



Vancouver Ostomy

# HIGH Life

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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

#### June 24 (AGM)

No meetings during the summer

#### September 16

#### Annual Christmas Luncheon & Party early December TBA

Unless otherwise specified, all meetings are held at:

Collingwood  
Neighbourhood House  
5288 Joyce Street  
Vancouver 1:30 pm



## A Cause for Exposure



The BC Cancer Foundation needs your help to raise funds and unleash a voice for devastating yet "hidden" cancers like prostate, colorectal, ovarian, testicular, bladder, cervical, and uterine that may affect you or someone you know.

Participation in the Underwear Affair helps lift the taboo connected with cancers below the waist. Why are these cancers considered "taboo?" These cancers affect areas of the body that may be uncomfortable to talk about and that are often seen as embarrassing or shameful. One may not want to see a physician to get screened for these types of cancers. This makes care and treatment an unexplored option to some of those who need it. Shedding light on these cancers means more awareness and more funding, making research and treatment a reality.

Proceeds from the Underwear Affair will benefit the BC Cancer Foundation, an independent charitable organization supporting research and care at the BC Cancer Agency. With cancer survival rates better than any other province in Canada, the BC Cancer Agency is a model for cancer care and control around the world. The BC Cancer Agency is leading the way in uncovering cures and putting these cancers behind us.

If you're still not convinced to register, consider these BC cancer statistics:

### MALE & FEMALE CANCERS BELOW-THE-WAIST

#### Colorectal

In 2006, an estimated 2,656 cases will be diagnosed with colorectal cancer

In 2003, 2,317 cases were diagnosed with colorectal cancer

In 2003, 784 people died from colorectal cancer

cont. page 4



## *From the President*

### THINK OF OTHERS

As ostomates, if we are not careful, it is easy to become self absorbed with the issues that affect us directly, the primary one being, of course, dealing with our ostomy. In addition to our ostomies to deal with, many of us have jobs, mortgages or rent to pay, children to put through post-secondary education, our retirement to prepare for, etc., as we try to find time to exercise, pursue our social lives, tend our gardens, and if we are fortunate enough, to put our feet up and read a good book. So, with our ostomies on top of our already too busy lives, like many others we risk losing our empathy for those less fortunate than us, and there are many.

After the initial awareness we gained of the plight of others that only came to light when we were in hospital with colorectal cancer, Chrohns disease or ulcerative colitis, many of us retreated, as soon as we were able, to the comfort of the cocoon that we call "our life". But, we ostomates should know more than most people the many hidden and not so hidden challenges that others have to face every day. Who is more able than us to have empathy for the challenges faced by others?

Ostomates should be on the forefront of helping others, whether by the gift of our time, funds, clothing we no longer wear, books we no longer read or "stuff" stored in our basements or garages. Two hundred years ago, the English writer Sydney Smith wrote: "It is the greatest of all mistakes to do nothing because you can only do a little." He said, and I am asking you to "do what you can."

Martin Donner  
President, Vancouver Chapte

## *From the Editor*



Ever wanted to run down the street in your underwear? [How about running down the street in someone *else's* underwear?] Here's your chance!! The BC Cancer Foundation will be holding its second annual "UnderWear Affair" fundraising 10 and 5 K run/walk this July 7th. The purpose is to give exposure (pardon the pun) to cancers 'below the waist' and raise money for research. At our meeting in April our chapter had the pleasure of meeting Carolina Radovan and Allison Clark from the BCCF. They gave a presentation on a fundraiser that addresses a sometimes taboo subject -- cancers of the reproductive organs, prostate and bowels -- in a lighthearted way. Even if you are not a runner, you can still participate by walking, volunteering, or donating. Registration is \$25 and the BCCF folks will assist you in achieving your fundraising goal. You can sign up as an independent walker/runner or form a team, or join an existing team. Last year the Foundation raised half a million dollars and hopes to beat this mark in 2007. It'll be the most fun you can have in your underwear!

For more information about the BC Cancer Foundation and the UnderWear Affair please visit

**[www.bccancerfoundation.com](http://www.bccancerfoundation.com)**

Time to change that photo! Editors get to do this.



## CASTRO DECIDED TO AVOID COLOSTOMY

-Reuters

Cuban leader Fidel Castro chose to avoid a colostomy and opted for riskier intestinal surgery that led to serious complications, the Spanish newspaper El Pais said in its January 17 edition.



The shortcut involved sewing the colon to the rectum but did not heal properly and broke apart, releasing gastric fluid with feces that caused serious infection, El Pais said on its Web site.

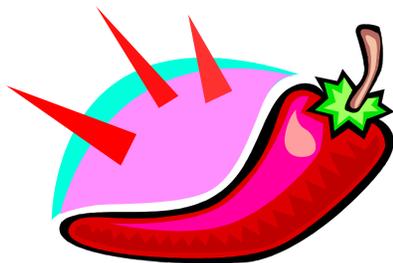
The newspaper reported a day earlier that Castro's prognosis was "very serious" and that he is being fed intravenously after three failed operations for diverticulitis, or pouch-like bulges in the large intestine that get infected.

El Pais cited medical sources at the same Madrid hospital where a surgeon who examined Castro in late December works.

## ARTHRITIS NEWS

- Life Peak, March 2007

The common **chili pepper** could provide hope for pain relief to sufferers of arthritis pain. Scientists at King's College in London, England, already know that chili peppers contain a compound known as "capsaicin." This amazing compound has been scientifically shown to relieve pain and reduce inflammation. Creams made with chili peppers have been effective at reducing arthritic pain so researchers are investigating using chili peppers in a pill form that will have similar effects. This study will be a two-year project, and if successful could help improve the quality of life for the millions of arthritis sufferers worldwide.



**Glucosamine (GS)** and **chondroitin sulfate (CS)** may

be the preferred medication for knee osteoarthritis, especially in people experiencing moderate to severe pain.

GS is extracted from the shells of crabs, lobsters, and shrimps. Chondroitin sulfate is extracted from animal cartilage such as shark cartilage. Recent estimates state that approximately six thousand metric tons of glucosamine is consumed around the world on a yearly basis.

A recent study has confirmed the efficiency of the above substances in osteoarthritis. The study conducted by the University of Utah has made this conclusion after testing 1500 patients over 24 weeks. However, it suggested that taking a combination of the two substances is much more effective than using one or the other separately.

In addition, the study has demonstrated that both of these supplements perform significantly better for moderate and severe pain rather than for mild osteoarthritis.

## CANCER RESEARCH IN VANCOUVER (NEWS1130)

Tuesday, March 20 - 10:36:00 AM Treena Wood/Province

There has been a huge cancer breakthrough right here at home. Researchers at UBC have found a protein that not only predicts invasive cancers, but also seems to cause them.

They're now working on "smart" molecules to block the protein's function. The ultimate goal is to generate new targeted, non-toxic treatments, which would be different from the standard "slash and burn" chemotherapy.

## THANK YOU TO VANCOUVER UOA

Dear Vancouver Chapter of U.O.A.,  
I am writing to inform you that my mother, Marlow McIver passed away in January of this year. Thank you for your informative newsletters over the years. She had a stack of them over a foot high -- many with post-it notes to remind her of the helpful and supportive information contained in each. You do a great service and it was always appreciated. Keep up the good work.

Sincerely,  
Wendy Ingham

# “CHANGING TIMES - SECOND REGARD”

**Calgary UOAC Conference, August 16 - 18, 2007**

The theme “Changing Times” chosen for the Calgary Conference reflects the tenth anniversary of the United Ostomy Association of Canada Inc.(UOAC), the past, the present and the future. In French “Second Regard” incorporates those features.

Plans are in hand for a keynote address by one of western Canada’s foremost colorectal surgeons; workshops with an Acute Care Nurse Practitioner for I.B.D; Manager of the Alberta Aids to Daily Living scheme; a Chapter Development Forum.

Calgary’s 20/40 Group is preparing a programme particularly relevant to their concerns, and participating in the whole conference.

As well as a western theme and lively entertainment in the evenings, a new concept is optional local tours on the Sunday following the conference, possibly one to the Ostomy Youth Camp.

Calgary has a great team, an exciting theme and is planning

a varied programme of presentations and entertainment to suit all age groups of ostomates and significant others, not to mention the excellent facilities and food of the Westin Hotel located downtown. We look forward to hosting members to attend from throughout Canada, bringing your families to enjoy an Alberta holiday before or after the actual conference. There are so many places to visit nearby - Icefields Highway - Royal Tyrell Museum, Drumheller - Head Smashed in Buffalo Jump - Bar U Ranch & Turner Valley early oil industry site - Banff Hot Springs. Travel Alberta gives many ideas for visits: see [TravelAlberta.com](http://TravelAlberta.com) or call 1.800.ALBERTA.

**For conference information,  
please call toll-free:  
1-888-969-9698**

**or visit the UOAC National Website for  
downloadable conference and hotel registration  
forms:  
<http://www.ostomycanada.ca/>**

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UNDERWEAR cont. from page 1

## **MALE BELOW-THE-WAIST CANCERS**

Prostate gland

In 2006, an estimated 3,116 cases will be diagnosed with prostate cancer

In 2003, 2,571 cases were diagnosed with prostate cancer

In 2003, 439 men died from prostate cancer

Of the 2,251 cases of prostate cancer diagnosed in 1998

there is a 95% 5-year survival rate

## **FEMALE CANCERS BELOW-THE-WAIST**

Cervical Cancer

In 2006, an estimated 136 women will be diagnosed with cervical cancer

In 2003, 607,387 pap smears were screened

In 2003, 151 cases were diagnosed with cervical cancer

In 2003, 52 women died from cervical cancer

Of the 187 cases of cervical cancer diagnosed in

1998 there is a 75% 5-year survival rate

The BC Cancer Agency’s cervical cancer screening program was the first organized program in the world to screen for cervical cancer. It is credited with an 85% reduction in the number of cases of cervical cancer and has reduced deaths by 75% since the 1950’s.



## Concerns With The J-Pouch

- Chicago IL New Outlook; Winnipeg MB; South Brevard FL; Metro Halifax News, March 2007.

Patients with ulcerative colitis (UC) who were treated surgically previously underwent a total proctocolectomy with permanent ileostomy. However, in the late 1970s, when the pelvic pouch (Jpouch) procedure was first introduced, the surgical approach to UC was revolutionized.

The pelvic pouch has now become the “gold standard” in surgical treatment. Although the operation avoids a permanent stoma and usually improves the patient’s quality-of-life, it does not restore the bowel function to normal.

Patients can expect to have many stools per day—as few as two or three for the fortunate few and as many as 40 for the less fortunate with the average being around eight - and these stools are pasty to watery in consistency. As with any bowel operation, patients experience many changes both short and long term. This article will discuss some of the potential long term problems that patients with a pelvic pouch may experience.

**Diarrhea:** The function of the pelvic pouch will change over the first year - improve as the pouch stretches and becomes larger after the ileostomy closure. However, there are still some people have 20 bowel movements or more, daily.

Dietary changes may help these people to decrease the number of bowel movements. Foods, which have been found to help decrease the water content of the stool, may help to reduce the number of trips to the toilet. These foods include applesauce, bananas, rice, creamy peanut butter, potatoes, cheese, marshmallows, pretzels, toast, yogurt and tapioca pudding. Bulking agents such as Metamucil, Citrucel, Fibercon, or Konsyl also help thicken the stool.

These products are ingested with little fluid to allow extra fluid in the gastrointestinal tract to be absorbed. A doctor sometimes prescribes medications such as Lomotil or Imodium. They should not be used without your doctor’s approval. Limiting the intake of fried and fatty foods and milk products may decrease diarrhea. Reaction to foods varies with each individual, and other foods may be found

to increase the amount of stool produced or change the consistency.

### **Bowel obstruction and emptying concerns**

To construct the pelvic pouch, the small bowel is stretched, along with the blood vessels that provide blood to the pouch, in order to reach the anus. This stretching may predispose a patient to bowel obstructions from scar

tissue, twisting

or kinking surgical intervention may be required to relieve the obstruction. Another concern, which may lead to problems with pouch emptying is a narrowing or stricture at the pouch-anal joint (anastomosis). This is diagnosed by an exam of the anal area. Strictures may cause symptoms that result in a progressive need to strain more and more to move one’s bowels. Usually, dilation solves the problem and rarely is an operation needed to correct the problem.

**Pouchitis:** Pouchitis is a non-specific inflammatory condition of the pouch. The cause is unknown, but it occurs much more frequently in patients who have a Jpouch for IBD versus those who have one for familial polyposis. Patients are at risk to develop pouchitis over their entire lifetime, as long as they have a functioning pelvic pouch. For some patients, pouchitis is an isolated event, but others can experience multiple episodes or even continuous “chronic pouchitis.” The symptoms are similar to a miniattack of UC. Patients report increased bowel movements, pelvic pain, abdominal cramps, malaise, fevers or blood in their stools. However, it is common for patients with a pelvic pouch to notice blood on the toilet paper with normal function of the pouch and yet not have pouchitis. The most common treatment is Flagyl (metronidazole) 750 to 1500 mg daily for 7 to 14 days. This is effective about 85% of the time. Improvement is usually seen within 48 hours.

### **Nautical Trivia**

**At sea a ship’s speed is measured in “knots” or nautical miles per hour (1.15 land miles per hour) The term comes from the days of sail when a series of knots, spaced at a distance of 47 feet 3 inches, were tied to a line of rope attach to a log. The log was trailed out behind the ship and as the ship steamed through the water the knotted line paid out. The number of knots which ran out while a 28 second sandglass emptied itself gave the speed of the ship in nautical miles per hour. Today, however, we have numerous electronic devices located on ships’ hulls which measure the speed by the rate of water flowing past. It transmits the calculated results to computers on the Bridge. This device is still to this day called a log.**

*(From the Princess Patter, The Diamond Princess, Feb 2007)*



## NEW PATIENTS' CORNER

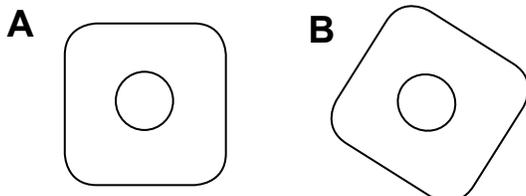


### MY SKIN IS ITCHY! WHAT SHOULD I DO?

When you first start wearing appliances, you may find that your skin is itching under or next to the barrier. Some itching in the beginning is normal, after all, you've never had to wear something over that part of your body for extended periods of time and your skin may take time to adjust. Try to limit the amount you scratch and if you must, try not to use your nails too much. Rub the annoying spots with your fingertips or palm. Repeated hard scratching with your nails will eventually make the area raw. **Constant itching** however, may be a sign that you are allergic to the type of appliance barrier you are wearing. Barriers, although they appear to be pretty much the same from brand to brand, have subtle chemical differences that can annoy some peoples' skin while others have no problem. You should try a different brand to see if this will alleviate the itching. Ask your ET nurse for some sample alternatives.

#### Some tricks to sooth itchy skin:

- oatmeal baths -- that's right, the stuff you ate for breakfast as a kid. Put some in a small cloth bag and put that in the bath water. You can also use the oatmeal bag as a sponge to directly bathe the skin around the stoma.
- milk of magnesia applied directly to the itchy area while doing an appliance change. Let it dry completely and apply your barrier as usual.
- rotate your skin barrier: Most of us put it on "square", like "A". Try putting it like "B", a 'diamond'. What this



does is change the area that is covered, giving some of your skin a rest. You can rotate barriers to any degree you want.

Showering without the appliance on is good for your skin too, even if you have an ileostomy or urostomy. If it's appliance change day, take advantage of the opportunity to shower au natural. If the stoma produces some waste while you're in the shower, don't worry about it. Just flush the tub or stall extra well with water and put some cleaner down the drain after you're done. If you have a colostomy that is slow-working and otherwise well-behaved, take the opportunity on change day to let it breathe for a while without a barrier on. Put some tissue over the stoma to protect it from your underwear and relax for a while at home. Your skin (and you) will love the break from constantly wearing an appliance.

**An itchy rash accompanied by the presence of raised red bumps** may be a sign that you have a fungal infection. This is more common in the summer months when you sweat more, and requires prompt attention. It would be wise to see your ET nurse to confirm a fungal infection, in which case she will recommend one of a variety of anti-fungal powders on the market. Some examples are Hollihesive, Stomahesive or Karaya type powders. To apply any of these, the correct method is to first remove the appliance, then clean and dry the skin. The skin must be completely dry. Dust an even layer over the affected area, smooth it around with your hands, then blow or brush off any excess. Apply your barrier over top as usual. You may also seal in the powder by applying a skin sealant over the barrier and allowing it to dry thoroughly. It should be noted that skin sealants are not recommended for use with extended wear barriers (they retard the adhesion).

### Tips & Tricks

- **If you use paste, do not spread it on the entire back of the barrier -- it will produce less than satisfactory results. use paste only sparingly to fill uneven areas and around the stoma. Paste is a great filler if used correctly.**
- **Colostomies: don't immediately reach for laxatives if you experience constipation! Chances are you may give yourself diarrhea which will make you think you need something like Imodium which will slow you down and before you know it you'll be on a merry-go-round of erratic bowel behaviour. Drink prune juice, lots of water and eat fruits and vegetables if your bowels are slow to work rather than taking OTC (over the counter) medications. Get more exercise and give your body time to find its natural rhythm. If diet and exercise are not moving things, try to avoid laxatives containing senna (Senokot) or buckthorn (Rhamnus purshiana) because long-term intake may damage the lining of your bowel and injure nerve endings to the colon. With colostomies, lack of output for a day is not harmful.**

# INTERNATIONAL OSTOMY ASSOCIATION (IOA) AROUND THE WORLD

-Deb Pelletier and Ranjit Hira. *Ostomy Toronto*, March 2006, via *Halton-Peel Ostomy News*, March 2007.

In February, Ostomy Toronto had the good fortune to have Dielwin (Di) Bracken attend their chapter meeting as a guest speaker. Di Bracken is truly a remarkable Canadian and ostomate. She spoke about her many trips around the world visiting countries in the role of President of the IOA.

As part of the IOA delegation, Di visited ostomates in Asia, Europe, North America, the Caribbean, South America, and the south Pacific. What is it like having an ostomy in Japan? Mongolia?

In Ho Chi Minh City, **Viet Nam**, the IOA delegation visited hospital and were given access to both doctors and patients. They found medical practitioners, with no specialized ostomy training, struggling to do the best for their patients. This was the first time that the nurses saw modern ostomy appliances. Few Vietnamese can afford proper supplies partly as a result of the difficulty in importing them. Di's team spent time training nurses to make appliances from plastic templates and plastic material. Because most patients have colostomies, nurses were also taught the art of irrigating -- lessening the need for wearing an appliance. As a result of their incredible need, FOW (Friends of Ostomate Worldwide) will be sending Viet Nam supplies in the near future.

**Mongolia** is a nomadic country with a very poor standard of living. There are no trained personnel and supplies are non-existent. Ostomates, in particular girls, suffer emotionally as a result of the stigma attached to individuals after their surgery. they also suffer physically as they try to manage an ostomy with no equipment. (Picture coping with your ostomy if you share a communal bathroom with the rest of your village). Mongolians were very eager to form an association and become part of IOA. They desperately need supplies and training!!!

In **China**, almost 1,000,000 surgeries are done every year. There are some ostomy groups but as a result of political pressures, they cannot form a national federation. Supplies are available in the larger cities, but are so expensive only the richest patients can afford them. On the positive side, there are well-run clinics in the largest urban centres. Coloplast has already established facilities in China and other manufacturers are keen to do so as well. Ostomy surgeries here are primarily the result of cancer.

Di recounts that the IOA delegation was in the middle of a visit at a hospital in Mumbai, **India** when an ostomate came in off the street asking for help. he had a primitive appliance and was in terrible straits. Supplies are available in India, but are expensive. In addition, doctors and nurses must be very sensitive to religious and cultural norms while at the



**Di Bracken**

same time meeting the basic needs of the ostomate.

**Australia** stands out as a leader when it comes to ostomy support organizations and funding of ostomy supplies. After surgery, new ostomates join the national association which then provides the supplies at no cost to the individual. Japan is phenomenal in its support for their ostomates. They are given pensions in varying amounts. In addition they have some public washrooms with special toilets, marked by sign, and designed for ostomates. Supplies are easily available and they have highly trained doctors and nurses.

With poverty endemic, ostomates in many South American countries cannot afford ostomy supplies. **Bolivia** is the poorest country by far and ostomates struggle with makeshift appliances. Here the most common reason for surgery is Chagas disease caused by a parasite (poor rural areas are affected the most). Chagas targets the body's digestive system, in particular the colon and esophagus. Severe attacks require ostomy surgery. The Bolivian situation is bleak without help from other countries.

Worldwide, Di Bracken concluded that most ostomates and

*cont. page 10*

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# Sleep and seniors: Insomnia isn't inevitable as you age

Getting enough sleep — so that you wake feeling refreshed — is just as important now as it was when you were younger. Sleep refreshes your body and your mind.

After years of rising early to work at the office, you looked forward to retirement — a time when you'd toss out that annoying alarm clock and catch some quality zzz's. But now you're finding that even though you'd like to sleep late, you're still rising with the sun. And the sleep you do get overnight isn't as restful.

Having difficulty getting to sleep and staying asleep (insomnia) is common as you get older. But that doesn't mean insomnia can't be avoided. Explore what could be causing your sleeping difficulties. Once you've figured out what's causing your insomnia, there's plenty you can do to get a good night's rest.

## What's normal sleep as you age

As you age, your body secretes smaller amounts of key substances that help your body decide when to sleep and when to wake up. Levels of growth hormone, which promotes deep sleep, and melatonin, which regulates your sleeping and waking cycle, decrease as you age. As a result, your circadian rhythm — the internal clock that tells you to go to sleep at night and wake up in the morning — changes. You might find yourself going to bed earlier and waking up earlier. As you get older, you might find that getting a good night's sleep becomes more difficult. You might find that:

- You have a harder time staying asleep
- You sleep lighter
- You wake up three or four times each night

But despite the frustrating disturbances, you still need the same amount of sleep that you needed when you were younger — generally seven or eight hours a night. Because you likely wake up more often

during the night and don't sleep as soundly, you may spend more time in bed at night or you might need a nap during the day to get those same eight quality hours of sleep.

On their own, these age-related changes don't usually signify a sleep disorder. If you're experiencing insomnia, your age usually isn't to blame.

About half of all seniors report difficulty falling asleep and staying asleep.



Several different factors can cause this problem.

## Health conditions that may contribute to insomnia

As you age, you're more likely to develop health problems that could cause your sleep patterns to change.

Examples include:

- Arthritis
- Osteoporosis
- Heartburn
- Cancer
- Diabetes
- High blood pressure
- Parkinson's disease

- Alzheimer's disease
- Incontinence
- Gastroesophageal reflux disease (GERD)
- Stroke
- Chronic obstructive pulmonary disease (COPD)
- Asthma
- Heart disease
- Enlarged prostate

Some conditions, such as arthritis, cause pain, which can make falling asleep difficult. Also, if you have chronic pain, you might wake yourself up if you adjust your sleep position during the night.

If you have diabetes, leg edema, enlarged prostate or incontinence, these conditions might cause you to urinate more frequently. Add to that the fact that your bladder capacity shrinks as you age, and you might find yourself getting up at night to use the toilet more often. Getting up so often can make it hard to get back to sleep.

Other conditions, such as heart disease and COPD, can cause breathing difficulties. If you have trouble maintaining steady, rhythmic breathing while you sleep, you might wake up several times in the middle of the night. Waking up like this may prevent you from reaching deep sleep.

Pay attention to what awakens you at night or what keeps you from sleeping. Talk to your doctor about your specific health condition. Changes to your treatment plan may reduce your sleep disturbances.

## Anxiety and depression

Anxiety, depression and other emotional problems can make it harder to sleep at night. At the same time, not sleeping at night can add to your anxiety and depression. Understand that anxiety and depression can be serious conditions. Don't hesitate to tell your doctor if you have feelings

of sadness or anxiousness that keep you up at night. These feelings can be treated.

### **Medications**

Some common medications can make it difficult to fall asleep or stay asleep, including:

- Antidepressants
- Beta blockers
- Bronchodilators
- Calcium channel blockers
- Corticosteroids
- Cardiovascular drugs
- Decongestants
- Gastrointestinal drugs

As you get older, you're more likely to be taking some type of medication. Talk to your doctor about your medications and the chance that they might be causing your sleepless nights. Your doctor might prescribe a different drug that doesn't cause insomnia, or he or she might discuss changing the time of day you take your medication.

Common nonprescription drugs such as alcohol, caffeine and nicotine also can make it harder to fall asleep. Try cutting down on these or eliminating them altogether. Be aware that nicotine withdrawal symptoms and even the nicotine patch can keep you up — but this is usually only a temporary problem.

### **Lifestyle changes**

As your responsibilities and daily activities change, your body adjusts accordingly. You might not get as much exercise as you did in the past. Being in a more rested state during the day means that your body doesn't feel the need to sleep like it used to. If your doctor says it's OK, increase your daily activities, for example, by taking a walk or spending more time in the garden.

Do your exercising during the day, or at least more than two hours before you go to bed. Exercise increases your core temperature, making it harder to fall asleep.

You might not spend enough time outdoors these days. Sunlight helps keep your body's circadian rhythm working appropriately. In general, you need about two hours of bright-light exposure each day to help your body gauge when to sleep and when to wake up. If you can't get outside to enjoy the sunshine, talk to your doctor about a light box — a box that emits a bright light that mimics the light given by the sun.

With more indoor time and less activity, you might find it tempting to nap during the day. If you nap for more than 20 minutes, you could find yourself having more trouble getting to sleep at night.

### **Sleep disorders**

Some sleep disorders are more prevalent among older adults, including sleep apnea and restless legs syndrome. Both can wake you up in the middle of the night. If you think you might have either condition, talk to your doctor. Your sleep partner might be aware of your sleep disorder because loud snoring or movement might wake him or her up. Your partner might be able to give your doctor some information about your sleep behavior.

### **What you can do**

The key to helping you get back to sleep is treating the problem that's causing your sleeplessness. If your sleep problem is affecting your daytime functioning, talk to your doctor about your concerns. Also talk to your doctor if:

- You have disruptive snoring or irregular breathing
- You think your sleep problems might be related to depression or anxiety
- You depend on pills to sleep
- It's been a month or more since you've been able to sleep soundly or fall asleep when you wanted to
- You generally feel anxious, and it's associated with lack of sleep
- You routinely feel sleepy at times when you need to be alert — such as when you're driving

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### **Sleeping pills: Not a long-term solution**

Sleeping pills, whether over-the-counter or prescribed by your doctor, aren't a long-term solution to your sleeplessness. Medications can sometimes be used short term and should be used only as directed by your doctor. Using prescription sleeping pills incorrectly can cause addiction or dependence. Sleeping pills, which can make you drowsy, can also put you at risk of falls and broken bones.

If you're struggling with your sleep, ask your doctor if sleeping pills might help. But don't turn to sleeping pills rather than remedying the underlying cause of your sleep problems.

cont. next page

**When someone else's snoring keeps you up**

The loud sound of your partner snoring next to you can be enough to wake you up and make it impossible to fall back to sleep. Snoring is common, and chances are that you or your partner has done a fair share of snoring every now and again. As you get older, snoring becomes more common, so as you both age, you and your partner are more likely to snore. Sometimes snoring indicates something more serious, such as sleep apnea. But usually it's just annoying. Snoring can be caused by:

- Drinking alcohol before bed
- Taking sedatives, such as sleeping pills or antihistamines, before bed
- Congestion from a cold or allergies
- Enlarged tonsils and adenoids
- Being overweight

Talk with your partner about what could be causing his or her snoring. If avoiding alcohol or losing weight doesn't seem to stop the snoring, your partner might want to talk to his or her doctor. In the meantime, try to block out the noise by:

- Wearing earplugs
- Creating white noise by running a fan
- Playing music



**Don't accept sleeplessness**

Don't accept sleeplessness as part of the aging process. The sooner you talk to your doctor, the sooner you and your doctor can get to work on a solution. Then you can get back to a good night's rest.

*IOA Worldwide, cont. from page 7*

the medical communities involved are enthusiastic and eager to learn. They want to form local chapters and national association, but left to themselves the task is overwhelming. IOA plays a very important role in improving the situation for all ostomates. As Di explains, one of the most successful and efficient programs involves "twinning". A country (ie: Mongolia) desperately needing resources is "twinned" with a resource rich country (ie: Japan) Supply shipments are organized, teams focused on teaching medical staff are provided, and initiatives encouraging collaboration and advocacy with both public and private institutions are set in motion.

Being an ostomate in Canada is undeniably fortunate, but, taking the direction of Australia and Japan, we should strive for better funding of ostomy supplies and more ETs in our own hospitals and community. Next time volunteers pack donated supplies for other countries, we will appreciate the impact of what we do. With Di Bracken as a role model we can be so much as ostomates and Canadians.

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# Meeting "Gab Session"

- by Arlene McInnis, Secretary

The first meeting of 2007 was held on Sunday March 3. There were 33 people in attendance which included new members and guests. After the business part of the meeting was concluded the group split up into two sections – those with ileostomies and those with colostomies. Over refreshments each group shared experiences and helpful ideas on ostomy care and the pros and cons of the various products everyone uses. We were also asked to think of the best piece of advice we could give to a new ostomate. It was interesting to hear how many different products are available and how it took each person time and trial-and-error to find the perfect setup for their condition and lifestyle. A number of people rotate between different products and some are still happy with the product they were introduced to in the hospital. A few people re-use their pouches after rinsing and hanging them to dry and others replace frequently. Wear time varied from a couple of days to over a week.



## Some of the highlights of the colostomy group -

- Try new products by asking reps or calling the company for samples. Routinely ask your supplier about new products and make sure they know you are interested in trying them.
- Visit your ET regularly either through the hospital or a clinic, such as Andy Manson at the Ostomy Care Centre in New Westminster 604-522-4265.
- Odour control in the bathroom is best achieved by using a room spray before you empty (it also helps to give the inside of the bowl a quick spray or use Just a Drop liquid first).
- Carry double your normal amount of supplies when traveling.
- Ask your ET nurse about irrigation as an option for bowel control and get opinions from practicing irrigators on this lifestyle choice.

## Highlights from the ileostomy group –

- Banana and peanut butter are two foods that can help thicken output. Some people also have success with marshmallows.
- Roll back the cuff of the tail before emptying to help keep it clean (this is not possible with all pouches)
- Using a small water bottle to quickly rinse after emptying helps keep the tail of the pouch clean and odour-free
- Write the date you change on your pouch or on a calendar in the bathroom (you can also write down skin condition to monitor any irritation)

## Both groups had excellent "Words of Wisdom" for new ostomates –

- Make sure your stoma is properly sited before surgery. A good ET is extremely important. Some will even suggest wearing an appliance filled partially with applesauce for a day to see how it works with your clothing and life style.
- Get a second opinion before undergoing surgery.
- Attitude is very important – mainly patience and acceptance.

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- Never give up and try to maintain your normal lifestyle.
- Thank God you are still alive! For most ostomates their surgery was a life saving event.
- Don't dwell on your new "condition" - you will manage and time is the best healer.

One last but important point mentioned was to make sure to save any unused supplies when you change styles or receive samples you can't use. Bring them to the meeting or call one of the executive so these supplies can be donated to Friends of Ostomates Worldwide (FOW) and distributed to those in need around the world.

## Things We Have Learned Dept:

1. Never take a sleeping pill and a laxative on the same night.
2. Never lick a steak knife.
3. Never say anything to a woman that even remotely suggests that you think she's pregnant unless you can see an actual baby emerging from her at that moment.



# Four Years with the Visiting Program

- by Debra Rooney (with research from Lottie Calli)

Has it really been four years since I began coordinating the Visitor Program? I first volunteered to be a visitor back in the fall of 2002. I'd completed cancer treatment, had successfully started irrigation, returned to work and was doing well living with a colostomy. Parts of that journey had been terribly difficult -- I would have progressed faster had I been given a visitor to speak with but none were ever offered. I don't know why. Perhaps no one was available. Perhaps my nurse didn't think I needed help [although I asked, pointedly, for counselling] I got through the rough patches with the help and support of my partner, my family, and a large circle of friends and colleagues. However, not everyone is blessed with that kind of social circle. Some people face the ordeal of surgery and adjustment largely on their own. As I began to reclaim my old life I wanted to do what I could to help others avoid some of the fears and miseries I had experienced. Somewhere I found Fred Green's email and wrote him to ask if I might volunteer in some way. He put me in touch with Maxine Barclay, who coordinated the Visitor Program at that time and she met me at my first UOA meeting. New faces can be an event at meetings so I got a lot of attention, in particular from Ivor Williams, who quipped, "I thought only OLD people got colostomies!"

Maxine put me to work in short order with a phone visit to a woman who had a new colostomy due to cancer. I prepared for that phone call as if studying for an exam and have often wondered if I wore the patient out with my determined and enthusiastic phone manner, but she was a good sport. Not long after, I was sent to Vancouver General Hospital, another visit for which I studiously prepared. What should I say? What would my patient be like? Would I be an inspiration or just a cheerful, well-meaning bore? It went well. It also should have been filmed, that first hospital encounter, because it encompassed several of the most common (and funny, in retrospect) hitches that can happen during a visit. I couldn't find my patient, went to the wrong floor and then wandered the correct ward trying to sort out room and bed numbers. I finally arrived in the middle of my patient's lunch and was asked to come back later. I drank a crestfallen coffee in the cafeteria, returned, and met my brand new colostomy patient who turned out to be quite a receptive woman. We chatted for a while, warming up to each other and then, across the hall, a wailing began. A female patient on the same ward was fighting her nurses, refusing a tube and the ensuing battle

was somewhat disturbing, clearly audible and LOUD. On and on the contest went, the patient howling and protesting, the nurses alternately cajoling or huddling in the hall planning the next attempt. My patient and I soldiered on, trying to make ourselves heard to each other over the din and partially succeeding and then! She became nauseous. It happens. My patient had one of those, "I don't feel so good" moments followed by a hearty upchuck right in the bed. I still retain my ex-university pub-crawling student instincts, which meant I had the presence of mind to shove a drinking glass under her chin to catch things. A brief request for assistance to one of the nurses not involved in the donneybrook across the hall got things cleaned up and my first visit was concluded. I've often wondered what became of that first woman I visited (she lived out of town). I never knew how she made out, or if indeed she survived, for her diagnosis was cancer. Many of the people the Visiting Program speaks with disappear from our lives, and we often wonder how they fared.

Since those first two visits I've done many more over the last four years -- as Visiting Coordinator I am the front line for deciding who sees whom and often I will take a colostomy visit that others



*Three Coordinators -- Elaine Dawn, Debra Rooney and Maxine Barclay at their annual lunch date, at the Raquet Club.*

are not available to do. Usually women only see women but sometimes I've seen male patients when no male colostomate was available. The first time I saw a male patient I was nervous that he would be disappointed not to have a guy to talk with but things went splendidly, as all my male visits have. My personal belief is that so long as people are matched properly in age and circumstance, sex matching is not critical. A person fresh out of surgery just wants to see someone who has been through the same ordeal and come out OK. They long to see somebody who *knows what it's like*.

Worst experience that ever happened to me in volunteer visiting? That first one was a challenge, but I can't say I have ever

had a bad visit. Each patient is unique, but we all share a common bond. I look forward to each and every new person I am privileged to call upon. Most inspiring visit? This would have to be a young man I saw who wanted to learn more about irrigation. He had been in a wheelchair for most of his life, and I have never met a more cheerful, willing and gracious patient. I left that man's hospital room deeply humbled. And ashamed of ever having complained about my own circumstances.

In addition to fielding requests for visitors -- I prefer to think of us as peer counsellors, actually -- I hold training seminars throughout the year as required to provide orientation to new volunteers. Currently we have a good depth of visitors for ostomy categories ages 50 and up. I'm very pleased to report that we can now offer visitor services in Mandarin. In addition, several 'youngsters' -- those in their 20's -- have stepped up to the plate this past year which has been a great help for visits to the under-30 set. Surgery at this young age is almost invariably an ileostomy. It has been problematic in years past finding suitable visitors to see young patients but the situation has improved. Requests for a visitor for a male under age 30 are

still very rare, which may explain the lack of male visitors under age 30. (The majority of new visitors are recruited within a year or two of leaving hospital). Type of visitor we currently need most? Anyone who has been successfully reversed, and/or with an internal pouch, and of course, males under 30. Most commonly referred surgery? Still a colostomy, usually due to cancer.

The Vancouver Visiting Program began in 1980, with chapter member Betty Hutton overseeing things for the next 8 years. Sandra Morris took over for the next two, and in 1990 Joan Williams was Coordinator. Glenis Taut took over from Joan in 1992 and served for 2 years until Elaine Dawn held the position. Elaine coordinated for 4 years until 1998 when Maxine Barclay assumed the position. Maxine handed over the reins to me in 2003 and here we are. I regret that the visiting statistics for most of those years are long gone.

For those of you who like statistics, the stats for the past three years are:

<b>2004</b>	<b>2005</b>	
<b>Colostomies - 23</b>	<b>Colostomies - 28</b>	
<b>Ileostomies - 19</b>	<b>Ileostomies - 25</b>	
<b>Urostomies - 19</b>	<b>Urostomies - 17</b>	
<b>Pre-op - 7</b>	<b>Pre-op - 9</b>	
<b>Other - 6</b>	<b>Other - 4</b>	
<b>TOTAL - 74</b>	<b>TOTAL - 83</b>	

<b>2006</b>	
<b>Colostomies - 32</b>	<b>Ileostomies - 23</b>
<b>Urostomies - 19</b>	<b>Pre-op - 5</b>
<b>Other - 8</b>	
<b>TOTAL - 87</b>	



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## Preventing Blood Clots

**After Surgery** -- *Village Total Health, March 2007*

Blood clots are formed by the process of coagulation - the blood's natural tendency to clump and plug an injured blood vessel. Blood clots are made of blood cells and fibrin strands. They serve a valuable function in wound healing and stopping the flow of blood after an injury, or surgery.

Blood clots are rarely dangerous on their own. As part of the body's natural healing mechanism, clots that have formed for whatever reason are usually dissolved (lysis) and reabsorbed by the body without danger or need for intervention.

They can be dangerous, however, when they form within arteries and veins and obstruct the normal flow of blood within the body. The patient who is bedridden after surgery is at greater risk for blood clotting due to slowed blood flow. (this is one of the reasons why they made you get up and walk far sooner than you

wanted to!!)

Your nurses and doctors will be checking regularly for blood clots. Let them know immediately if you have any tenderness in your legs, especially the calves. If a blood clot is suspected, tests will be performed to confirm the diagnosis and medications ("clot busters") will be started to help reduce the size of the clot. In some cases the clot may be removed via a catheter (thrombectomy) Your doctor may prescribe other aids to prevent clotting or further damage such as:

- elastic stockings which will be removed and replaced during the day as required
- inflatable stocking or "booties" which

apply alternating pressure to the legs or feet to encourage blood flow. These will also be removed and replaced as required.



The patient can help prevent clots from forming by walking the hospital halls, but if this activity is not possible, exercises performed while in bed can also help:

- tighten and release the buttocks for several seconds frequently throughout the day.
  - move the feet up and down, as if working the gas pedal of your car
  - pretend you are writing your name or leading an orchestra with your feet. Do this frequently throughout the day
  - Change position in bed
- Even if you can't leave your hospital bed for a period of time, these leg and feet exercises can help keep circulation healthy.

## VISITOR REPORT

Requests for patient visits this reporting period came from Vancouver General, Lion's Gate, St. Paul's and Mt. St. Joseph's hospitals:

Colostomy	5
Ileostomy	8
Urostomy	1

**TOTAL**      14

*Many thanks to my excellent crew this round: Lisa Saunders, Linda Jensen, Martin Donner, John Jensen, Diana Mercer, Arlene McInnis, Sharman King, Annabelle McLennan, Betty Taylor, Sean Mair and Elaine Dawn. And thank you again to Maxine Barclay for standing in while I was on holidays!*

The Vancouver Chapter of the UOA wishes to thank the following individuals for their kind donation to our chapter:

**Michael Brown**  
**Dave Walker**  
and  
**Wendy Ingham (in memory of her mother, Marlow McIver)**

*A warm welcome is extended to new members*

**Dave Walker**  
**Judy Momeyer**  
**John Slaney**  
**Lynn Goldblatt**  
**Bill Lawton**  
**Lisa Saunders**  
**Norma Primiani**

## 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 newsletters, 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** **The Underwear Affair Run**  
[http://va07.uncoverthecure.org/site/PageServer?pagename=va07\\_homepage](http://va07.uncoverthecure.org/site/PageServer?pagename=va07_homepage)  
(BC Cancer Agency website promoting The UnderWear Affair fundraising run)

**NEW** **Types of Surgery for Invasive Bladder Cancer**  
<http://www.cancerhelp.org.uk/help/default.asp?page=3169>  
(Aside from diagrams that put the urostomy on the wrong side for some strange reason, this is a useful site explaining the various types of surgery for bladder cancer)

**NEW** **Odour Control**  
[http://www.imtek.biz/Merchant2/merchant.mv?Screen=CTGY&Category\\_Code=sp-bath](http://www.imtek.biz/Merchant2/merchant.mv?Screen=CTGY&Category_Code=sp-bath)  
("Smelleze" bathroom deodorizer, can be used in the home for chronic room odour)

### Disability Tax Credit

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(Mon., Wed., Fri.) Tel (604) 822-7641

### St. Paul's Hospital

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Tel (604) 682-2344  
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Tel 604-875-2345  
Local 7658

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RELOCATED OR RETIRED?**

**PLEASE ADVISE THE EDITOR IF UPDATES ARE NEEDED -- THANK YOU!**

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