

The Mailbag

The Ostomy Support Newsletter Of Jacksonville, Florida

Support group meets the 3rd Sunday of each month 3 p.m. 4836 Victor Street

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SPRING



Next chapter meeting will take place on
Sunday Sunday March 18th
Come join us!
3PM 4836 Victor Street
Speaker TBA



Jacksonville Chapter is a member of the United Ostomy Association of America.
Please take the time and visit their Website <http://www.ostomy.org>.

Public TV Documentary Movie

UOAA entered into a contract for the publication of a five-minute ostomy public awareness movie that will appear on public TV; the National Medical Report as shown on cable; network and international TV as part of Voice of America.

This excellently produced project—coordinated by UOAA President Elect Kristin Knipp—can now be viewed on the UOAA Internet site at www.uoaa.org/uoaa_psa.shtml. One may also view the movie at <http://uoaa.wordpress.com/>.

We encourage you to send one of these links to anyone with an interest in ostomy surgery; i.e., our members, local medical professionals, family and even friends who you might want to have better understanding about our organization.

Urinary Diversion: Past, Present and Future

By Jerome A. Green, MD

Extraordinary advances in the field of urinary diversion have been made in the last twenty years. Presently, many methods of diversion exist. The evolution of urinary diversion is intriguing and enables superior treatment options for bladder disease.

The urinary tract consists of the kidneys, ureters (the tubes allowing urine to flow from the kidneys and into the bladder), a bladder and a urethra (the urinary outlet). Kidneys filter wastes, water and salts from the blood, resulting in urine production. The bladder stores the urine until it is voluntarily emptied through the urethra and out of the body.

Urinary diversion, first described in 1852, is a surgical technique that diverts urine away from the bladder. The reasons for bypassing the bladder include bladder cancer, disease, trauma, birth defects and bladder removal (cystectomy). Two broad categories of urinary diversion exist. A non-continent diversion, called a urostomy, is any isolated bowel segment (conduit) that allows urine to drain freely through the skin (through a stoma). A continent diversion, such as a continent urostomy, neobladder or ureterosigmoidostomy, is a surgically created substitute for the bladder that is emptied naturally or with a catheter.

Almost every segment of the bowel or intestine has been used in the past for urinary diversion. The ileum, the end portion of the small intestine, is most commonly used because the procedure is technically easy and has fewer metabolic side effects.

The type of diversion selected depends on a number of factors: age, general health, reason for diversion, manual dexterity, body shape, bowel disease, motivation for maintenance of body image, willingness to self-catheterize, tolerance of nighttime leaking, potential for recurrence of cancer, and prognosis of bladder disease. Regardless of the type, all diversions are associated with some short- and long-term complications, especially metabolic problems.

The oldest form of urinary diversion is ureterosigmoidostomy (U), which was first described by Smith in 1878. A U is a direct connection between the ureters and the lower part of the large bowel or colon. Voiding or urination is via regular bowel movements. Over 60 different U techniques were reported by 1936. This was the method of choice until the 1950s, when the metabolic effects and the development of secondary bowel cancers were discovered. These secondary cancers, located at the connection of the ureters and the colon, have been known to develop up to 26 years after the operation. This technique is still used today for rectal reservoirs, although cautiously because the long-term results are not available.

Although first described in 1911, the ileal conduit did not become the preferred method of urinary diversion until 1950. The technique of forming the ileal conduit has undergone very few changes since then. The operation is technically the simplest and one of the shortest compared to all other forms of urinary diversion. For a time, this was the only choice available to patients. Over the past two decades, advances have been made in other techniques that eliminate the need for an external pouching system. Currently, the ileal conduit remains the most popular method of urinary diversion because it has few and infrequent complications.

The continent urostomy was first attempted in 1888, revised in the 1950s by Dr. Gilchrist and successfully implemented in the 1980s. This type of diversion has a reservoir, which collects and stores urine and is emptied by inserting a catheter through a stoma located on the surface of the abdomen. Presently, there are more than 40 different types of continent urostomy diversions. Two popular stomal forms are the Kock pouch, made entirely from the ileum, and the Gilchrist, Indiana, or Miami pouch, which is formed from the right side of the colon and a small segment of the ileum.

The stoma is designed for easy catheter insertion and must be leak-free, i.e., continent. The continent urostomy requires a longer operation and a lengthier hospital stay and has a higher long-term complication rate. Long-term complications occur in approximately 15% of patients. The continent

urostomy is not recommended for individuals who are of advanced age, have more severe cancer, decreased kidney function, or previous abdominal radiation therapy. Although the long-term results are not available, patient surveys have shown a better overall quality of life with a continent urostomy than the ileal conduit.

The neobladder became popular in the 1980s. The procedure involves replacing the diseased bladder with a bladder fashioned from intestine. The neobladder empties through the urethra, the normal urinary opening. Careful patient selection is the key to success. Similar to all continent diversions, there are many techniques and types available. After surgery, the patient must learn a new way of voiding. Completely emptying the neobladder may always require the patient to catheterize to finish each time. Although the complication rates are higher, the patient may have a better quality of life than with other diversions because of the more natural way of voiding. While long-term results are unavailable, the neobladder is currently considered the procedure of choice for selected patients with bladder cancer.

Not all types of diversion are suitable for every patient. There is no easy way to predict how each person will react to a particular type of diversion. However, research has shown that the selection of the most appropriate type of diversion, effective pre-operative counseling, and consulting with family members and other patients can help lead to a better quality of life.

In summary, there are several options for bypassing the diseased bladder: the ileal conduit, the continent urostomy and the neobladder. Continuous research will shed light on the long-term effect of the different methods of urinary diversion. The future of urinary diversion looks bright. In the next few decades, newer surgical reconstructive techniques, with lower complication rates and improved quality of life, will be developed. The advent of gene cloning and tissue engineering will enable the growth of a new bladder. As the ultimate goal of medicine is prevention, the prevention of bladder diseases is the key. We hope that in this millennium, urinary diversion will become unnecessary.

Bacteria and Ostomies

By Liz O'Connor, CWOCN

Many patients having ostomy surgery worry about bacteria. Those with colostomies and ileostomies ask if their stomas will become infected from the discharge of stool. They heard this from concerned sources. This is a myth! The stoma is accustomed to the normal bacteria in the intestines. Definitely, keep the skin around the stoma clean and be careful of adjacent wounds. You want to keep the fecal drainage away from the incision.

Do not worry about the ostomy becoming infected from the normal discharge. This does not happen. Nature has provided for us well. Our bodies are made so that the intestine is accustomed to having stool on it. Stool is what it was made to handle. We also have good bacteria in the stool that works with our bodies to help in the digestive process. These bacteria do not hurt us.

The urinary ostomy patient is more likely to be susceptible to infection than people with fecal ostomies are. Urine is normally sterile. Therefore, it is important to keep the urinary pouch very clean.

On days it is not changed, the pouch should be rinsed with a solution of 1/3 part white vinegar to 2/3 parts tap water. Allow this solution to run up over the stoma to prevent crystals from forming on it. The vinegar produces a mildly acid environment in your pouch. Bacteria cannot multiply as readily in an acid condition.

The night drainage system should be cleaned daily. White vinegar and water can be used for this too. Perhaps some of you use an ostomy disinfectant or a diluted Lysol solution. When the drainage system has sediment that cannot be removed by cleaning it, the system should be discarded and replaced with a new one. Saving a few pennies by using it too long can cost more in the end if you have to treat an infection.

Drinking plenty of liquids is important for all people with ostomies, but especially for the person with a urostomy. Many urologists also prescribe vitamin

C to help keep urine acidic and less susceptible to infection. Check with your doctor before increasing your intake of liquids. Some people, those with kidney disease or diabetes, may need to restrict liquid intake.

Pouching systems should be changed no less than twice a week, according to new directives by the WOCN Society. For one thing, the skin under the skin barrier must be inspected so that problems may be solved before they become too serious. Learn what is normal for you. We each need to manage our ostomies individually.

Ostomy Facts

From published sources

- There are about 500,000 people with ostomies at any one time in the U.S.
- Ostomy surgery is increasing about 3% per year worldwide.
- There are now more temporary ostomy surgeries being performed than permanent ones.
- The most common flange size is 45 mm.
- More people wear two-piece pouching systems than one-piece.
- Pouches have no expiration date, per se, depending on how they are stored.
- Skin barriers should be stored in a cool, dry and dark place to preserve quality.
- An ostomy is not a barrier to living a normal life. In fact, it is a way to enhance it.
- People with ostomies are employed in virtually every type of profession.

2012 UOAC Conference in Toronto

"Caring in a Changing World"
 August 15 – 18, 2012
 Delta Chelsea Hotel
 Downtown Toronto

http://www.ostomycanada.ca/events/biennial_conference_of_uoac



http://www.ostomy.org/conferences_events.shtml



Check Us Out On The Web

www.ostomymcp.com

Other Websites Of Interest:
 United Ostomy Association of America: www.uoaa.org
 Your Ostomy Community Connection Center: www.c3life.com

Ostomy Chat Room Weekly Meetings

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

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

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

UOAA Chat Sundays 9pm ET / 6pm PT
<http://www.yodaa.org/chat.php>

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 __

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