The Mailbag

The Ostomy Support Newsletter Of Jacksonville, Florida

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

Next chapter meeting will take place on
Sunday Sunday May 20th
Come join us!
3PM 4836 Victor Street
Speaker TBA
Meeting will be hosted by
Kimberly Starky of Medical Care Products

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 athttp://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.

PAINS YOU SHOULD NEVER IGNORE

(By Dr. Mallika Marshal)

Pain is your body's way of telling you something is wrong, and failure to address it could lead to serious problems.

Chest/Shoulder Pain. It could mean that you're having heart problems. Sometimes it's a pain in the chest, sometimes in the left arm, shoulder, neck, or jaw. However, many people who've had heart problems say it's not really a pain, but a pressure or discomfort. Now there are other things that can cause pain in the chest such as acid reflux, inflammation of the chest wall muscles, or inflammation of the lining of the lungs. But the thing we really worry about and want to rule out is a heart attack. So if you develop these symptoms, especially if you have risk factors for heart disease or are over 40, you need to contact your doctor right away or call 911.

Pain in the mid-back. If you experience pain in your back or between your shoulder blades, it's most likely caused by arthritis. But pain in this area, especially if it's severe or sudden can indicate an aortic dissection in which blood actually gets trapped in a tear of the main artery in the body, the aorta. This can be life-threatening. It more commonly occurs in people with high blood pressure or people with a history of heart disease, so if you're concerned, call your doctor right away.

Abdominal pain. We all get the occasional bad stomach ache but what we are talking about here is sharp pain that that hurts so much that it takes your breath away. This kind of pain could signal appendicitis or a ruptured appendix which is a very serious condition that needs to be treated right away. Severe abdominal pain could also signal problems with your gallbladder, pancreas, or even an ulcer.

Calf pain. Whenever we hear someone complain of calf pain, we worry about a blood clot or deep venous thrombosis in the leg. These clots affect about 2 million Americans every year and can be life-threatening...if the clot breaks off and travels to the lungs. People most at risk are those with cancer, pregnant women, people who have had recent leg surgery, bed-ridden patients, and people who have been on long plane flights. So if you have pain in your calf, especially if there's redness and swelling and no recent injury or muscle strain, you need to call your doctor right away.

Feet or leg pain. Burning in the feet or legs could be a sign that you have peripheral neuropathy or nerve damage. One of the most common causes is diabetes which we all know is a very serious condition. And the sad fact about diabetes is that many people who have it don't even know they do. So a burning sensation in the feet could be the first indication. Other causes of nerve damage could be injury, inflammatory conditions such as Lupus, or vitamin deficiencies. So talk to your doctor.

POUCH CHANGES - HOW OFTEN

Via: GB News Review, Green Bay, WI. & So. NV Town Karaya

This question is among those most frequently asked, particularly by Ileostomates and urostomy patients. Like any other question, there is no one answer that applies to all ostomates

An informal survey revealed that people change their appliances as much as 3 times a day, and as infrequently as every 2 to 4 weeks. Obviously, there must be reasons for this great variation. After pointing out that the great majority of ileostomy and urostomy patients change in the range of once daily to once a week. Let us explore some of the reasons. People on either side of this spectrum can have a skin problem or skin which is nearly indestructible. Some of the reasons for the variation in time between changes include:

Stoma length: A short stoma exposes the adhesive material to moisture which decreases wearing time.

Amount or consistency of effluent: Profuse effluent tends to loosen the seal. Skin Type: Moist or oily skin tends to decrease adhesion time.

Skin Irritation: Decreases adhesion. The appliance should be changed more frequently to evaluate the success of your attempts to heal the skin.

Experience: Good technique, such as allowing glue (adhesive) to dry well, increases adhesion. Personal Experience: Preferences, convenience, and odor control.

Ileostomy Retraction

(by Gail Whilihite, RNET, South Brevard, TX, and Sterling, IL, Groups)

An ileostomy stoma should be at least three-quarter inches in length, and some surgeons advocate a longer length of one inch to one and a half inches. A spout-like stoma is necessary to deposit the effluent into the bag, preventing pooling of contents at the base of the stoma. Conversely, a stoma that is too long is subject to exter- nal trauma and injury. Weighing the consequences, it is preferred to have a stoma somewhat too long than one too short.

There is a difference between the creation of colos- tomy and ileostomy stomas. Frequently, when fashion- ing a left-sided colostomy, the surgeon will create a flush stoma. The contents of the left colon are relatively inert and usually regulated with irrigation; therefore, little or no functional problems occur with a flush colostomy stoma. An ileostomy stoma is never constructed as a flush stoma; nevertheless, sometimes the stoma may retract for various reasons.

The common cause of stoma retraction is post-op weight gain. Prior to their operation, most ileostomates have lost considerable weight. Following surgery, weight

gain can be rapid and many times excessive. What once was an adequate stoma now retreats within the expanding envi- ronment. Another cause of retraction may be inadequate fixation of the opposing serosal (membrane covering the external walls of the intestine) layers following eversion (being turned outward or inside out). If these layers fail to adhere, healing and subsequent scarring may tend to draw the stoma into the abdomen.

Problems resulting from retraction are: decreasing adher- ence of the appliance and skin breakdown. The pooling of the excoriating intestinal contents causes loosening of the adherent bond, resulting in accumulation of ileal effluent on the skin. This skin effluent contact naturally produces breakdown. The combination of irritated, weeping peris- tomal skin and continual pooling lead to an unbearable situation, which must be remedied.

The treatment for a slightly retracted stoma is the use of convex faceplate. The convexity applies pressure to the skin surrounding the stoma, thus pushing the stoma outward. When using a convex faceplate, it is important not to lose the convexity by applying thick washers or foam pads, etc. The skin and faceplate should suffice to maintain the ad- vantages of both convexity and skin protection. If the use of a convex faceplate proves unsuccessful or if the retrac- tion is severe, then surgery is advised, extending the length and creating a new, longer stoma.

Antibiotic Side Effects

Edited by B. Brewer, 12/2011 UOAA Update

Many times ostomates who must take powerful antibiotics suddenly find they have itching and burning under their pouches and have poor pouch adhesion. A side effect of antibiotic ther- apy can be a yeast infection on the skin around the stoma. You may hear health professionals call this monilia.

At first it may appear as tiny white pimples, but in a few days it is a red rash. This is caused by the antibiotic killing some normal bacteria in the body as well as the bacteria causing infection or illness. At the same time you may also notice sores in your mouth, diarrhea, and a similar rash on the perineal area.

Contact your doctor for a prescription of mycostatin or nystatin powder. Put the powder directly on the irritated area. Apply a coat of sili- cone skin barrier such as Skin Prep or Bard Pro- tective Skin Barrier, etc. Let this dry!!! Apply your pouching system as usual. Eating foods such as yogurt or drinking buttermilk helps to replace some of the normal bacteria in the gastrointestinal tract.

HOW TO TREAT AN ILEOSTOMY BLOCKAGE

UOAA Patient Reference Card, UOAA Update 3/12
Symptoms: Thin, clear liquid output with foul odor; cramping abdominal pain near the

stoma; decrease in amount of or dark-colored urine; or abdominal and stomal swelling.

Step One: At Home:

• Cut the opening of your pouch a little larger than normal, because the stoma may swell.

• If there is stomal output and you are not nauseated or vomiting, only consume liquids

such as sodas, sports drinks, or tea.

• Take a warm bath to relax the abdominal muscles.

• Try several different body positions, such as a knee-chest position, as it might help move the blockage forward.

• Massage the abdomen and the area around the stoma as this may increase the pres- sure behind the blockage and help it to pop out. Most food blockages occur just be- low the stoma.

Step Two: If you are still blocked, vomiting, or have no stomal output for several hours:

• Call your doctor or WOC Nurse (ostomy nurse) and report what is happening and what you have tried at home to alleviate the problem.

• Your doctor or WOC Nurse (ostomy nurse) will give you instructions (e.g., meet at the emergency room, come to the office).

• If you are told to go to the emergency room, the doctor or WOC Nurse (ostomy nurse) can call in orders for your care there.

• If you cannot reach your WOC Nurse (ostomy nurse) or surgeon and there is no out- put from the stoma, go to the emergency room immediately.

Important: Take all of your pouch supplies with you to the Emergency Room (pouch, wafer, tail closure, skin barrier spray, irrigation sleeve, etc.)

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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