detecting bladder cancer at an early, potentially curable stage. Currently, diagnosis and follow-up of this common cancer entails invasive and often painful procedures, and some cases are not discovered until after the disease has spread and can no longer be cured.

The new test could make it feasible to test patients when there is even a slight suspicion of bladder cancer and could make it much easier to monitor bladder cancer patients for recurrences following treatment. More than 46,000 people develop bladder cancer each year in the U.S., and many of these cases recur despite treatment. The five year relative survival rate for bladder cancer patients is 77 percent.

Clinicians praise both the simplicity and the specificity of the proposed urine test, which works by detecting a protein known as autocrine motility factor (AMF) in the urine samples of patients. AMF is secreted by cancer cells and induces movement of these cells. The substance plays a key role in enabling cancers to spread locally and to metastasize to distant sites.

Ultimately, the scientists hope to modify their assay so that it can be used to measure AMF in the blood, making it possible to detect cancers from all parts of the body.

WOUND MANAGEMENT

The Perineal Wound

If you are a new ostomate and had your rectum and anus removed as part of your ostomy surgery, you will have what is called a perineal wound, the area of the perineum where the anus and rectum used to be. This area requires a great deal of care and attention and can be quite tender for a long period of time. - You may feel like you will never be able to sit comfortably again, and eating and watching TV while standing up is no fun!

The area may take a long time to heal, because it takes a long time for scar tissue to fill the opening. The amount of time can vary from two months to more than a year, depending upon the individual circumstances. This area does not usually have a good flow of blood that is necessary for quick healing!

It is very important that the outer part of the wound does not heal before the inner part, lest abscesses and fistulae may form. Fluids may accumulate in these areas, forming pockets, allowing infection to set in. Some surgeons pack the wound with gauze and leave it open to allow healing from the inside out. Other surgeons believe that the skin should be stitched together. This requires drainage tubes and the use of absorbent pads.

While you are waiting for the perineal area to heal, you may be more comfortable siiting on a soft cushion. It is not a good idea to sit on a "doughnut cushion" because it causes the skin to pull outward, putting more strain on the area and causing pain. Stretching the area can also slow down the healing.

Sitz-baths can be both soothing and helpful. Park your derriere in warm water. Not only is this pleasant, relaxing and comfortable, but it can stimulate the blood circulation for better healing. To further reduce the healing time, keep the area clean. Use a hand-held shower spray twice a day for ten minutes (or as directed by your doctor). To avoid infections, follow doctor's order to a "T."

COLOSTOMY–GENERAL

Colostomy

What is the difference between a descending colostomy and a sigmoid colostomy? These ostomies are named for the area of the large intestine where they have been created. Our large intestine consists of four parts: The ASCENDING, moving up on the right side of the abdomen; TRANSVERSE, running along the waistline; and DESCENDING, heading downward on the left side. At a point about three-quarters of the way

down is the SIGMOID which connects to the rectum (or the last ten inches of the large intestine). Colostomies may have permanent or temporary stomas. The opening may also be a double barrel, which is two separate openings or may be a loop. In loop ostomies, a loop of the intestine is brought out of the abdomen and is held in place with a rod. The most common type is the end stoma, which has a single opening.

The consistency and form of the feces depends on how much intestine is left in the body. Since the purpose of the large intestine is to remove liquid from the fecal material, the further along the intestinal tract the stoma occurs, the more formed the material. Feces form an ascending or transverse colostomy will be loose and watery, without form. Feces from a descending stoma will be soft-formed to formed. The sigmoid stoma located lower in the bowel will generally result in a more solid, formed type of bowel movement.

Previous bowel habits play a major role in bowel function after surgery. If you have loose stool prior to surgery, chances are good that you will have loose stool after surgery regardless of stoma location.

(JoAnn Mok, LPN, ET)

Colostomy & Constipation

Way back before surgery, did you go to the bathroom after a hot cup of coffee, milk cold juice, bourbon or beer? Well, whatever made you feel that need then can make you feel the need now. Check it out. See if your irrigation can be helped by some of the things you used to do. Of course, if you have had colostomy surgery for a number of years, your previous habits may not be the same now. Your body can, however, be trained as it was before, and you can adapt yourself to certain habits which can help you to be in control.

A glass of hot water or juice, or a cup of coffee before a morning irrigation may initiate gut reaction. Also, a glass or two of water after the water return starts is usually helpful. If you irrigate before going to bed, a glass of ice water or a cup of hot coffee should get you started. If you have not drunk much water during the day, it would be wise to drink an extra glass or two to make sure your tissues will not absorb so much or you may be left with little or no return.

But what if you do not irrigate? Part of the difficulty in elimination of waste matter experienced by colostomates is due to lack of bulk in the diet. Consumption of white bread, pastry and highly refined foods does not provide the roughage and bulk necessary for proper evacuation of the colon. The deficiency can be overcome in part by the simple addition of bran to the diet. Bran can be made into muffins. Add raisins and molasses to taste.

Diet. There is no such thing as a colostomy diet. A colostomy is not an illness, so try to eat the same foods you have eaten and enjoyed in the past. If you are on a diet for a condition such as diabetes or high blood pressure, of course you should stay on this diet. Foods can be acidic or alkaline, bland or spicy, laxative like or constipating. Individuals react differently to food. Try to return to your formal, normal diet; those foods, which disagreed with you in the past, may still do so. Chew well and see the effect of each food on your colostomy output.

To maintain good health, the body requires carbohydrates, proteins, fat, minerals, and vitamins. Water is not nutritious but is absolutely necessary. Having a balanced diet is a fitting way for people to maintain good nutrition and keep bowel activity normal. Every day your body needs meats or fish, dairy foods, vegetables and fruits, cereals and bread, and liquids. Talk to your physician or ET nurse if you have problems.

Colostomy Bowel Control

Patients with a right-sided colostomy do not have as much remaining colon as those with a left-sided colostomy. Because of this there is usually too little colon left to absorb enough water to make a solid stool. This type cannot be controlled by irrigation, but instead behaves very much like an ileostomy with a fairly continuous discharge. The left-sided colostomy is often described as a “dry colostomy” because it discharges formed stool. One has the choice of attempting to manage this type either by trained control or irrigation control.

Only one-third of the people who attempt to train themselves to control the colostomy without irrigation are successful in doing so. This type of training relies very heavily on diet and medication to achieve regularity. Many physicians in this country feel that control is more easily and satisfactorily achieved by irrigation.

However, there are some patients who can’t achieve irrigation because they have an “irritable bowel." This problem has nothing to do with the colostomy. It is just part of some people's makeup. Some people, even before they have their colostomy, may have very irregular bowel habits. They retain these habits after the colostomy is performed, so that regular irrigation does not assure them of regularity. When this condition exists, the physician will sometimes suggest that the patient dispense with irrigation since it will not produce the desired regular pattern, and the person may become frustrated trying to achieve this. In this case, once again the colostomy is treated much like an ileostomy with the wearing of an appliance all of the time.

Ostomy Chat Room Weekly Meetings

Yahoo Peoples with Ostomy2* - Mondays, 8:00 pm US Central time
http://clubs.yahoo.com/clubs/peopleswithostomy2

StuartOnline Ostomy Chat* - Tuesdays, 8:00 pm US Central time
http://www.stuartonline.com/id10.html

Community Zero (Ostomy) Support* - Wednesdays, 9:00 pm US Eastern time
http://groups.yahoo.com/group/ostomatessupport/

Shaz & Jason's Chat* - Saturdays, 8:00 pm UK time / 3:00pm US Eastern Time
http://www.ostomy.fsnet.co.uk/chat.html

Yahoo UK Ostomy Support* - 1st & 3rd Sundays, 8:00 pm UK time / 3:00 pm US Eastern Time
http://clubs.yahoo.com/clubs/ukostomysupport

Use this form to join our chapter! **You do not have to be an ostomate to be a member and/or support the work of UOA. All information on this form will be kept confidential.**

Name____

Address ____

City ____________________________________State _________________Zip ________________________

Phone# Home _________________________________ Work# ____

Email Address ____

Type of intestinal or urinary diversion: Colostomy __ , Ileostomy __, Urostomy __, Ileoanal Pull-thru __
Continent Ileostomy __, Continent Urostomy __, None __, Other __

You may use my name in chapter Newsletter & Directory: Yes __ No __

Mail to: Patti Langenbach, PO Box 10239 Jacksonville, FL 32247-0239

Medical Care Products, Inc
Toll Free 800 741-0110
WE ARE ON THE NET
www.ostomymcp.com

Medical Care Products, Inc
PO Box 10239
Jacksonville, FL 32247-0239

TO:

**Join us
Sunday Feb.
19th starting at
3 PM**
**Baptist Medical Center
8th Floor
Meeting Room C**

Medical Care Products, Inc
Family owned an operated for over 40 years
Call For Free Catalog
800 741-0110
We accept Medicare Insurance Assignments

Visit Our Web:
www.ostomymcp.com