



Vancouver Ostomy

# HIGHLife

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A non-profit volunteer support group for ostomates. Chapter website: [www.vcn.bc.ca/ostomyvr/](http://www.vcn.bc.ca/ostomyvr/)

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### REMAINING 2007 MEETING SCHEDULE

April 22  
 June 24 (AGM)  
 No meetings during the summer  
 September 16



Unless otherwise specified, all meetings are held at:  
 Collingwood  
 Neighbourhood House  
 5288 Joyce Street  
 Vancouver 1:30 pm

APRIL MEETING:  
 Speaker: TBA followed by group discussion

## Disability Tax Credit Form

Income tax time is coming up soon for many of us. If you have a colostomy, ileostomy or urostomy you may be eligible for a tax credit. The form required is not widely advertised and does not come with your standard income tax form, you must request form # T2201 and it will be sent to you. The DTC was instituted some years ago for individuals who 'have an impairment in physical or mental function' that is deemed 'severe and prolonged'. Individuals with an ostomy are deemed to have a significant impairment in the bodily function of elimination (bowel or bladder) and are therefore eligible the same as, for example, someone with a severe visual impairment.

The form is not difficult to complete and once done, you need to take it to your doctor for verification of your condition. You are only eligible for the disability amount if a qualified practitioner (your doctor) certifies, on the form, that you have a prolonged impairment and certifies its effects, and if the income tax people approve your form. Your doctor may write his or her own letter detailing the extent of your situation, or you may write your own assessment and present it to your doctor for his or her certification. Some doctors will charge for this service.

You can send Form T2201 at any time of the year, but it's recommended that you submit it before you file your income tax return. If you send it in later, or at the same time, it will still be processed but this may take longer for your submission to be assessed. If you are deemed ineligible, the form will not affect the outcome of your usual tax return. If you have had your ostomy for some time, a successful DTC assessment will be pro-rated back to either the date on which you had your surgery, or the date when form T2201 was first instituted (if your surgery was performed many years ago). How much you get back will vary depending on your income, and when your ostomy surgery was first performed.

To obtain a copy of the Disability Tax Credit Form you can call **1-800-959-2221** and request Form #T2201. Or you can order online at [www.cra.gc.ca/forms](http://www.cra.gc.ca/forms). You can request more than one copy of this form, which will be mailed to you.



## *From the President*

### ASK AND I WILL TELL

We have all heard of policies in the military and professional sports commonly referred to as “Don’t Ask, Don’t Tell”. You might wonder how such policies may relate to us. Prior to my ostomy surgery I was only vaguely aware of ostomies, ostomy surgery, how ostomies worked and the lives that ostomates could have. While

no one expressed it to me in this manner, it seemed to be one of those subjects about which a non-ostomate would never ask, and an ostomate would never tell.

I think that the lack of information about ostomates and ostomies has led to a lack of empathy and harmful misperceptions. I remember in my very early days as an ostomate speaking by telephone with a fellow ostomate whose situation was similar to mine. He told me the fact that he had an ostomy was a very closely guarded secret. He certainly did not want any of his co-workers or friends to know he had an ostomy. Even though I had his telephone number, and he had mine, at his request, we communicated by using first names only. I never did learn his last name.

I decided very early on that that was the wrong approach for me. While prior to my ostomy surgery I was one of the ignorant masses, I think it best for ourselves and future ostomates that we do what we can to intelligently inform those with whom we work and play about our ostomies. We are not holding some deep dark secret that if it gets out makes us bad people. We are the same people we were before our surgery. Keeping that information to ourselves does nothing to educate the world with respect to the plight of hundreds of thousands, if not millions, of ostomates around the world. It is not so much that we are the lucky few (comparably speaking) to live in North America – but there are millions of ostomates living in third world countries in appalling conditions without any decent ostomy supplies, care, nurses or, most important of all, compassion. We need to raise the awareness of ostomates and ostomies. This will help benefit those less fortunate than us, and we can start that process by raising the awareness here.

Let no one think I am saying we must now all run out and do a “show and tell”. Rather, when talking with friends, colleagues and family, as circumstances permit, we should quell that urge to withhold that piece of vital information about ourselves (and the thousands of others suffering in silence).

Others may disagree, and each will tell or share only to the extent they are comfortable. While it is only somewhat analogous, I remember the harm and the hurt caused by our “well-meaning” public being so inadequately informed about persons with AIDS and the HIV virus. Like leprosy, it was thought too horrible to talk about – and as a result ignorance reigned, empathy withered. We can do better. Therefore, ask and I will tell.

Martin Donner,  
President

## *From the Editor*



I’ve never considered myself ‘disabled’ -- inconvenienced, anxious, irritated and annoyed on occasion to be sure, but never ‘disabled’. So it was with mixed feelings that I applied for

the Disability Tax Credit last year. I never knew about this form or the tax refund that can be possible, until I attended Andy Manson’s Ostomy Education Day last year. Jim DeGeer and Sandra Dunbar, both from the Coquitlam chapter, were present and told me about form T2201. It seemed too good to be true and I felt foolish asking for a tax refund for poor ‘impaired’ me but I completed the form anyway, took it to my doctor who was in agreement that I qualified under the terms stated, and mailed it in. Months passed and I assumed my petition had been shelved or disallowed. And then I got a refund, pro-rated back to 2001, the year of my surgery. You could say I was astonished. I never thought you could get money just for not being able to go to the bathroom the conventional way.

Are we, as ostomates, ‘disabled’? The word has a negative connotation and seems out of step with so many of the people I know who have ostomies and travel, work, play, raise kids and generally live their life as well as those who do not have an ostomy. (or possibly better for we appreciate the gift of life, that second chance, perhaps more keenly than those who have never been seriously ill) Managing our ostomies, although we learn to be adept at it, is still a profound change in a basic body function. So I’ve revised how I look at the term ‘disability’. Disability, to my mind, (and in the mind of Revenue Canada,) exists if one cannot perform certain physical or mental functions, and under the terms of DTC T2201, we ALL qualify.

I encourage everyone who has not already done so to look into the DTC and submit a completed form. Don’t be put off by that word ‘disability’.



## **Continent Ostomy Port (COP)**

Zassi is currently developing the world's first non-surgical Continent Ostomy Port (COP) System, which will radically change the market for ostomy management. The COP designs are intended to restore bowel continence to millions of men, women and children who have been rendered incontinent and have an abdominal stoma due to ostomy surgery. Global expenditures linked to ostomy management approach \$2 billion annually. The Company's breakthrough innovation, the COP System, consists of a Continent Ostomy Port (COP) and an Automated Irrigation Pump System, which will bring to market the first "pouch free" continent ostomy system.

The Continent Ostomy Port (COP) is a small indwelling, self-retained, catheter-based device that can be placed into a patient's existing stoma in an outpatient setting without requiring any surgical revision. Subsequent replacement ports can be inserted at home or at alternate care sites by either the patients themselves or a caregiver trained to use the products. The port is constructed of a pliable, biocompatible material that has a retention bolster located at its tip, which allows retention and sealing of the port within the stoma. The COP's patented design obviates the need for undesirable ostomy pouches by restoring users' continence and control by allowing patients to discharge stool at a time and place of their choosing. The COP System also includes an Automated Irrigation Pump that is used to irrigate the colon to facilitate rapid evacuation of bowel contents through the COP device. By restoring continence and increasing the speed of stool evacuation, both components of the COP System work together to radically improve the user's quality of life by freeing them

from incontinence and dependence on externally affixed collection systems that are uncomfortable and periodically fail to adhere or work reliably.

## **NEW UOAC CHAPTER IN BC**

Congratulations to Quesnel and district which has formed a new UOAC chapter. Back in April of 2006 ostomates who were travelling to Prince George to attend meetings and see the ET nurse there felt a chapter could be formed closer to home. With the help of Prince George members, ideas were put together and an Executive was chosen. Meetings on the first Wednesday of each month were decided upon, and by-laws were drawn up in July. These were approved at the August meeting and sent to the UOAC, which approved Quesnel's affiliation. The new Quesnel chapter has 20 members, with Morris Turner as President, Dallas Bourdin as Vice-President and Bonnie Stowards assuming the dual position of Secretary/Treasurer. Michelle Wilkins rounds out the roster as an additional volunteer. Their first newsletter, "The Caribooster" was issued in November. Congratulations and best wishes to our new BC chapter!

## **RETIRING!**

Beth Schultz, a well-known ET nurse in the lower mainland, will be retiring mid-March of 2007. Beth has worked at several locations throughout her nursing career, the most recent being Vancouver General Hospital since 1993 as part of the ET/WOCN team. We wish Beth all the best in her retirement and extend a hearty thank you for all the help and support she has given the ostomy community over the years.

# Urinary Tract Infections and the Urostomate

- by Terry Gallagher, UK



**So you suspect you may have a urinary tract infection? There are a number of signs and symptoms which will suggest this to you. Let's look at those first:**

- Cloudy urine
- Thick and/or offensive smelling urine
- Visible blood in the urine
- High fever (39 C or greater),
- Rigors (this is uncontrollably shaking like shivering)
- Flank pain (pain in the back and side around the kidney region which is often worse on one side)
- Nausea, vomiting, and diarrhoea.

Symptoms will develop rapidly over a few hours or a day. Not all of the above may be present, certainly not at first. The usual first sign is a change in urine. If you notice this, should you 'wait and see' so that you don't bother your doctor unnecessarily, or should you go to your doctor straight away? The answer is very definitely the second one - go to your doctor as soon as possible. There are a number of reasons for this. The longer the time before effective treatment begins, the worse the infection will get, with increasing temperature until convulsions and/or unconsciousness result. People die of this! The longer the delay, the longer that treatment will take as the infection will have taken a firm hold by then. In addition, leaving it to 'wait and see' may result in your having to be admitted to hospital for intravenous antibiotic treatment as an emergency.

The problem is that many doctors may not understand that a urinary tract infection in a urostomist is not the same as a urinary tract infection in a normal person. Let me explain why. In a normal person with a bladder, there are valves at the ends of the ureters (the tubes from the kidneys to the bladder) where the ureters enter the bladder. When our ureters were joined to the section of ileum or small intestine used to make our ileal conduits or urostomies, we lost these protective valves. The purpose of the valves is to prevent the back flow of urine, and hence infection from the bladder to the kidneys. Without these valves, any germs getting into our urostomies will almost certainly end up in our kidneys. Therefore, for the urostomist, a urinary tract infection is, in fact, **complicated** (because we have an abnormal urinary

tract due to our urostomies) **acute pyelonephritis** - kidney infection.

Many doctors, especially hospital doctors in A&E (and I speak from bitter personal experience!) do not realise this. If treatment is delayed by more than 48 hours from the onset of infection, permanent kidney damage may occur.

What should we expect when we go to the doctor with these symptoms? The doctor should collect (or arrange for his practice nurse to collect) a urine sample. This can be tested on the spot using a test strip. This can show up high levels of blood, protein and ketones, all of which indicate a urinary infection. A sample should be sent away for testing for antibiotic sensitivity - to see which antibiotic will best treat the infection. The doctor may take your temperature and will certainly prod and poke you in your flanks around the kidney area to look for tenderness caused by the infection. If your doctor tries to poke your abdomen where your bladder used to be, gently remind him or her that they're wasting their time as you don't have a bladder to be tender and inflamed (It does happen! The doctor would normally poke the abdomen first, then check the renal angles - the flanks - as virtually all of his other patients have bladders to be infected.)

What treatment should you be getting? There are recommended treatments set out in the 'British National Formulary' and in 'Prodigy' - Department of Health produced guidelines for GPs. The recommended treatment in the UK, for example, is as follows:

- An immediate injection of a broad spectrum antibiotic such as cefuroxime or a quinolone (usually ciprofloxacin) especially if the patient is severely ill; gentamicin can also be used.
- A broad-spectrum cephalosporin or a quinolone such as ciprofloxacin. A minimum of a 14 day course of antibiotic should be given.
- Because a urostomist has complicated acute pyelonephritis, the doctor's guidelines actually recommend that he should consider hospital admission. If this takes place, then the hospital will often do a renal ultrasound to check that no kidney damage has occurred and that the problem is not

*cont. page 10*





## Achieving Digestive Health in the Colon

*Reducing Gas, Bloating and Diarrhea/Constipation*

*-by Arlene McInnis*

As I approach my four year anniversary of becoming an ostomate I have come to the conclusion that my stoma is pretty well behaved – it's my digestive system that causes most of my problems! I'm fortunate in having a well-sited colostomy stoma of a decent length that empties nicely into my pouch and a flat tummy. The issues I've dealt with that cause much frustration and anxiety have been chronic, noisy diarrhea and excess gas. No matter how much people say I'm extra sensitive to those noises when diarrhea and gas hit, even my pets turn to look at my tummy! Also for me I can easily fill up a pouch numerous times over a couple of hours before my colon becomes totally empty and settles down. I've learned how to restrict my eating so this hyperactivity disturbs social activities as little as possible but this in itself is stressful. So after trying every over-the-counter diarrhea/gas remedy without success (Imodium causes my whole system to shut down and my doctor's suggestion of bran both landed me in the ER!) I turned to looking at my diet.

I've suffered from a mild form of Irritable Bowel Syndrome (IBS) since undergoing radiation therapy over 30 years ago. This ailment is difficult to diagnose as symptoms vary in most people but if digestive and bowel complaints are present after all other recognizable illness are ruled out IBS is usually the problem. (IBS also presents itself with chronic

constipation or a combination of diarrhea and constipation.) Although it is not known exactly what causes IBS there is mounting evidence that IBS is precipitated by some type of insult to the gut – dysentery, food poisoning, intestinal flu, pregnancy, radiation therapy or abdominal surgery. As every ostomate has gone through some type of surgery and/or radiation therapy it is very likely that many digestive issues can be related to IBS. After a friend with IBS (a non-ostomate) suggested I try the diet that gave her tremendous relief from her digestive issues I decided to do some research as a last resort. These ideas are also good even for those who do not have IBS but suffer from excess bloating, gas and digestive distress.

There are numerous books which explain IBS but the best I've found are those by *Heather Van Vorous – Eating for IBS and The First Year IBS - An Essential Guide for the Newly Diagnosed* (the library does carry some of her books). There is also an excellent website [helpforibs.com](http://helpforibs.com). The most important change I made in my diet which resulted in immediate improvement was the addition of foods with soluble fibre to my diet. Soluble fibre becomes a thick gel in the colon which adds bulk and gives the muscles of the colon something gentle to grip during contractions and aids in slowing transit time for those with diarrhea. It also softens the stool which helps relieve constipation. It is recommended that nothing be eaten on an empty stomach except soluble

fibre. I also take a supplement which is the easiest way to get soluble fibre into the system. My supplement of choice is Benefibre. It is an over-the-counter product (comes in a powder or capsule) that is pure soluble fibre made of guar gum with no additional additives. Some of the other products on the market contain psyllium or inulin which can worsen bloating, gas and other IBS symptoms and should be avoided. It's a good idea to start off slowly and take with lots of fluid. I take my Benefibre first thing in the morning and before dinner. Since starting this product I can now go most of the day without having to empty my pouch – a major accomplishment for me! I also try to eat and snack on soluble fibre foods during the day. Insoluble fibre foods which for most people are a very healthy addition to the diet tend to cause very powerful stimulation to the GI tract of those with IBS. Insoluble fibre acts like a broom and is very hard on the sensitive lining of the gut of those with IBS.

Some examples of soluble and insoluble fibre foods:

**Soluble (good!)** – rice, pasta and noodles, oatmeal, French or Sourdough breads, flour tortillas, potatoes, carrots, turnips, squash, bananas, applesauce, mangoes, avocados, cornmeal, quinoa, barley

**Insoluble (bad!)** – whole wheat products, bran, seeds and nuts, beans and lentils, most raw fruits

*cont. page 13*



## Can You Wash and Re-Use Your Appliances?

Can you re-use ostomy pouches? Some people wash and re-use their appliances because they feel it is wasteful to throw out reusable items. Or sometimes generating all that non-biodegradable garbage bothers the environmentally-minded. Some folks feel cleaner if they 'rotate' to a fresh pouch more frequently than waiting to change the whole appliance. And if you've forgotten to re-order and find yourself down to your last pouch with no re-supply immediately available, you might need to re-use that last one. We're all different and we all manage our supplies in the manner that suits us best. There's nothing wrong with re-cycling your appliances but you need to be realistic about how long you can extend the life of a pouch. *You can only re-use the pouch part of a two-piece system.* Forget anything else. You simply cannot re-use the flange part once it's removed.

**Cleaning:** empty as you normally do, then remove and rinse the pouch with water into the toilet. (a squirt bottle is handy for this). Next put a bit of soap into the pouch- dish detergent suds up well -- plus some more water and swish it about, over the toilet, holding both ends. You want to get rid of any solid matter. There's no need to put the whole pouch right IN the toilet as this will only get your hands needlessly dirty and soil the outside of the pouch as well. Just get the inside clean. Now rinse the whole thing well under the bathtub faucet, using cool or lukewarm water. A bit of vinegar as disinfectant squirted inside the pouch will finish the job and you can lay it flat to dry. Run extra water down your bath drain along with some tub cleaner.

Pouches that are all plastic can be re-used a number of times but inevitably, they will develop odour and discolouration and should be thrown out when this happens. Pouches with a fabric covering will become tatty looking with repeated re-use but this is cosmetic.

**An easier way:** If you dislike the idea of washing pouches but still want to wear one that is clean inside throughout the day, consider pouch liners. These are very thin clear flushable plastic liners made to be worn inside the pouch. The barrier ring keeps them in place until it's time to empty, when you simply remove the liner and contents and flush it all down the toilet. A fresh liner is then put into place and you're good to go. The most well-known brand of liner in this area is Colomagic. At pennies a unit, liners are a cost-efficient alternative to cleaning or changing your entire pouch.

*Note: liners only work with 2-piece systems*

## Ileostomates should consider this before donating blood!



If you were a blood donor before ileostomy surgery, it may be unwise to continue this practice. Having an ileostomy places you at much greater risk for dehydration because you no longer have the body's natural 're-hydrator', the large bowel. Mild dehydration caused by the loss of a pint of blood is temporary and not dangerous for those with an intact set of bowels, but for an ileostomate, the consequences can be serious. If you have a rare blood type and feel it is your civic duty to donate, drink extra fluids both before and after your donation.

## Tips & Tricks

- If you are taking a bismuth preparation, try to stop taking it for one day before having an intestinal X-ray or tell the doctor, because it sometimes shows up opaque on an X-ray.
- A large teaspoonful of bulk gelatin dissolved in water or lemon juice once a day may help firm up loose stool.

## Colostomy Irrigation:

**results of 25 cases with particular reference to quality of life**

- *Journal of Clinical Nursing, Volume 14 Issue 4 Page 479 - April 2005.*

**Aims and objectives.** The aim of this study was to document our results with colostomy irrigation with particular emphasis on the possible contribution of irrigation on quality of life.

**Background.** Colostomy irrigation is a useful method of achieving faecal continence in selected conditions, and may improve quality of life. When successful, irrigation offers a regular, predictable elimination pattern and only a small covering is needed for security between irrigations.

**Methods.** The digestive disease quality of life questionnaire-15 (DDQ-15) and Short Form-36 were used to analyse quality of life before and 12 months after stomatherapy in a series of 25 irrigating patients with permanent end colostomies. During the same time period, 10 similar patients with left-end colostomies who also received counselling but did not consent to colostomy irrigation were also analysed for comparison.

**Results.** Colostomy irrigation was found to be effective for achieving faecal continence in selected patients with end colostomies with no complications or significant side-effects. The digestive disease quality of life questionnaire-15 score improved significantly in both groups after stomatherapy in the irrigating and non-irrigating groups. The poststomatherapy digestive disease quality of life questionnaire-15 score of the irrigating group was also significantly higher than that of the non-irrigating group. Although none of the poststomatherapy item scales of Short Form-36 differed significantly between the two groups, stomatherapy with irrigation resulted in significant improvements in role limitation due to physical problems, social functioning, role limitation due to emotional problems, general mental health, vitality and bodily pain. On the contrary, the non-irrigating patient group showed significant improvements only in social functioning and general mental health.

**Conclusion.** Our findings suggest that colostomy irrigation can be a useful method of achieving faecal continence in selected conditions. It is safe, and it may help improve many aspects of quality of life.

**Relevance to clinical practice.** Colostomy irrigation is free from complications and significant side-effects, and it may serve as a useful adjunct to conventional stomatherapy. Therefore, the enterostomal therapy nurse should assess the appropriateness of routine irrigation as a method of stoma management for patients with left-end colostomy.



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**DELIVERY AVAILABLE**

A warm welcome is extended to new Vancouver UOA chapter members:

**Qing (Jack) Zhang  
Rod Dirk  
Darsho Johal  
Robert Liverant**

**The Vancouver UOA would like to thank the following individuals for their kind donation to the chapter:**

**WD Crowe  
Darsho Johal  
Robert Liverant  
Bob Copps  
Louise Hemming  
Jane Short**

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# Activity helps seniors think, sleep better

MSN Health News,  
BruneiDirect.com News  
December, 2004

Chicago - Senior citizens can improve their sleep and thinking in just two weeks by becoming socially and physically active, say Northwestern University researchers.

Their findings, reported in the Dec. 14 issue of the journal *Sleep*, echo other studies on the benefits of social and physical activity. Isolation and inactivity aren't believed to be good for anyone, regardless of age. But they can be particularly risky for seniors.

"Many of the health changes associated with aging, including the decline in sleep and cognitive abilities, can be attributed to



sedentary lifestyles and social disengagement among older adults," say the researchers, who included Susan Benloucif, PhD, of the neurology department at Northwestern's medical school.

Sleep and thinking often suffer with age. More than half of adults over 65 report at least one sleep complaint, and more than a third say they can't stay asleep all night or they arise

in the morning's wee hours. Sleep problems can start in middle age and tend to worsen every decade.

Likewise, mental abilities often falter with advanced age. Sleep problems might have an impact, since daytime sleepiness is associated with mental decline in older adults, say the researchers.

Of course, not all senior citizens have those problems. Staying socially and physically active may be a key to preserving mental function and getting restful sleep as the years gather.

Past studies have shown that physically fit younger and older adults sleep better and that regular exercise can slow or even reverse age-related declines in thinking and memory in middle age, say the researchers.

How much activity does it take to reap the benefits? To find out, Benloucif and colleagues recruited their own "dream team" from independent-living retirement homes and residential apartments.

Four men and eight women aged 67-86 enrolled. Those who weren't healthy had chronic but stable

medical conditions including high blood pressure, diabetes, and arthritis. Some had no dementia; others had mild cases of dementia.

Every day for two weeks, participants engaged in social and physical activity for 90 minutes. That may sound like a lot of time, but the pace was reasonable.

First, participants engaged in mild to moderate exercise for 30 minutes.

They stretched, warmed up, and walked or practiced stationary exercises for the upper and lower body.

Next, they sat down and chatted for half an hour while playing cards or board games. Afterward, they walked rapidly, danced, or did calisthenics for 20 minutes at mild to moderate levels. A 10-minute cool down ended each session.

Participants tried the 14-day program twice -- once at 9 a.m. and once at 7 p.m. -- to see if morning or evening sessions yielded better results.

Several tools tracked sleep and mental abilities. Subjects kept sleep diaries and rated their alertness, sleepiness, weariness, happiness, sadness, calmness, tension, and vigor. They also wore wrist monitors to verify their sleep patterns.



Participants also took tests covering memory, math, spatial processing, symbol copying, visual search, attention, verbal reasoning, and speed and coordination. Tests were conducted with paper and pencil, and also on laptop computers. The researchers let the participants practice on the laptops for a day before the tests.

Participants said they slept better than before the study, and their test scores improved by 4%-6%. Their wrist monitors didn't confirm better sleep, but subjective sleep quality might be just as important, say the researchers.

Morning and evening sessions were both helpful, although evenings may have had more consistent effects. As long as seniors get regular social and physical activity, the time of day doesn't matter much, the researchers conclude.

**Urinary Tract Infections cont. from page 4**



due to kidney stones.

What you should not be offered as an antibiotic is nitrofurantoin which does not have any effect on a kidney infection.

The most common bacteria causing us to have infections are coliforms - bacteria from the bowel. Of these, the most common is E Coli (about 80% of all urinary tract infections) and other bacteria include Enterococcus faecalis, Klebsiella and Proteus species,

Our general practitioners have a problem in that we are a very special group requiring a treatment regime very different from the normal patient presenting with a urinary tract infection. Because of this, doctors sometimes don't realise that we do need that different treatment because our infection will always involve one of both kidneys whereas the vast majority of his or her patients will have a lower urinary tract infection of bladder and urethra.

The vast majority of you can stop here, but there remains the 'awkward squad', of which I'm a fully paid up member. Why? Because some of us suffer from short bowel syndrome. In

my case this is because I have an ileostomy (formed first) and a urostomy. In the process, rather more small intestine than normal was removed, meaning that people in the same situation suffering from short bowel syndrome cannot absorb tablet antibiotics properly. If you know this to be the case with you, gently suggest to your doctor that you try an antibiotic suspension which is absorbed more easily. If this fails, then, I'm afraid, it means definitely hospital admission to receive your antibiotics by intravenous methods.

(Sources of information: the Electronic BNF at <http://www.bnf.org.uk/> , the NHS Direct on-line encyclopaedia and Prodigy at <http://www.prodigy.nhs.uk/guidance.asp?gt=Pyelonephritis%20-%20acute> )

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# Journey of the Digestive Tract, part 1

by Jenny Robulack, RHN

For people with digestive disorders, either an intestinal disease or an ostomy, it is very important to not only know what to eat but also how your digestive tract works. Even if you don't have digestive trouble, learning more helps you prevent future digestive problems.

Over the months I will introduce you to your digestive system, help you understand how it works and what it needs. We will begin with the mouth and work our way down to the anus (whether it applies or not!).

Have you every wondered where digestion begins? Is it when you see the juices roll off the ripe red tomato for your rainbow coloured salad? Or is it at the first scent of onions frying for your chicken stir-fry? Perhaps it could be just the thought of laying your chops around a moist, warm, fudge brownie. These all get your digestive juices going, your stomach wakes up and your saliva starts flowing.

With all of these wonderful sensory triggers, your mouth is more than ready to accept your nutritional gift. Together, your saliva and teeth are ready to start the digestive process.

Your teeth begin the process with mechanical breakdown of the food. They grind the food into a fine pulp from a good thorough chewing. This is a very important step. Thorough chewing helps reduce digestive upset, prepares food for nutrient absorption and the longer you chew your food, the more saliva you produce. The movement of chewing also strengthens your immune system. The action stimulates the parotid glands (located behind your ears) which releases

hormones that tell the thymus gland to produce T-cells. These cells are white blood cells which are crucial for fighting infections.

Saliva provides your mouth with a slippery surface, washes the food and debris from your mouth to keep it clean and contains enzymes. By lubricating the food, saliva creates a safe environment for the transport down the esophagus from the mouth to the small intestine. One of the enzymes in saliva is called amylase and its job is to break down carbohydrates. This is why if you chew bread long enough it begins to taste sweet. This is a great experiment for you to try, you not only experience chemistry in your mouth but you will get an understanding of how long you should chew your food for.

It's important to avoid any liquids while you eat. Liquids interfere with saliva and cause the body to secrete less digestive juices later in the digestive tract. Save your drinking until before or after eating.

Your mental and emotional state play a key roll in digestion. This is the perfect opportunity to sit down and relax for an hour while you savor every sight sound and mouthful. Don't eat on the run or while doing other things. Enjoy the company you're with (even if it's just you) and take time to chew every bite.

After digestion begins in your mouth, your food journeys through the esophagus into your stomach.

Your stomach is located on the left side of your abdominal cavity and is nearly hidden by your liver and diaphragm. It is the storage tank, the garborator and the second stage of digestion. It churns, mixes and pummels food to physically break it down into smaller

more manageable sizes.

Alkaline mucus lines your stomach to protect it from the ever so important hydrochloric acid. This stomach acid, along with many other digestive enzymes and juices, are secreted from one or more of the 6 different sets of glands on the stomach wall.

Pepsin is one of the enzymes that digest protein and it requires an acidic environment to break down amino acids. This environment created by hydrochloric acid is also responsible for keeping the intestinal tract free from bacterial growth. Another important secretion in your stomach is Intrinsic Factor, which is needed for the absorption of Vitamin B12 in your small intestine.

The order in which you eat your food and how well you chew it is very important. Foods are digested at different speeds. Liquids and fruits are the quickest to digest, next are vegetables and starchy foods like grains and proteins such as meats, legumes and beans are slowest to breakdown. It is ideal to eat foods in order of speed digestion to prevent fermentation, gas production and stomach upset. Fats and oils can also help to slow the digestive process. Try starting with desert, you will find that you feel less "heavy" and full at the end of a meal.

The key things to remember when preparing a meal plan, eating and shopping for your foods is to take it slow, chew well and enjoy every sight, sound, smell and taste. Every meal should be a celebration. If you remember this, the first part of digestion in your mouth and stomach will be successful and the rest of your digestive tract will thank you for it.

*References:*  
*Essentials of Human Anatomy & Physiology, Seventh Edition, Elaine N. Marieb*

## VISITOR REPORT

Requests for patient visits this reporting period came from Vancouver General, Lion's Gate, and independent inquiries:

Colostomy	5
Ileostomy	4
Urostomy	0
Pre-op	1
Other	1
<b>TOTAL</b>	<b>11</b>

Thank you to my excellent visiting crew this round: Martin Donner, Myron Donner, Sharman King, Lennea Malmas, Arlene McInnes, Lisa Saunders and Linda Jensen. Thank you as well to Maxine Barclay for handling the Visitor Program while I was on holidays in February.

*"When you are dissatisfied and would like to go back to youth, think of Algebra."*



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An Enterostomal (ET) nurse will be available if you wish to be assessed.

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#### Achieving Digestive Health, cont. from page 5



and vegetables especially with skins, greens, sprouts, berries

It was hard to give up or limit these insoluble fibre foods as we were brought up to believe they were a must for colon health but I was amazed at how well my system behaves without them. I do indulge occasionally but make sure I have eaten a good amount of soluble fibre first.

Other suggestions I have found helpful include cutting back on caffeine, alcohol, fatty foods, excess sugar and dairy products and drinking more filtered water. I have found peppermint (not good for people with acid reflux), fennel and chamomile teas very helpful in reducing spasms which cause gas as well as peppermints drops/candies made with real peppermint oil (Altoids are good!). I also dabble in food combining and have found eating fruit on its own 30 minutes before or after other foods helps to reduce gas and other assorted "rumblings".



## Church Bulletins

(these gems actually appeared in church bulletins or were announced in church services)

*"Miss Charlene Mason sang 'I will not pass this way again,' giving obvious pleasure to the congregation."*

*"Scouts are saving aluminum cans, bottles and other items to be recycled. Proceeds will be used to cripple children."*

*"Potluck supper Sunday at 5:00 pm -- prayer and medication to follow."*

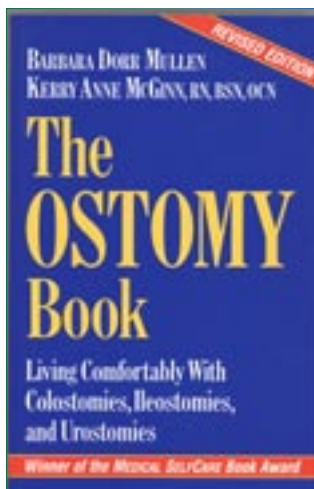
*"Irving Benson and Jessie Carter were married on October 24 in the church. So ends a friendship that began in their school days!"*

*"Please place your donation in the envelope along with the deceased person you want remembered."*

*"Low Self Esteem Support Group will meet Thursday at 7 pm. Please use the back door."*

*"Weight Watchers will meet at 7 pm at the First Presbyterian Church. Please use the large double doors at the side entrance."*

There are other numerous suggestions given in Heather's books and website to help relieve IBS symptoms. I found the addition of soluble fibre to be the easiest and quickest to help with my problems. As always these are the solutions that have worked for me. Although none of the changes I have made involve drugs, obscure herbal remedies or drastic diet changes it is always a good idea to talk to your doctor before making any abrupt change in your diet. Some medications can react to herbal products such as peppermint, fennel or chamomile. Please follow the instructions on any over-the-counter product.



## REVIEWS

This addition to our lending library was one of the first written accounts by an ostomy patient about their experiences of being diagnosed with cancer, undergoing colostomy surgery and reclaiming their life. Originally published in 1980 and updated 12 years later, the book chronicles the journey of

writer Barbara Dorr Mullen as she learns to cope with her new body. Her daughter, Kerry Anne McGinn, an oncology nurse, joined her mother in the project and together they produced a book that filled a void in the days when there were few resources available for ostomates written by someone who actually had an ostomy. Portions of this book are understandably

dated -- some procedures, products and treatments are no longer standard and some readers will be surprised at the amount of personal time the author was given by her doctors. These are minor caveats, however and the book is well worth a read by both new and experienced ostomates. Although she had a colostomy, Dorr Mullen has taken great efforts to include detailed information of interest to all categories of ostomies, as well as different age groups. This book is not commonly available in bookstores, but it can be ordered new or used online. Half the royalties from sales are donated to the United Ostomy Association (US).

## NEW EDUCATION AND LIBRARY BOSS!

Chapter member Emelia Prychidcho has kindly accepted the job of handling our library, video and DVD collection. These materials are available, free of charge for members to borrow at our meetings. We have a variety of titles dealing with ostomies, diet, cancer, IBS, ulcerative colitis and Crohn's, to name a few. Members are reminded to bring borrowed materials back at the next meeting or Emelia will be after you!

## Internet Addresses of Interest to Ostomates

These websites have a good deal of ostomy and related information.

Several have links to other websites. Why the l-o-n-g addresses? These are the page codes that take you directly to the material listed; sometimes more generalized headings will take you all over the internet before you can locate the one that deals with ostomy subjects. It definitely takes a bit of careful typing. A faster way to access these is to open our website\*, go to the HighLife newsletter section, and cut and paste the addresses directly from there.

\***Vancouver Chapter:** <http://www.vcn.bc.ca/ostomyvr/>

UOA of Canada Inc.: [www.ostomycanada.ca](http://www.ostomycanada.ca)

NEW

<http://www.zassimedical.com/index.asp>

(Zassi is a medical device company focused on the design, development, creation and commercialization of new products for the gastrointestinal (GI) tract.)

NEW

[www.cra.gc.ca](http://www.cra.gc.ca)

(Revenue Canada main website. Start here to order Disability Tax Credit Form #T2201)

NEW

<http://members.boardhost.com/hernia1/>

(Hernia surgery discussion board. Although this site does not have a lot of ostomy-related hernia entries, it has numerous posts on a wide variety of personal hernia experiences, diagnosis and surgical results.)

NEW

<http://www.helpforibs.com/>

(Very informative site for those interested in managing irritable bowel syndrome. Strategies, tips and diets)

NEW

<http://www.uoaa.org/forum/viewforum.php?f=12>

(Newly created section devoted to irrigation on the American UOAA forum. Excellent resource for both new and experienced irrigators)



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Dr. F. H. Anderson, Internal Medicine  
Dr. Martin Gleave, Urologist - VGH  
Deb Cutting, WOC Nurse, VGH

ET NURSES -- IS YOUR INFORMATION CORRECT?  
PLEASE ADVISE THE EDITOR IF UPDATES ARE NEEDED

## STOMA CLINICS IN VANCOUVER / MAINLAND AREA

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

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Deb Cutting, RN, ET. 604-875-5788  
Eva Sham, RN, ET.  
Candy Gubbles, RN, ET.  
Neal Dunwoody, RN.

**UBC Hospital** 2211 Westbrook Mall  
Eva Sham, WOCN 604-822-7641  
(Mon., Wed., Fri.)

**St. Paul's Hospital** 1081 Burrard Street  
Anne Marie Gordon, RN, ET. 604-682-2344  
Ext. 62917 Pager 54049

**Children's Hospital** 4480 Oak Street  
Amie Nowack 604-875-2345  
RN. Local 7658

**NORTH VANCOUVER** Lion's Gate Hospital  
Annemarie Somerville, 231 East 15th Ave., N. Vancouver  
RN., ET. 604-984-5871  
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