Vancouver Ostomy
HIGH Life

Volume 36 - Issue 2 **MARCH APRIL 2004**

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INSIDE

NEXT MEETING:

SUNDAY, APRIL 18
Jewish Cultural Centre
950 West 41st Avenue
1:30 pm

Executive meeting:
Saturday, April 3, 1:30 at Lottie's

Speaker: TBA

Origins of Ostomy Surgery

"And Ehud put forth his left hand, and took the dagger from his right thigh and thrust it into his belly. And the haft also went in after the blade: and the fat closed upon the blade, so that he could not draw the dagger out of his belly: and the dirt came out" *Judges 3:21-22 (King James Version).* Ehud's mortal attack on King Eglon of Moab appears to be the first recorded observation of a traumatic opening into the bowel.

The origins of ostomy surgery are entrenched in the antiquity of surgery. The earliest reports of openings into the gastrointestinal system described rupture or perforation as a result of trauma rather than surgery. This is not difficult to comprehend when one considers the history of violence and wars that has accompanied man's journey down through the ages.

Hippocrates 460-377BC

It is appropriate that the word 'stoma' has its origins in the ancient Greek language for they were often at war and appeared to have had considerable experience in perforating injuries of the abdomen. Ancient Greek physicians such as Hippocrates (460 - 377BC) and Celsus (53BC - 7AD) wrote that wounds of the large intestine were not deadly, where as wounds of the small intestine and bladder were (Richardson 1973) Another ancient medical figure was Galen (130 - 200AD), who was surgeon to the Emperor Marcus Aurelius and the Roman gladiators, and one presumes very experienced in traumatic perforations of the abdomen. In his prolific writings he discussed surgical management of the large intestine and abdominal wall following penetrating injuries, however, he believed little could be done to save the person with a rupture of the small intestine (Haeger 1989).

Throughout the ages, military surgeons have been presented with great challenges in caring for traumatic wounds. These challenges were exacerbated from the 14th century onwards, for it was in 1346 at Crecy that artillery was first used in battle (Leavesley 1996). Those that survived traumatic injuries to the abdomen, it seems, did so largely as a result of human endurance rather than on account of surgical skill. Cromar (1968) reported that a soldier, George Deppe, who was wounded at Ramillies in 1706 lived for 14 years with what

cont. page 6

President's Message

By now many of you will have heard of the sad loss of our very good friend Ivor Williams, who will be so sadly missed by so many throughout the Association. Ivor gave much of his time to volunteer work, not the least of which was his devotion to the Vancouver UOA chapter. It would have been his wish that we carry on and so we shall. Our thoughts go out to Joan his wife, and to all his family.

The summer camp for young ostomates will be coming around soon, and I shall be applying for a grant from the Sun newspaper. The CBC ran a program on this camp, a tape of which we watched at the February 15 meeting.

We are looking for an interested volunteer willing to be mentored into the position of Treasurer for our chapter. Bookkeeping or accounting experience is an asset, but just as valuable is an interest in getting involved with our executive and being tutored how to prepare our financial statements. Incumbant treasurer Lennae Malmas would be happy to teach you the ropes!

Hope to see you at the meetings.

Ron

From the Editor

It is with very heavy hearts we report the death of Ivor Williams, past President, Editor and dedicated supporter of the UOA Vancouver Chapter. Ivor was one of the first chapter members I met, one of the first to make a point of introducing himself at my first meeting. Some months later he mentored me when I took over the newsletter, and I was again charmed by his good humor and kindness. He answered my questions, gave tactful advice, and cheerfully lugged piles of paperwork over Lion's Gate Bridge for me. There was so much more I looked forward to working on with him -- more articles, the website, and general 'computer geekology'. (Ivor was intrigued by computers and at an age when others might have avoided the new technology he embraced and taught himself much about the medium) I knew Ivor but a short time yet I'll miss him deeply.

So, Ivor, to steal one of your own phrases: (you could write, too)

"It's been a pleasure"

Debra

EDUCATION AND LIBRARY AVAILABLE

A variety of ostomy literature concerning all types of ostomies is available through our Education & Library Coordinator.

IMPORTANT NOTICE

Articles and information printed in this newsletter are not necessarily endorsed by the United Ostomy Association and may not be applicable to everybody. Please consult your own doctor or ET nurse for the medical advice that is best for you.

DONATIONS AND BEQUESTS

We are a non-profit volunteer association and welcome donations, bequests and gifts. Acknowledgement Cards are sent to next of kin when memorial donations are received. Tax receipts will be forwarded for all donations. Donations should be made payable and addressed to:

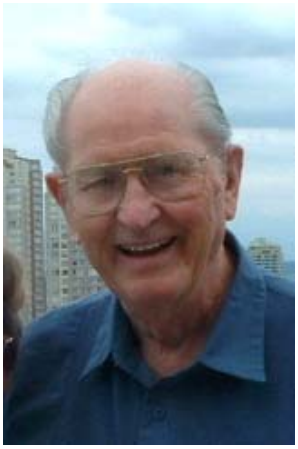
UOA OF CANADA LTD.
VANCOUVER, BC, CHAPTER
Box 74570, Postal Station G
Vancouver, BC V6K 4P4

MEMBERSHIP DUES!

A number of members are in arrears -- are you one of them?? If so, please send your $30 in to Mien van Heek. If you're not sure about your renewal date, please call her at **604-926-1519**

Now don't make us come after you . . .

IVOR WILLIAMS -- A Giant Passes



December 9, 1925 - February 4, 2004

Ivor passed away in his 79th. year, on February 4, 2004 at 3:00 pm at Vancouver General Hospital of complications arising from open heart surgery. He died peacefully, surrounded by his family. Ivor was born in Regina, the son of Welsh immigrants who came to the Canadian Prairies in the early 20's to seek their fortune and help teach the pioneers in Saskatchewan the wonderful ways of the Welsh as well as how to sing and mine coal.

With his passing, The Vancouver Chapter has lost one of its most devoted members. Ivor was a very special person. Not only did he lead an exemplary life as a family man and model citizen, he help make Canada a better country by volunteering his time and energy as a member and Officer of several charitable organizations. And he was a god-send to the Vancouver Chapter of the UOAC. Although not himself an ostomate, Ivor accompanied his wife, Joan - *herself a member of the Executive Committee since 1972* - to many of the Vancouver Chapter meetings and volunteered countless hours of his time assisting the UOAC in any way he could. He helped organize and acted as **Treasurer** of the UOA 1980 National Conference in Vancouver and was **Program Coordinator** of the UOAC 2001 National Conference in Richmond. He also attended many National and Regional UOA conferences in the United States and UOAC conferences here in Canada as a delegate of the Vancouver Chapter. He was a member of the **Vancouver Chapter Hall of Fame** and a recipient of the **Vancouver Chapter Outstanding Service Award**.

But most of all, faced with the immediate demise of the Vancouver Chapter in 1989 because no ostomate member would accept the position, after serving several years as **Chapter Treasurer** and **Chairman of the Memorial Fund Committee,** Ivor agreed to serve as **President** during the years 1989-90; 1990-92; 1997-98 and 1998-00. In addition, he volunteered for the very time consuming position of **Editor** of the Vancouver Ostomy Highlife from September 2000 to April 2003. Without Ivor's dedicated volunteer service, there is little doubt the Vancouver Chapter of the UOAC would now be just a faded memory, long since lost in the mist of time.

We were indeed fortunate for his presence and participation and we will truly miss him; his sense of humor, his compassion, his optimism, his generosity, and most of all his friendship, which he gave freely and unquestionably to anyone who wanted it, never asking or expecting anything in return. Ivor was a leader, not a follower and didn't hesitate to go where others feared to tread. But he also had a well honed sense of Prairie caution, and would not readily agree to follow others down a road with too many bends and potholes and too few STOP signs. He was one of a kind, the salt of the earth, a Welsh boy from the Prairies who will not soon be forgotten.

- Fred Green - Past President

Donations in Ivor's Memory

A celebration of Ivor Gordon William's life for friends and family was held February 21, at the West Vancouver Seniors' Centre, where all present paid their respects to this lovely man and to his family.

It was Ivor's wish that any donations in his memory be made to the United Ostomy Association of Vancouver, or to the charity of your choice.

The Vancouver UOA Chapter would like to extend a warm welcome to the following new members:

Harry Gold
Betty Lindstrom
Wolfgang Harder

Many thanks to the following people for their kind donation to the Vancouver UOA chapter. Your contribution is greatly appreciated!

Margaret Boone
William Schulz
Thomas Woodcock

Origins, cont. from page 1

appeared to be a severely prolapsed double-barreled colostomy.

Acute bowel obstructions and perforations occurred not only within the realm of the military but royalty has been sorely effected. King Stephen of England died in 1154 with what was termed "iliac passion", a Saxon term described in 923AD as: "a disorder in which a desire cometh upon a sick man for discharging his bowels, and he is not able, when he is out in the outhouse" (Brooke 1980, p1). The first recorded royal, though not the last, who had an ostomy was Queen Caroline, wife of George II, who died in 1736 from a strangulated umbilical hernia. She endured 7 days of suffering before her gut ruptured, but alas to no avail, for she died 3 days later (Leavesley 1996).

William Cheselden (1688-1752), a British surgeon, had a 73 year old patient, Margaret White, who ruptured her abdominal wall following severe vomiting. Cheselden removed the gangrenous portion of prolapsed gut and left the sound portion, thought to be small intestine, hanging through her umbilicus (Richardson 1973). Although she lived for some years we are left to ponder how she may have managed her ostomy.

Surgeons of that period were reluctant to operate on the bowel for fear of peritonitis and inevitable death to the patient. This was not only harmful to a surgeon's reputation but the major stimulus for what is considered today, some bizarre medical practices. These included purging with laxatives and enemas, attempted dilatation via the anus, blood-letting and the consumption of large amounts of mercury in the hope that the heavy weight of the substance would push through the obstruction. Death due to mercury poisoning ws a common side-effect (Leach 1986). Thomas Sydenham, a noted London physician during the mid-1800's, recommended horseback riding as a means to assist the passage of stool through obstructed gut and his treatment for paralytic ileus was to keep a kitten on the distended abdomen, presumably for the warmth (Leavesley 1996). Failed treatments such as these usually resulted in the death of the patient.

Colostomy Surgery

History records but a few pioneering surgeons who were brave enough to experiment with attempts to create an artificial anus when medical treatments failed. The first planned colostomy procedure was performed in 1776 when a French surgeon, M Pilore operated on a M Morel. Surgery was seen as a last resort when other aggressive non-surgical treatments such as purgatives, dilatation and the consumption of 2 pounds of mercury had failed to clear his malignant bowel obstruction. An opening was made into the caecum and the bowel was sutured to the skin. A sponge held in situ with an elastic bandage was used to control the effluent between regular enemas. All went well for two weeks until the patient died two weeks later. An autopsy attributed the cause of death not to surgery but to a gangrenous small bowel, from which was retrieved the two pounds of mercury (Cromar 1968).

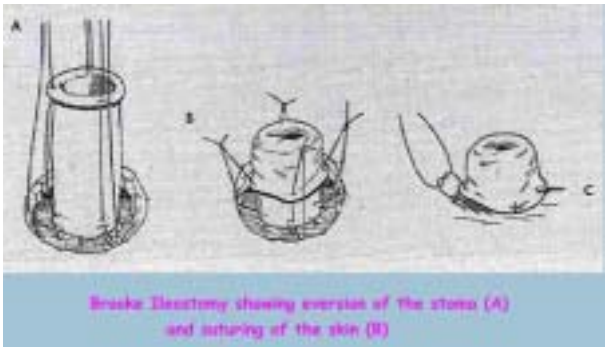
SHIP AHOY?

Planning on taking a cruise? If you're relying on your ship's medical centre to stock emergency ostomy supplies, you could be out of luck. I sailed with the Princess line last fall on the sparkling new Coral Princess. This was a lovely ship, outfitted in every way, with a medical centre prominently noted. Out of curiosity I decided to see if ostomy supplies were available. The centre was a bright office with friendly staff who immediately understood what I was asking about, but they stocked no ostomy supplies of any sort. When asked why this was the case, the front desk nurse said they used to keep some products on hand but found that these rarely met passenger needs. Wrong brand, wrong model etc. so they discontinued the practice. Now, if a passenger runs out of supplies the ship's doctor will issue a prescription for replacements to be filled at the next port of call.

Considering that the next port of call could be days away or not have the things you need, once again all travelling ostomates are advised to ***TAKE EVERYTHING YOU'LL NEED WITH YOU!***

The first successful left inguinal colostomy recorded was performed by a French surgeon, Duret, in 1793 on an infant who was born without a rectum. Although the infant was close to death prior to surgery, he recovered to live for 45 years (Richardson 1973). Other European surgeons who added their names to the list of pioneers were Professor Fine, from Geneva, who in 1797 performed the first transverse colostomy, albeit by mistake. Fine had endeavoured to perform an ileostomy on a female patient with an acute malignant obstruction and it wasn't until an autopsy was performed following her death 3 months later that he learnt of his mistake (Cromar 1968). A Danish surgeon, Hendrik Callisen (1740-1824) described in his surgical textbook, a surgical lumbar approach for performing a colostomy, this he claimed would reduce the risk of damage to the peritoneum and thus reduce the risk of peritonitis. However, his colleagues of the day disagreed with his technique stating that the increased benefits didn't outweigh the increased difficulty to perform such a technique (Richardson 1973).

The first British surgeon to perform a colostomy was George Freer who in 1815 operated on an infant with imperforate anus and in 1817 on a 47 year old farmer with rectal obstruction (Cromar 1968). Both patients lived but weeks, the farmer's demise was no doubt assisted by an excess of therapeutic zeal post-operatively, for daily purgatives and numerous enemas via the stoma resulted in a ruptured caecum. The second surgeon to perform colostomy surgery was Daniel Pring who operated in 1820 on a patient who was quite coincidentally named Mrs White. Pring described in detail the formation of a sigmoid colostomy and Mrs White's complicated recovery. It is perhaps the first record of post-operative stoma complications such as skin ulceration and prolapse and discussions of ostomy appliances. It appears that Mrs White found what appeared to be



Brooke Ileostomy showing eversion of the stoma (A) and suturing of the skin (B)

an elaborate truss-like appliance not as effective as a pad and binder in containing her two stools per day (Richardson 1972).

Pring's comments highlight the necessity even in 1820, of providing expert stomal therapy care and choice of appropriate appliances for stoma management. Pring thought the colostomy was a great benefit for it was his belief that the colostomy: "has afforded her a moral, as well as a physical advantage; for she is now at a no loss for an interest, and is provided with something to think of for the rest of her life" (Richardosn 1973, p18).

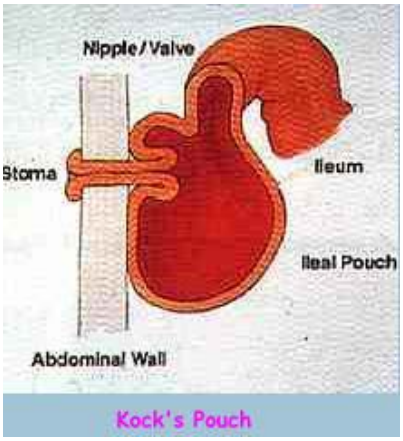
Generally, few surgeons of the day were courageous enough to perform bowel surgery for they feared to enter the peritoneum for risk of causing mortal sepsis. Knowledge of bacteria, antiseptics and the importance of asepsis was yet to be gained. Jean Amussat (AD 1796-1856), a French surgeon, believed that the ignorance of his colleagues was also compounded with the fear of compromising one's reputation if the patient should die. Amussat carried out a retrospective review of all published surgical colostomy procedures. He found that between 1716 and 1839 there were 27 cases listed but only 6 people had survived (Richardson 1972). Even with the later advances in medical science, colostomy surgery was not looked upon favourably, and performed most reluctantly, up until the end of World War I.

Ileostomy Surgery

The first recorded operative ileostomy was in 1879 by Baum, a German surgeon from Danzig. A temporary ileostomy was performed on a patient with a malignant obstruction however, the patient died just over 9 weeks later from peritonitis following a leaking anastomosis. A successful recovery in a patient following an ileostomy procedure was reported by Maydi from Vienna in 1883. Finney from Johns Hopkins Hospital described a procedure that gave a loop stoma flush to the skin. The complications to a para-stomal skin that resulted from the latter technique discouraged it's use (McGarity 1992). Ileostomies carried with them unacceptably high morbidity and mortality rates up until the 1950's. The high mortality rate was often due to the critical, often moribund condition of the patient following acute or lengthy episodes of ulcerative colitis or Crohns Disease.

There was still a lot to be learnt in the care of the patients with a spectrum of conditions broadly termed Inflammatory Bowel Disease. During the first half of this century an ileostomy stoma was made by prolapsing a small section of ileum and allowing it to heal to the skin surface. Ileal dysfunction, a complication attributed to obstruction of the stoma and characterised by cramps and excessive loss of ileal fluid, dehydration and electrolyte disturbance, resulted. It wasn't until 1952 that Professor Bryan Brooke from Britain described a technique for eversion (turning back on itself) the stoma that the problems was solved. This procedure continues to be used today for fashioning an ileostomy stoma (Brooke 1952).

In an attempt to eliminate the need



for wearing an appliance, a Swedish surgeon named Nils Kock developed a continent ileostomy in the 1960's. An internal pouch or reservoir was made from lengths of ileum and the patient taught to empty regularly using a catheter. Leakage remained a problem however, and in 1972 he overcame the problem by designing an intussescepted valve in the ileal outlet which provided a leak-proof mechanism (Kock 1976).

The Kock's pouch offered another choice for some people but it was still a far cry from the normal means of defaecation. Rudolph Nissen, a Berliner, successfully performed an ileo-anal anastomosis in 1933 in a patient following the removal of the large intestine. However, diarrhoea complicated quality of life for many people and few were satisfied. In order to reduce the degree of diarrhoea experienced by a patient with an ileo-anal anastomosis, Peck in 1971, created an ileo reservoir or artificial rectum (McGarity 1993). This surgery became known as restorative proctocolectomy and various surgeons went on to describe individual techniques which are identified by an ileal pouch alphabet such as J, S, W and H that we know today (Tjandra & Fazio 1993).

Urinary Diversion Surgery

The first record of diverting urine from the ureters into the rectum was performed in a child with congenital abnormalities in 1851 but the child died (Richardson 1973). Verhoogen and de Graeuwe fashioned a pseudo-bladder from caecum and created an appendicostomy in 1909 similar to the urinary pouches of the 1980's. Coffey in 1911, devised a procedure where he implanted the ureters into the sigmoid colon and thus urine and faeces were evacuated via the anus but this method was abandoned because of electrolyte disturbance (Brooke 1980).

Successful urinary diversions were not achieved until 1950 when an American surgeon, Eugene Bricker, described a procedure using a small section of terminal ileum, as a conduit to deliver urine from the ureters to the abdominal wall, and for fashioning a urinary stoma (Turnbull 1994). Since the fifties, Bricker's ileal conduit procedure has remained the most commonly used technique for urinary diversion.

Source: Keryln Carville RN BSc(Nsg) STN, Silver Chain Nursing Association, Perth, Western Australia

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Michael Arab and Karen Coughlan, with one of their products

At the general meeting Feb. 15, Michael Arab and Karen Coughlan of Keir Surgical gave a presentation of ostomy products as well as a very informative talk on PharmaCare coverage of interest to ostomates.

Fair PharmaCare Administrative Reviews

Under certain circumstances, through its Administrative Review process, PharmaCare may agree to:

- base your Fair PharmaCare financial asistance for 2004 on more recent income information; or
- waive the inclusion of the net income of your spouse; or,
- apply a dependent's drug costs towards your deductible if you are a separated, custodial parent or a legal guardian.

Decrease in family net income of more than 10%

Fair PharmaCare financial assistance for 2004 is based on your 2002 family net income. If you have experienced a decrease in net income of 10% or more since 2002, you may request that PharmaCare consider more recent income information.

Joint Custody

Dependent children are normally registered as part of the family of the parent on whose Medical Service Plan contract the child is included. However, if you are a separated spouse, you may submit a request that the child's drug costs be applied toward your deductible if you have greater than 50% custody of the child.

Non-parental Custody

If you are the legal guardian of a child, you may submit an appeal to have the child's drug costs applied towards your deductible if you can provide acceptable supporting documentation to substantiate the claim.

cont. page 13

Spotlight on ET/WOCN nursing staff

Annemarie Somerville

Annemarie Somerville hails from the ET nursing team at Lion's Gate Hospital where you can find her three days a week. The ET staff there recently moved into bright and spacious new offices, a most welcome improvement for both staff and patients! Many thanks to Annemarie for all the publications she's generously loaned and for taking the time to write her 'interview'!

I decided early on in high school that I wanted to go into nursing. I completed my nursing degree at the University of Alberta in Edmonton. I initially had planned to work in pediatrics and quickly had to abandon that idea as I found it difficult to watch young children in pain. This was probably one of my wiser choices, as now that I have two young boys, I feel I would have an even more difficult time.

After graduating in 1990, I moved to Vancouver. I started to work at LGH on a medical floor. To my embarrassment this is where I got my first hands on ostomy training from one of my patients. He turned out to be a great teacher and I still use some of his tips to this day.

I moved on after two years and transferred to a surgical ward where we primarily did abdominal, vascular and lung surgeries. Here I got a vast amount of experience with various ostomies and wounds.

A year into nursing I had an ET nurse approach me to do my ET training. At that time I felt so green I couldn't imagine taking the plunge. It took another eight years and getting pregnant to realize I needed a change. I never choose easy times to make big changes. It took me a year, but I finally managed to complete my course out of Emory University in Atlanta Georgia. It was a great experience I will never regret.

After completing my ET training in early 1999, I worked for a short time at VGH and UBC before returning back to LGH. I continue to work at Lions Gate hospital 2 to 3 days per week. I have also had the opportunity to run a small ostomy clinic out of Keir surgical for the past three years. It was a wonderful relaxing environment to work in, and having all the products needed easy at hand is an ET's dream.

My new career has opened many doors. I've met many wonderful colleagues and very appreciative patients. The patients and their families I work with on a daily basis, are what keep me grounded in nursing.

In addition to ostomy care a large portion of my time is focused on wound care. Up to approximately 70 % of our time can be spent on skin breakdown prevention and wound management.

We probably do more colostomies with loop ileostomies being a close second. The majority of the stomas are for cancer of the colon and diverticulitis and

There have been quite a few improvements in appliances. I feel having the added competition of Coloplast on the market has encourages Hollister and Convatec to be more innovative. There have been several new products introduced that have proven to be helpful. There are the Eakin seals and related products, clip free pouches, two piece systems that have adhesive rather than snaps. There are more products that are presently available in the States and have not yet made it to Canada. The wonderful thing about ostomies is that there are a multitude of products out there.

What are the bigget challenges facing new ostomy patients? I believe this very much depends on the patient's ability and life perspective. For the elderly, I often find that the concern and challenge is 'can I manage this on my own and stay independent?' For the younger set, incorporating their new ostomy onto their body image and lifestyle can be a real challenge.

Most importantly I reinforce with my patients that they are not alone. I encourage independence, but let them know the resources available should challenges arise. I strongly encourage patients to seek out others (e.g. through the visitor program, UOA meetings, the internet) with similar experiences, and thereby trying to make their own adjustments smoother.

Our Stories

A young man's journey with Crohn's disease

Kayaking with Crohn's

by Patrick Williston

When I was 28 I ran the New York City Marathon, defended a Master's Thesis in botany, moved from Vancouver to Smithers and began working as a ecological consultant in northern BC. It was a busy year. I did not know at the time that New York would be my last race for a long while because that year I also started to develop the symptoms of Crohn's Disease.

The disease progressed rapidly as I did not respond favourably to the conventional treatments of Asacol, anti-inflammatory drugs and steroids. I found it increasingly difficult to do field work (which is more-or-less essential for my job, conducting rare plant research) and was eventually hospitalized because of dehydration and pain relating to infected abscesses. It was a difficult time, and I was fortunate to have the support of my girlfriend, Paula, as well as friends and family.

A northern BC wedding, Aug. 30/03

During this time, I was administered the new drug Remicade, and even had some expenses covered by Remicare, a financial assistance program provided by the drug company. This reduced the severity of my condition and even contributed to the healing of my fistulae and abscesses; however, the relief was temporary, and a few months later the inflammation in my colon was worse. I tried several different dietary approaches and yet I continued to lose weight and energy. Eventually I decided, with the advice of my GI specialist, that it was time for a surgical approach. About a year after being diagnosed with Crohn's, I underwent surgery to de-function my colon, resulting in an ileostomy. I would retain my colon, only it wouldn't be hooked up to the rest of my intestine, thus giving it a chance to heal. It would also be my introduction into the ostomy world.

The surgery went well; I gained some weight and got used to the ileostomy reasonably quickly. I planned for a summer of field work and Paula and I even decided that it would be a good time to get married. Things were definitely looking up.

Paula and Patrick working in the Selkirks, July 28, 2003

Paula and I spent several weeks during the summer conducting a rare plant inventory in the spectacular Selkirk Mountains east of Revelstoke. The work went well and though I was often fatigued, I was also inspired by the landscape, my supportive colleagues and nature of the work. When the work was done, we did some hiking and plant hunting with friends in Bella Coola and then went whitewater paddling back in Smithers.

By the end of summer Paula and I were preparing for our wedding; a week of celebrating with friends and family. It was a very enjoyable and memorable time. Many who came had never experienced the beauty of northern BC and I was only too happy to take them paddling down the spectacular Bulkley Canyon or hiking up majestic Hudson Bay Mountain. At seven months post-op, life with the ostomy had proved to have few limitations and I was hopeful that I was gaining control of my disease. Did we live happily ever after? Well, not exactly. My colon had other ideas.

About a week after the wedding I once more found myself at the mercy of my terribly inflamed colon. It was worse than ever and I was running to the bathroom every 20 minutes right through the night. I didn't sleep for four days and ended up back in hospital on high doses of steroids. Once again I tried dietary restrictions, healing touch, and lots of rest, but my condition continued to deteriorate. I was 50 pounds below my normal body weight and completely sapped of energy. I wanted to give the diet a chance,

so I spent the next three and a half months waiting for something good to happen. I was unable to work or exercise and spent much of the time staring listlessly into space. It was painful to walk, stand or sit and I had difficulties cooking and cleaning. I wasn't exactly the ideal new husband, and I am not sure how I would have coped without Paula's help. When the abscesses began to worsen again, I knew it was time for a new approach; this time the colon was going for good.

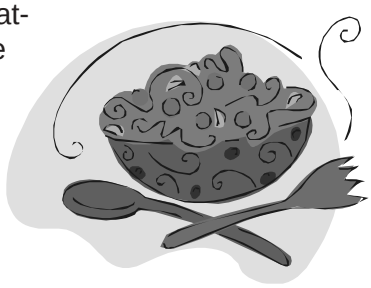
Patrick, 7 months after his first surgery

By late November, 2003, I had become very weak and more-or-less emaciated. I made it to St. Paul's Hospital in Vancouver for the surgery that would finally separate me from my severely diseased colon. The whole colon was removed and though I was somewhat melancholy about being bound to life with a stoma, I was also relieved to be rid of the unrelenting illness caused by the inflammation. Because of my poor condition, the recovery was slow. I experienced several painful blockages in my small intestine and had difficulty gaining weight. But I also knew that if I was patient, good health was just around the corner.

In the past few weeks I've managed to gain about 25 pounds. I'm no longer listless and have resumed helping with cooking (and even cleaning!). The holiday feasts and festivities were timely and made a positive contribution to my constitution. Life has renewed meaning, I am now able to work and may soon be able to enjoy the winter recreation of my northern home. Paula and I are planning a walking tour of southern Italy for when we've caught up on work, probably in April. This summer I will return to running and if things go well, maybe I'll try a marathon next year. I am now 31, and after three challenging years with severe Crohn's, the prospect of a disease-free life with a stoma is very attractive. Sure, the ostomy has provided some awkward moments, and will certainly provide more in the years to come, but I am looking to the future with much hope, excitement and anticipation, wondering what adventures lie ahead. From this angle, it is looking very promising.

How Does Fibre Affect Ileostomates?

Whether or not to include fiber, and to what extent, should be based on the ileostomate's tolerance of foods. The intestine has a remarkable capacity to adapt. Matt/digested food in the small intestine is quite watery, and after it moves into the large intestine, a good portion of the water is reabsorbed into the body. Most fiber is indigestible material (from plants) that acts like a sponge, soaking up water and increasing the bulk of the intestinal contents - making matter move through the system more quickly. In a person with a colon, fiber is essential to preventing constipation and keeping a person "regular." This is the main function of fiber. Another theory about fiber is that is promotes mucosal growth, thus keeping intestines healthier, promoting gut function. Usually, a person without a colon (ileostomy) doesn't have a problem with constipation, and may have mostly watery stools or diarrhea. Again, over time, a person may adapt, especially if the last section of the small bowel (ileum) is still intact. So, consuming too much fiber, or too much 'insoluble' fiber may aggravate a person's diarrhea or watery stools. If this is the case, limiting insoluble fiber (bran, popcorn hulls, seeds, nuts, skin/seeds/stringy membrane parts of the fruits and vegetables) may be helpful. However, another type of fiber (soluble) may be beneficial to the ileostomate. The function of soluble fiber is to make intestinal contents 'thicker' and can actually prevent diarrhea. This fiber is found in oatmeal, barley, dried beans, peas, Metamucil and in the pulp of fruits and vegetables. Most foods have a combination of both types of fiber, but the above examples show the differences. Just as a side note, I worked with a lady years ago who had 'short bowel syndrome' -- all of her colon and a significant part of the small bowel were removed. She found that adding pectin (Certo -- used to make jam and jelly) to her daily diet helped to minimize diarrhea. She added a little to some applesauce every day.



Source: Kay Leck, MPH & Registered Dietician, Napa Valley, CA. via Philadelphia UOA Journal; Greater Cincinnati, OH Chapter; The Re-Route Oct .2003.

Too Much of a Good Thing

by Sharon Williams, RN/ET

(reprinted from HighLife, December 1989)

Do you need one or more hours to change your appliance? Does your stock of ostomy supplies resemble the store front of a local pharmacy? Do you need a "roadmap" to remember what product goes on first, second, third, etc? If so, you may be the victim of the "too much of a good thing" syndrome.

Occasionally, an individual will come to the Stoma Clinic carrying a large sack containing a vast array of skin care products. He explains, "All item are needed in order to apply my pouch". Unfortunately the reason the individual usually seeks assistance is due to a problem with appliance adhesion, skin breakdown or inability to afford ostomy products. One particular gentleman who comes to mind was utilizing a special skin cleanser and cream, two types of skin cement, a double-face tape disc, a paste, and a popular skin-barrier wafer before the pouch was applied. He had started out with a fairly simple system of ostomy management. However, in his quest to achieve what he felt should be a seven-day wearing time with his appliance, he had been adding product after product. Besides the many items he was now using, he had what he described as a "closet full of products at home". After checking his abdomen, it became obvious that what he had need of was a product change. He also needed a more realistic view of wearing time for his particular situation. Realistically, not everyone may be able to achieve a seven-day, leak-free wearing time. It is much better to anticipate leakage and establish a regular time PRIOR to this. Here are a few hints to remember to help achieve a successful ostomy management system:

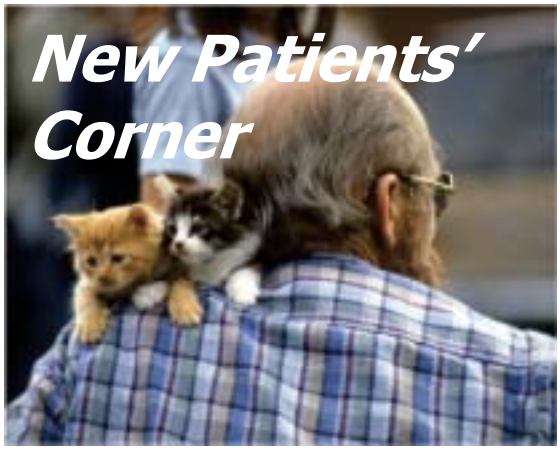
1. <u>Keep it Simple.</u> Do not use extra cement, skincare products, etc., unless absolutely necessary. Sometime, extra products can actually interfere with apliance adhesion or create skin problems. Plain water is still the best cleansing agent for around the stoma.

2. <u>Do Not continue to Use Therapeutic Products When the Problem has Been Solved.</u> An example: Kenalog spray and Mycostaten powder should not be used routinely when changing the appliance. These products are prescribed for particular skin problems. Kenalog is usually recommended for its anti-inflammatory effect and symptomatic relief of the discomfort associated with skin irritation. However, continued and prolonged use of Kenalog afte the problem is resolved may lead to some "thinning" of the outer layer of skin, thus making it more susceptible to irritations. Mycostaten poder is useful for yeast infection. However, using Mycostaten after the infection clears serves no purpose.

3. <u>Seek advice</u>. See your physician or ET Nurse if you find yourself a victim of this syndrome. They can provide assistance in selecting the most appropriate and economical ostomy management system for your needs.

God grant me the senility to forget the people I never liked anyway, the wisdom to remember those that I do and the eyesight to tell the difference."

- Anon



At a recent chapter meeting a subject came up that I found intriguing. One of the participants in the rap session stated that he found himself depressed and withdrawn even though it had been a year since his surgery. He wondered how long he could expect that feeling to last and I think, whether it would go on for the rest of his life. Some ostomates adjust almost immediately. These folks see an ostomy as a cure for an illness that threatened their lives or restricted their activities. Others take a few months, generally feeling better about the situation as soon as they master the fine art of pouch changing and maintenance.

For many, ostomy surgery begins a process that appears, and is, very close to the grieving process, and like any grieving process, the amount of time needed to feel emotionally whole again will vary. It took me almost 2 years following my surgery before I felt like I had regained my former personality and was ready to move on with my life. So there is no magic amount of time needed to adjust to your new ostomy. Allow yourself the time you need to realize that the feelings of depression and isolation will eventually go away. If the depression is severe, don't be afraid to seek professional help.

If your isolation is caused by lack of confidence in your appliance, seek help from an ET nurse. If your appliance is working fine but you still feel separated from others, seek help from other ostomates. Go to a meeting and meet others in the same situation. If you don't already have one, call your local chapter and get an ostomy visitor who can talk to you about how they managed their post-operative emotions but above all, give yourself time to adjust.

- by Mark shaffer, Metro Denver

Sources - Hemet, San Fransisco CA; The Re-Route, Evansvill IN; Regina Ostomy News, Sask.; Ostomy Toronto Dec 2003; Coquitlam connection, Feb 04

HINT & TIPS

If your pouch doesn't stick well, are you applying it right after showering in a high-humidity bathroom? Skin must be perfectly dry to receive and hold the appliance. Also, oily products such as Dove Soap, can cause the wafer to loosen and fall off. if you are beginning a new medication for any reason, keep a close eye on your appliance. Contact your doctor immedieately if you suspect the medicine is going straight in and out. When taking liquid medicines, do not use a tablespoon instead of the measuring device that came with the medication. Tableware can give as much as 20% larger dose than desired. Washing ostomy bags with Woolite will keep them soft and odorless.

- Source: The Re-Route, Oct./03

WHY IS A UROSTOMY ALWAYS ON THE RIGHT?

A urostomy is not always on the right, but most commonly it is because ther terminal ileum is used, the last little bit of ileum befor it goes to the colon (a segment of 10 - 12 cm. long in eleocecal valve). it just so happens to be closest to RLQ (right left quartr), and it is easiest to bring it out there to keep the blood supply intact.

It is important to finda site that is convenient to the patient, far enough from the incision to allow a pouch to be put on early after surgery. You do not want the stoma in a roll of skin where leakage occurs more frequently. The ET will typically evaluate the patient with his/her clothes on to see where the belt line is, how his/her clothes fit and what it looks like with him/her lying, standing, and sitting. The ET will then place a mark with indelible ink at the best stoma site. That is something one cannot do on the operating table. I have worked on cases where we used a piece of the sigmoid colon going into the bladder. In conjunction with general surgeons, the bladder was removed and we took a piece of the sigmoid colon in the left upper quadrant for the ileal conduit and in the left lower quadrant for the colostomy.

Source: Thomas Rosvanis, MD; via pittsburgh; Ottawa ostomy news Jan 2004

Visitor Report Jan/Feb. '04

Requests for hospital, in-home andphone visits for this reporting period came from VGH, ST. Paul's and Lion's Gate hospitals and from within the chapter itself.

Colostomy	4
Ileostomy	2
Urostomy	4
Pre-op	2
Total	**12**

Many thinks to my excellent crew this round: Al Ashcroft, Maxine Barclay, Arlene McInnis, Bill Clark, Ron Dowson and Alan MacMillan.

PharmaCare, cont. from page 6

Families in which one spouse is a resident of a long-term care facility
Normally, the income of both spouses is included when calculating Fair PharmaCare assistance. However, if
if you are facing financial difficulty because your spouse is a resident in a long-term care facility, you may request that PharmaCare waive inclusion of your spouse's income when calculating your Fair PharmaCare assistance.

New residents of Canada
If you have recently moved to Canada and have filed an income tax return with the Canada Customs and Revenue Agency for the relevant tax year (2002), PharnaCare may accept alternate proof of income or information from a more recent tax year.

PharmaCare Administrative Review contact information
For additionalinformationon Administrative Reviews:

- Visit the PharmaCare Web site at www.healthservices.gov.bc.ca/pharme
- Contact the Fair PharmaCare Registration Desk at 1-800-387-4977 (Monday to Friday, from 8 am to 8 pm, or Saturday and Sunday, from 8 am to 4 pm)

Internet Addresses of Interest to Ostomates

These websites have a good deal of ostomy and related information. Several have links to other websites.

UOA of Canada Inc.: www.ostomycanada.ca

UPDATED **Stuart OnLine:** www.stuartonline.com
(click on ostomy support information; has message board as well)

International Ostomy Association: www.ostomyinternational.org

Vancouver Chapter: http://www.vcn.bc.ca/ostomyvr/

Coquitlam Chapter: www.geocities.com/coqcon

NEW **http://www.vesalius.com/** *Ever wanted to see your actual surgery? Slides, live video, operative reports on a wide variety of procedures. Not for the squeamish. (Membership fee required for some views)*

http://www.j-pouch.org/ - J-pouch site

Friends of Ostomates Worldwide: www.fowcanada.org/

Crohn's & Colitis Foundation of Canada: www.ccfc.ca

NEW **Colon Wars:** http://home.vicnet.net.au/~youinc/

Marlin Medical Group:http://joe.monkeydepartment.com/colon/
(Young man's personal weblog. As can be guessed from the title, surgery did not alter his sense of humor)

Shaz's Ostomy Pages:http://www.ostomates.org/cgi-bin/yabb/YaBB.pl
(previously listed, very active message board for all ages, types of ostomies)

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Dr. Martin Gleave, Urologist - VGH
Deb Cutting, WOC Nurse
Mariette Carmen, RN. ET *(retiring spring 2004)*

STOMA CLINICS IN VANCOUVER AREA

Pre-surgical counselling and post-operative follow-up.

VANCOUVER
Vancouver General Hospital 855 West 12th Avenue
Deb Cutting, ET. Tel (604) 875-5788
Beth Schultz, ET.
Eva Sham, ET.
Candy Gubbles, ET.

UBC Hospital 2211 Westbrook Mall
Shannon Handfield,
WOC Nurse Tel (604) 822-7641
Sharon Evashkevich, ET.
Maureen Moster, ET.

St. Paul's Hospital 1081 Burrard Street
Mariette Carmen, Tel (604) 682-2344
RN. ET. Ext. 62917 Pager 54049

Children's Hospital 4480 Oak Street
Janice Penner, Tel (604) 875-2345
RN. ET. Local 7658

NORTH VANCOUVER **Lion's Gate Hospital**
Annemarie Somerville, Tel (604) 984-5871
RN., ET., CWOCN

NEW WESTMINSTER **Royal Columbian Hospital**
Muriel Larsen, RN. ET., Tel (604) 520-4292
Laurie Cox, RN

Westminster West End Pharmacy
Andrea (Andy) Manson, RN. ET. Tel (604) 522-4265

SURREY **Surrey Memorial Hospital**
Lisa Abel, RN. ET. Tel (604) 588-3328

LANGLEY **Langley Memorial Hospital**
Bev Wootton, RN. ET. Tel (604) 534-9903

ABBOTSFORD **M.S.A. General Hospital**
Sharron Fabbi, RN. ET. Tel (604) 853-2201
Extension 7453

CHILLIWACK **Chilliwack General Hospital**
Heidi Liebe, RN. ET. Tel (604) 795-4141
Extension 447

WHITE ROCK **Peace Arch Hospital**
Margaret Cowper Tel (604) 531-5512
RN. ET. Local 7687

WHITE ROCK & RICHMOND **E. T. Resources, Ltd.**
Elaine Antifaev, RN. ET. CWOCN Tel (604) 536-4061
FAX: (604) 536-4018

MEMBERSHIP RENEWALS!

Members, when you receive your membership renewal slip in the mail, PLEASE don't delay in sending your renewal cheque in to our hard-working Membership Coordinator, **Mien van Heek.** Your prompt response will save her from sending out reminder letters, and ensure that your membeship is kept up to date so you won't miss any issues of HighLife or Ostomy Canada Magazine.

Would you like to receive HighLife electronically? Issues are now available in printable 8 1/2 x 11 PDF format. Please email the editor and you will be added to the newsletter email list. Your issue will reach you faster, and save the chapter mailing costs. (AND it's in COLOUR!) You will need Adobe Acrobat to read these files. For a free version of this software, go to:

http://www.adobe.com/products/acrobat/readstep2.html

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Your ad is seen by all chapter members in the Vancouver area, numerous affiliated chapters across Canada, ET nurses, and new patients in hospital. HighLife is published 6 times yearly. Advertising rates are:

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Size:	1/4 page	1 issue	40.00	6 issues	150.00
Size:	1/2 page	1 issue	60.00	6 issues	200.00
Size	full page	1 issue	100.00	6 issues	300.00

If you wish to place a new ad, or upgrade an existing one, please contact the editor, **autodraw@shaw.ca** *Electronic artwork can be received as well as hard copy and photo images.*

MOVING?

Please phone or send us your new address so you don't miss any issues of Highlife or Ostomy Canada.

MEMBERSHIP APPLICATION

Vancouver Chapter United Ostomy Association

Membership in the UOA of Canada is open to all persons interested in ostomy rehabilitation and welfare. The following information is kept strictly confidential.

Please enroll me as a ☐ new ☐ renewal member of the Vancouver Chapter of the UOA.

I am enclosing my annual membership dues of $30.00, which I understand is effective from the date application is received. I wish to make an additional contribution of $ _____ , to support the programs and activities of the United Ostomy Association of Canada. Vancouver Chapter members receive the Vancouver ostomy highlife newsletter, become members of the UOA Canada, Inc. and receive the Ostomy Canada magazine.

Name _____ Phone _____

Address _____

City _____ Postal Code _____ Year of Birth ____

Type of surgery: ☐ Colostomy ☐ Urostomy ☐ Ileostomy ☐ Continent Ostomy

All additional contributions are tax deductible. please make cheque payable to the

UOA, Vancouver Chapter

and mail to: Mien van Heek, 2604 Haywood Avenue, West Vancouver, BC V7V 1Y6