Spring 2005
NEWSLETTER

INSIDE OUT

VOLUME 2
ISSUE 11

STOMA SUPPORT GROUP WORKING WITH ST. MARKS AND NORTHWICK PARK HOSPITAL
Incorporated with St. Mark's Hospital Foundation Charity Registration No. 1088119

Bob's Hello

Hi Everyone,
Yes it's time for another of our newsletters, and everyone is trying to forget the cold and get ourselves ready for the spring and, eventually, the summer months, (lets hope they are better than last year).
Things have been a little quiet, mainly due to my not being as active as I have been in the past. Sorry, but my health has been letting me down a little. I am on the mend and fighting back, but it has given me time to think.
I have been your Chairperson since it started some five years ago, when Claire Bossom, Celia Myers and I sat in the Stoma Care Department and thought about putting together a Stoma Support Group for everyone. In that five years we have achieved many things and I hope have been there for you when you needed advice or just an ear for you to talk to.
Both Celia, and now Claire have left us. Celia as you know, retired and Claire has moved on to pastures new nearer her home in High Wycombe. I also think it is time for you perhaps, to choose a new Chairperson, to bring new and fresh ideas into the group.
We will be holding our Open/Information Day on the 10th September 2005, at the same time we will hold our AGM, where you can decide. Enclosed with this newsletter will be a nomination form for you to elect whom you wish to put forward for any of the posts available.
Talking of our open/information day, we have been lucky enough to get Professor John Northover to talk on Cancer of the Bowel research and Dr Simon Gabe who will talk to us on new developments on Crohn's and Colitis.
Until next time, God speed and may your troubles be little ones.

Best Wishes
Bob
Chairman, Inside Out

Inside Out Coffee Mornings

In the Out Patients Department of St. Mark's, Level 3
10.00am to 12 noon

We are there to enable you to seek advice about your stomas, or if you just want a good old chin-wag and a cup of tea or coffee, then you are more than welcome.

April	Wednesday 6th, Thursday 21st
May	Tuesday 3rd, Wednesday 18th, Tuesday 21st
June	Monday 13th, Tuesday 28th
July	Wednesday 13th, Thursday 28th
August	**No Coffee Mornings Due to Holidays**
September	Monday 5th, Tuesday 20th
October	Wednesday 5th, Thursday 20th, Monday 31st

Dear 'Inside Outers'

Sitting trying to compose an interesting missive for our newsletter, the sun is shining, the sky is blue but it's oh so cold outside. If you are indoors in the warm, as I am, you could be forgiven for thinking it was spring but it most certainly isn't. I hope that you have all come through the winter period unscathed. We are all ready heading for March (doesn't time fly when you're having fun or it does when you are older) and spring will be with us shortly.

It's been quiet through the winter, I think we must be all suffering from the SAD syndrome. Anyway, down to business - have you all paid your membership fee? Come on now. Its only £5.00. If you haven't got/ filled in a standing order form, let me know and I will send you one; or you can send a cheque for £5.00 (or more!) made payable to St. Mark's Foundation (Inside Out) - this can be sent to me at my home address on the back page.

When you receive this copy of Inside Out, will you check that your name, address, and postcode are correct. Misreading handwriting and having the address list re-typed sometimes means errors have inadvertently been made. Please check and let me know by phone, letter or by e-mail if anything is incorrect. As I have already said, Spring will be here very soon with summer following very soon afterwards. This sets one's mind to thinking about holidays, warm seas, swimwear and luxury underwear for both men and women. Pick up a CUIWEAR leaflet in the stoma department at St Mark's; when you buy, we get commission. Everyone who has bought from CUIWEAR has been very pleased with the quality of the goods and the service given to our members, myself included.

At this moment in time there is not a lot going on. The coffee mornings are still well supported with different manufacturers making an appearance about once a month. Unfortunately I rarely get to these mornings but hear a lot about them.

The next time I will definitely see you is at out AGM on September 10th 2005, slightly later this year because of the non availability of the Himsworth Hall - so please put the date in your diary now.

Wishing you all the best of health in 2005.

Diane Owen - Secretary/Treasurer

A short message from the editor

Diane, our estimable secretary/treasurer has mentioned CUIWEAR, you will remember that she wrote of her delight in her swimsuit in the winter newsletter and the care that CUIWEAR took to ensure that it arrived on time. I have purchased several differing types of the underwear and have found them all very well made, in lovely material and well designed, also delivered quickly. I can thoroughly recommend them, consequently I will not be shopping elsewhere for such items.

J.E.M.G

Irrigation

Colostomy irrigation has been used as a method of controlling colostomy output since the 1920s, but remains largely underutilised. It has been estimated that only 4.7% of colostomists in the UK irrigate in contrast to the USA where the majority of these individuals irrigate. Colostomy irrigation is the practice of installing a measured amount of lukewarm water into the colon via the colostomy. There are some people, who find it hard to adjust to life with an appliance and may wish to look for an alternative method of stoma management. An alternative method is colostomy irrigation, which is a way of achieving faecal continence. Although irrigation can offer a safe way to control how and when the colostomy works, it is not suitable for everyone as the appropriate stoma for irrigation is an end colostomy with a formed stool. Therefore anyone wishing to irrigate will be required to attend the stoma care clinic for a full assessment.

The assessment carried out will gather important medical data and underlying conditions such as:

- Active inflammatory bowel disease, such as Crohn's disease as there is a potential risk of the formation of a fistula, diverticular disease or radiation colitis. Irritable bowel syndrome will also make it inadvisable for the patient to irrigate.
- There must be caution with individuals who have cardiac or renal disease as they may have potential fluid overload complications.
- Stoma complications such as hernia, stenosis or prolapse can make it difficult for the person to irrigate.
- Those with the tendency to diarrhoea, which is not controlled by diet or drugs, or those who respond to stress by having diarrhoea. The ideal consistency would be a formed faecal output.

Psychological, physical and social needs are taken into account, as it is paramount that the individual is motivated to master the procedure and technique involved. An appropriate level of manual dexterity and eyesight is also required. Irrigation is time consuming, thus adequate bathroom facilities are essential.

It is usually suggested that irrigation is taught approximately three months post operatively, however individual circumstances will always be assessed for example, wound healing, chemotherapy and general post operative recovery. The consultants approval must be obtained before any teaching commenced. The general Practitioner would also be notified.

The Advantages and Disadvantages of Irrigation

Advantages

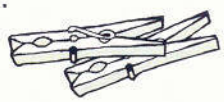
- Individual in full control of their bowel function
- Confidence in personal appearance increased
- No need to wear an appliance
- Freedom to relax more in social activities
- Wind, irregular bowel motion and odour will be reduced
- Increased confidence regarding appliance leakage
- Do not need to dispose of used appliances
- Less equipment to carry around
- An Irrigation kit comes in a small bag and is available on prescription

Disadvantages

- Colostomy irrigation is time consuming and can take up to one hour each day or alternate day
- It is important to irrigate at about the same time each day
- Inadequate toilet facilities (only one bathroom) may make this procedure difficult for ostomist and family members
- Individuals may find this method difficult away from home
- Can not stop/start procedures. It must be continuous

If you are a suitable colostomist for irrigation, an appropriate time should be arranged with your stoma nurse, to commence teaching. The period of teaching will depend on the individual, but at least three consecutive days should be sufficient before you are left to irrigate independently. The equipment that is required is an irrigation set, which includes a cone, tubing, and irrigation bag or water reservoir and irrigation sleeves. A hook, on which to hang the irrigation bag and ideally this should be secured to the wall at shoulder height when sitting on the toilet. Lubricating gel is used to insert the cone more easily. A colostomy bag or cap to wear after irrigation.

It is essential that teaching be carried out with your stoma nurse until you feel confident to commence independently as situations may arise that require attention.



- Unable to administer fluid as cone tip may be resting against the mucosa therefore moving the cone around whilst irrigating may help to resolve this. Often the individual is very tense (especially on the first attempt), deep breathing exercises may help, but on some occasions the procedure may need to be stopped and tried another day.
- Abdominal pain can be caused by the fluid entering too quickly, thus check the height of the reservoir. It is important to remember that there are no nerve endings in the colon and it is therefore easy to burn the bowel. In contrast to this if the water is too cold then the bowel will contract making the evacuation of the faeces an impossibility. It is vital that the temperature is tested first. The temperature should be tepid, approximately 37°c.
- Alcohol, particularly red wine drunk the night before may lead to a degree of dehydration and the retention of more irrigation fluid than normal.
- The experience of the breakthrough of stool may be due to administering too much water, thus less may be required. If too much water enters the ascending colon it may seep out during the day. Between 800mls to 1200mls depending on the individual is to be used.
- Bleeding from the stoma may be caused by tenseness. This can be eased by gently massaging the stoma with a gloved finger lubricated to dilate the aperture.

As mentioned previously, irrigation is not suitable for everyone, however it is an alternative that is a safe way to control how and when your stoma works.

Sarah Varma
Stoma Care Specialist
St. Mark's & Northwick Park (Community)

STOMA ('Parastomal') HERNIAS

A Hernia is a weakness or split in the muscle wall of the abdomen which allows the abdominal contents (usually some part of the intestine) to bulge out. The bulge is particulary noticeable upon tensing the abdominal wall muscles - such as occurs when coughing, sneezing, straining or simply standing.

Stomas pose an additional problem.

When a stoma is brought out to the surface of the abdomen it must pass through the muscles of the abdominal wall, thus a potential site of weakness is immediately created. In the ideal situation the abdominal wall muscles form a snug fit around the stoma opening. However, sometimes the muscles come away from the edges of the stoma thus creating a hernia - in this case, an area of the abdominal wall adjacent to the stoma where there is no muscle.

Factors that can contribute to causing a stoma hernia to occur include coughing, being overweight or having developed an infection in the wound at the time the stoma was made.

The development of a stoma hernia is often a gradual phenomenon, with the area next to the stoma stretching and becoming weaker with the passage of time. This weakness, or gap, means that every time one Strains, coughs, sneezes or stands up, the area of the abdomen next to the stoma bulges, or the whole stoma itself protrudes as it is pushed forwards by the rest of the abdominal contents behind it.

They may make it difficult to attach a bag properly and sometimes their sheer size is an embarrassment as they can be seen beneath clothes. Although a rare complication, the intestine can sometimes become trapped or kinked within the hernia and become obstructed. Even more seriously the intestine may then lose its blood supply, known as strangulated part of the bowel from being irreversibly damaged.

Regardless of inconvenience or pain, hernias are defects in the abdominal wall and should not be ignored simply because they might not hurt.

There are surgeons who advocate that small stoma hernias that are not causing any symptoms do not need any treatment.

Furthermore, if they do need treatment it should not be by operation in the first instance but by wearing a wide, firm colostomy/ileostomy belt. This is probably true with small hernias, in people who are very elderly and infirm or people for whom an anaesthetic would be dangerous (serious heart or breathing problems for example).

As with all hernias size will increase as time goes by. Stoma hernias are rarely painful, but are usually uncomfortable and can become extremely inconvenient.

We feel that nowadays operative repair of the stoma hernia should be given more serious consideration to improve the quality of life, prevent progressive enlargement of the hernia with time and make it easier to manage the stoma.

Repair of Stoma Hernias - The Usual Approach

If symptoms are severe enough, the hernia is repaired. The repair of a stoma hernia requires that the abdominal wall tissue is made to fit back snugly around the stoma, leaving no weakness. Over the years many different surgical approaches to this problem have been tried.

There are two options. One can move the stoma to a new site on the abdomen, i.e create a new opening elsewhere and repair the hernia at the old site as one would any other hernia, or one can try to repair the hernia around the stoma, leaving the stoma where it is.

Repair of the hernia without moving the stoma involves opening the abdominal wall over the hernia adjacent to the stoma and re-suturing muscle and supporting tissues in the area. Although this may appear to be the most straightforward way of doing it, this is not always a successful method.

If the original stoma site is unsatisfactory for other reasons, or if the hernia is very large it may be necessary to re-site the stoma, making a new stoma through fresh, healthy tissue. The area of the hernia, together with the site of the original stoma is then repaired, usually by stitches.

This can be a more successful procedure regarding repair of the hernia, but is a more major operation because of the many technical, surgical difficulties in dismantling the existing stoma and transferring it from one side of the abdomen to the other.

Development of Stoma Surgery and Stoma Care

Date	Milestone
4th Century BC	Praxagorus:- 1st bowel decompression via a colostomy which he closed after emptying bowel of its contents.
1707-1709	Heister:- Performed enterostomy operations on battle casualties in Flanders.
1776	M Pillore:- Caecostomy for obstructing carincoma of the rectum.
1793	Duret:- Colostomy operation on a 3 day old baby with imperforate anus, who survived.
1815	Mr Freer of Birmingham performed left iliac colostomy for imperforate anus in a neonate who died after 3 weeks.
1818	Mr Freer performed a left iliac colostomy in an adult with a rectal structure.
1820	Mr Pring:- Left inguinal colostomy in a 64 year old woman with a carcinomatous obstruction of the bowel.
1824	Mr Martland of Blackburn - left iliac colostomy for a 44 year old bookmaker with a carcinomatous obstruction. Described the appliance used, which remained unaltered in principle until the 1950's.
1839	Amussat reported 29 cases treated by colostomy - 4 babies and 5 adults survived.
1884	Mayde used a goose quill to support the colostomy loop.
1887	William Allingham wrote about the surgery of double lumen loop ostomy which he performed.
1913	Brown used temporary ileostomy for the management of ulcerative colitis.
1917	JP Lockhart:- Mummery reviewed 50 colostomists, and gave the first advice on stoma care.
1927	Lockhart:- Mummery recommended the procedure of colostomy irrigation.
1944	Development of the Koenig bag reported by Strauss; rubber bag developed which adhered to the skin. Salts took over the English manufacture.
1952	Bryan Brooke performed the eversion ileostomy.
1956	Ileostomy Association formed.
1958	Norma Gill, an ostomist, becomes the first stomatherapist in USA.
1966	Colostomy welfare group formed.
1969	Barbara Saunders becomes first Stoma Care Nurse in UK at Barts.
1971	Urinary Conduct Association formed.
1972	First stoma care training course commenced at Barts.
1978	DHSS circulated recommendations or provisions of stoma care to all H.A's.
1992	RCN working party produces Stoma Care Nursing Standards.

The best and most beautiful things in the world cannot be seen or even touched - they must be felt with the heart.

When one door closes another door opens but we so often look so long and so regretfully upon the closed door, that we do not see the ones which open for us.

Juices for Health

Irritable Bowel Syndrome:

Diarrhoea interspersed with constipation is the classic symptoms of irritable bowel syndrome, which can be brought on by stress, as well as other causes. Mild, yet nutritious juices (containing B vitamins and vitamin C) may help settle the stomach and bring a little relief. It is best not to overwhelm the stomach with combination juices, and juices should be diluted before drinking.

Juices

Each recipe makes approx. one 8fl oz/230ml glass of juice. Adults can drink up to three glasses diluted, daily, but do vary the juices for maximum benefit. Juice each ingredient then blend using a spoon.

1 apple - 4fl oz/115ml still water or
1 pear - 4fl oz/115ml still water or
10 carrots - 4fl oz/115ml still water or
2 stalks of celery - 4fl oz/115ml still water

Some Golden Rules

Beginners should drink up to 3 8fl oz/230ml glasses of juice a day. Veterans can up the amount to 6 glasses. Always dilute dark green vegetable juices (i.e. broccoli, spinach, and watercress) and drink red vegetable juices (i.e. beetroot, red cabbage) by 4 parts to 1. They are very potent in taste and effect.

Drink vegetable and fruit juice in order to get the maximum nutritional benefit. Too many fruit juices will overload your system with the fruit sugar, fructose.

Fruit juices cause a rapid rise in blood sugar, and anyone suffering from candidiasis should be cautious regarding excessive sugar intake. If you are prone to suffer from thrush, therefore, or suspect you may have a yeast infection in the digestive tract, you should take professional advice before increasing your intake of fruit juices (vegetable juices are, on the whole, not a problem in such cases). This advice also applies to anyone with low blood sugar or with diabetes.

Never mix vegetables and fruit juices together in the same glass or you may well suffer from embarrassing flatulence! The exceptions are apple and carrot, which you can mix with anything.

Do not look back and ask why, look forward and ask, why not.

Only I can change my life. No one can do it for me.

LOOK

He who asks is a fool for five minutes, but he who does not ask remains a fool forever.

Useful Contacts

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NACC
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Urostomy Association
0800 018 4724

British Colostomy Association
0800 328 4257

CUI Wear
Underwear + Swimwear for ostomists
0800 279 2650 Quote Ref IOU256

Want to join the support group?

If you have a colostomy, ileostomy or a urostomy and you would like more information, please complete the form below and send it to:
Clare Bossom & Sarah Varma c/o Stoma Care Department, St. Mark's & Northwick Park Hospital, Watford Road, Harrow, Middlesex, HA1 3UJ

Name _____

Address _____

_____

Postcode _____ Telephone _____