



Published by the Vancouver, BC Chapter of the United Ostomy Association of Canada, Inc.
Box 74570, 2768 West Broadway, Vancouver, BC V6K 2G4

A non-profit volunteer support group for ostomates. Chapter website: www.vcn.bc.ca/ostomyvr/

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A Patient AND a Doctor!

Working and studying to become a surgeon is a demanding task for any medical student. When you're also dealing with a diagnosis of ulcerative colitis, the obstacles can seem overwhelming. But they didn't stop a young medical student (name and photos have been removed at the request of this individual) from realizing her lifelong dream.

Shortly after being diagnosed in the summer of 2003, she took a pre-emptive approach -- one that's not appropriate for all patients -- toward her UC by electing to undergo an open proctocolectomy -- removal of the colon and rectum by open surgery -- followed by a Brook ileostomy in March 2003.

"This all happened during my senior year of medical school, yet I remained determined to graduate on time." And that's just what she did, earning her Doctor of Medicine degree and beginning her residency in general surgery in June 2003. Here's how she reached her goal.

"I was in a senior in medical school, and I wanted to be a surgeon more than anything in the world. But after my diagnosis, I walked around angry for months because I thought UC was going to steal my dream from me. It was difficult for me to stand through cases in the hospital OR for hours without having to run to the toilet."

It all changed the day she met a fellow UC patient -- a local doctor who had experienced the same problems at the same age. They found that they had a lot in common, including ways to cope with their UC symptoms at work. "Pretty unpleasant stuff -- something only those of us with UC can appreciate."

Her friend's accomplishments "inspired me because they made me realize

cont. page 10

2005 MEETING SCHEDULE:

June 12 AGM

Nomination and induction of executive

Open rap session

Jewish Cultural Centre

950 West 41st Avenue

Vancouver

1:30

Executive meeting June 4, 1:30 at Joan Williams'

September 18

2005 Xmas

Luncheon

TBA





President's Message

Spring is here again, mind you the last few days have felt like winter. I hope that you are all keeping well and warm.

The executive committee has been working very hard on all of your behalfs, and I would like to thank them personally for all their efforts.

Once again I have applied to the Vancouver Sun newspaper for a grant towards the costs of sending two children to the summer camp. I am hoping that we will be successful. We will not know until the middle of July.

Let us hope that the weather will be good to us for the summer, and look forward to seeing you at our meetings throughout the year

National office is looking for two individuals to help run the UOAC. The positions are for two directors to be elected to the UOAC Board. The elections will take place in August in Winnipeg. This is a two year term and will run from August 2005 to August 2007.

Any person interested please contact me or Debra.

Regards from your president. Ron

The Vancouver UOA Chapter would like to extend a warm welcome to new and renewing members:

Joy Jones
Leonard Cooper

IMPORTANT NOTICE

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

From the Editor



We would like to welcome new executive volunteers Emelia Prychidko and Cindy Hartman who will be assisting with phoning and treasury, respectively. Welcome and thank you, ladies!

At our last meeting Ron addressed the issue of changing our meeting hall to another location from our current one, the Jewish Cultural Centre on West 41st. Hall rental has gone up dramatically so it may be wise for us to cast about for an alternative should this rise in fees occur every year. The JCC is a good space, convenient for some, but inconvenient for others as a location. Should we move meeting halls? Would YOU be more inclined to attend meetings if they were held at a place easier to get to? Or would you prefer to stay at the JCC? We need your input and suggestions. Currently we are inquiring about the availability and cost of meeting spaces at St. Paul's hospital as a possible alternative. Give us a call with your thoughts on this -- stay or move?

Doing any travelling this summer by air? The US is taking security ever more seriously so be prepared for the unexpected! I'm now able to say I have had my first official body search at the airport. Usually I empty all pockets and remove anything that might remotely be read as 'metal' but somehow I set off the alarm anyway. Three times. "Over this way, ma'am," instructs the security officer pointing me towards a lady in full uniform of the TSA (Transportation Security Administration) Quite a polite sort she was and explained what she'd be doing but left no doubt in my mind that if I gave her any trouble I'd be dispatched with polite ruthlessness. The search began. Arms up, legs apart, sit down, lift your feet, pat pat pat and then (you know what's coming, don't you?) lift your shirt and show me the inside of your waistband. "Is that a bandage?" she asked and I said, "No it's a colostomy bag." (OK, I was lying -- I wear patches but let's not split hairs here. Or flanges.) She didn't miss a beat and said, "OK, thank you!" and sent me on my way. No big deal.

Now if I could just figure out some way to get a bottle of gin in that patch . . .

Debra

DONATIONS AND BEQUESTS

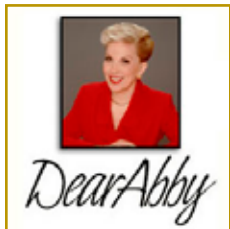
We are a non-profit volunteer association and welcome donations, bequests and gifts. Acknowledgement Cards are sent to next of kin when memorial donations are received. Tax receipts will be forwarded for all donations. Donations should be made payable and addressed to:



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In the News, Letters

Below is a quote from UOA April News: At Last, Ostomy Is Becoming a Household Word! At least it was on Monday, April 5, when Dear Abby printed a letter from a new ostomate in search of help. "Abby" referred him to UOA... and the phones rang off the hook. They received more than 500 phone calls, and traffic to their Website increased more than five-fold. They have seen an increase in publications sales, membership applications, and additions to their electronic distribution list. Dear Abby is the largest syndicated column in the world and it helped bring ostomy out of the closet on April 5, 2004. What a difference a little publicity can make!!



DEAR ABBY: I am a 54-year old married man with two wonderful children. Two months ago, I was diagnosed with colon cancer. That was the first shock. Then I learned that I would need to have part of my colon removed and would have a permanent

colostomy. I was devastated. I had the surgery and am healing, but I don't know how to get on with my life. I need more help with self-care than my doctor can give me. I also have questions about intimacy, returning to my career and participation in activities with my family. Is there any place I can find support from other people who have had this kind of surgery? I feel so alone – B.J. IN GEORGIA

Dear B.J.: You are not alone. There are an estimated 759,000 people with ostomies in the United States, and I am told that number increases by about 65,000 each year. One of them is a woman who works out with me at my gym – and believe me, she lives a very full life and misses out on nothing in her business or personal life. You should contact the United Ostomy Association Inc. It's a nonprofit organization whose mission is to provide education, information and support for people who have had ostomy or related surgeries. There are many resources available for you. Call the toll free number, (800) 826-0826, between 7:30 a.m. and 5 p.m. PST an individual will answer your call and provide ostomy information and referrals to local support chapters and special-interest networks. The UOA Inc. Web site is www.uoa.org. It contains information about different types of surgeries, ostomy management tips, patient discussion boards, organizational activities, and links to sources for ostomy products. Please don't procrastinate about contacting them. It will make a positive difference in your rehabilitation and help you to return more quickly to a full, productive life. Ed. Note: In Canada, the United Ostomy Association of Canada Inc. at: 1-888-969-9698. Web site: <http://www.ostomycanada.ca>. Email: uoacan@astral.magic.ca.

Summary of Interview with Ms. Cindy Hartman UBC Undergraduate Medical Program "Doctor, Patient and Society" Course

My interview with Cindy was a valuable learning experience which I feel privileged to have done. The purpose of the interview was to gain some insights into the social impacts of living with a chronic condition, for example a pelvic pouch.

Cindy, who originally had an ileostomy, followed by a pelvic pouch, was very pleasant and open to interview, and demonstrated a positive attitude towards accepting and coping with her condition. Not only was she able to share information about the surgical procedures involved, as well as the requirements of living with a pelvic pouch, she was able to share her story about the events leading up to her diagnosis, her experience with health care, and the effects on her personal life. My interview with Cindy was educational and will always remind me that everyone has a story, and to never forget the individual behind an illness, or chronic condition. I was also encouraged by Cindy's experiences with the health care system [during the 80's when she had her initial surgery] which she reported to be quite positive on the whole. In summary, I feel very fortunate to have been given this opportunity, and would like to thank Cindy for sharing her time and her experiences with me.

Sincerely,
Emma Martin
UBC Medical Undergraduate
Year 1

CAVILON BARRIER FILM=NEXCARE LIQUID BANDAGE SPRAY

by Charlotte Allen, RN, CWOCN, editor of Abilene (TX) Tomy Tabloid

I have just recently found out from the 3M™ company that one of my favourite products for treating peristomal skin irritation can now be found at Wal-Mart. I have always recommended Cavilon™ No Sting Barrier Film for minor skin irritation or to use over stoma powder or anti-fungal powder. Wal-Mart now carries the same product for a fraction of the price you will pay at a DME.

It goes by the name Nexcare™ No Sting Liquid Bandage Spray. It is found by the Band Aids and other first aid products. It does not hurt if some of this gets on the stoma when applying. You will be able to gently remove this white-grey coating from the stoma. As its name says, this product does not sting when applied to open, irritated skin. Just be sure this protective film is dry before you apply your ostomy wafer/barrier. The Nexcare™ No Sting Bandage Spray and the Cavilon™ No Sting Barrier Film are the same product. One is packaged and marketed for use in medical facilities and the other is for consumer use.

Source: Evansville IN Re-route; Halton/Peel Ostomy News, April 2005

The King's Royal Urine

In 1812, physicians caring for England's "Mad" King George III reported a bluish tinge to the King's urine that left a "pale blue ring upon the glass near the upper surface." At the same time the blue urine was reported, it was also noted that the King was suffering from one of his frequent severe bouts of constipation and vomiting. Although this phenomenon stymied King George's physicians, modern science has a theory that explains King George's 'royal indigo' urine was the result of normal bacterial action in the digestive process.

An essential amino acid called tryptophan is not found in the body but must be obtained from dietary intake -- commonly found in turkey. Through a series of complex bacterial transformations, tryptophan is metabolized into an enzyme known as indoxyl. Indoxyl changes into indigo (blue) and indirubin (red) in the presence of alkaline urine, creating a purple colour.

It is likely that sulphatase enzymes created by bacteria in the King's urinary tract or present on his chamber pot caused indoxyl to be slowly released by oxidization, which then became indigo blue and appeared on the porcelain of his chamber pot to the utter amazement of his physicians.

Today, even though theories exist to explain it, the etiology of Purple Urine Bag Syndrome (PUBS) remains controversial. Many believe it is associated with constipation,

alkaline urine and bacteria in the urinary tract that produce the enzyme sulphatase/phosphatase. It occurs in chronically catheterized female patients more frequently than in catheterized males. PUBS is also known to occur in people with a urinary



stoma. Chronic constipation is commonly associated with bacterial overgrowth in the colon in which tryptophan has been converted to indoxyl. A study conducted in Japan suggested that a higher bacterial yield in urine, in combination with other factors such as female gender and alkaline urine, acts as the most important factor in the development of PUBS.

PUBS is a rare occurrence, is often asymptomatic (having no

symptoms of illness or disease) and appears to be benign (not dangerous to one's health).

A classic case of PUBS presents itself when a person's bedside drainage bag, catheter tubing or urostomy pouch turn reddish-blue or purple. It is thought that the indirubin (red) is dissolved in the plastic of the drainage bag, ostomy pouch or urinary catheter and that indigo (blue) crystals in the urine coat the bag or catheter's inner surfaces, combining to form the characteristic purple colour. The longer the drainage system is used, the deeper the purple becomes. People with PUBS are susceptible to urinary tract infections. A strong odour is also often associated with PUBS.

Interventions (such as high daily doses of vitamin C as ordered) to keep the urine acidic should be included in the plan of care, as well as efforts to prevent constipation and maintain adequate hydration. Precautionary steps should be taken regularly and more frequently than usual if PUBS is noted. Good hygiene, peristomal skin care and catheter care should always be maintained.

PUBS has stymied doctors since 1812. While scientists believe they know more about the syndrome today, it still remains a subject requiring further investigation.

Source: Gwen B. Turnbull, RN, BS, ET: excerpts reprinted from Ostomy/Wound Management, Vol. 51, January 2005; London & District ON; Metro Halifax News April 2005

Presentation April 17

Ever wondered how people coped before today's appliances came on the market? Helen Manson, retired RN and ET, gave a most fascinating presentation at the last chapter meeting April 17. When Helen took her ET training in 1972 she was presented with major challenges in patient care. Understanding and care of ostomies was a far different picture in the 70's than it is now, with few resources and sometimes little support for patients. Helen was to meet many who struggled to adapt to the rudimentary appliances available at the time, or who sometimes resorted to making their own. The results of these efforts were both a testimony to patients' ingenuity and a reminder to us today that although we may still cope with difficulties, ours are minor compared to what conditions were like 30 years ago. People arrived in Helen's office wearing things with metal parts, leather, or canvas webbing. Some custom made their own molds. One person's solution included a short bamboo tube. The array and variety of homemade appliances was both astonishing and sobering.

During her years in practise, Helen collected and saved a large number of these homemade appliances from her patients and had the forethought to save them in an archival collection. In her own words, she literally "took this off a patient" and fitted them with the better appliances that were evolving. With her patients' permission she also documented their ostomies and the apparatus they wore in pictures. The result is a remarkable, and rare, history preserved.

As an ileostomate herself, Helen brought a level of compassion to her patients that was sometimes sadly lacking years ago. She also brought a sense of humor, much in evidence at our meeting!



Yes, each of these gadgets was actually worn or used by a patient at one time. Some are manufactured, some are homemade. "A" -- early manufactured bags "B" -- metal plate "C" -- bamboo tube "D" -- homemade mold



Early irrigation device



More of Helen's collection



No odour control here



Well done! Helen receives a thank you certificate from chapter president, Ron



An early type of flange

OUR STORIES

Paula Rose is a member of the large and growing internet community of ostomates that meets through a network of Internet Forums. In a short time Paula has progressed from 'newby' to moderator on one of these international sites. Here is her story.

My name is Paula Rose Ford and I'm 61 years old. I have been married to my darling Bill for better than 43 years. We have two daughters, Teresa and Kimberley. We also have three beautiful grandchildren, Joe 18, Ryan 15 and Megan 13. We have lived here in Nashville all our married life. I have had my stoma for over 3 years now. This is how it came to be.

In early 2001 I noticed I was much more tired than normal. I had been passing blood in my stool for months but was told it was hemorrhoids so I didn't worry a lot. I lost 16 pounds in two months without even trying and I felt like sleeping a lot. It was October and time for my yearly physical. I told my doctor what had been going on and she did a very good physical, blood work and a hemocult. I was very anemic and had lots of blood that showed up in my stool. She also saw that I was diabetic and I didn't know that. It had to be new because I was in and out of the doctor's office many times that year.

She sent me on to a GI for my very first colonoscopy. He did a flexible scope, found three polyps and the cancer at the top of my rectum. It had eaten thru my colon and that was what was causing all the blood. Not hemorrhoids at all. My GI sent me the next day on to a colorectal surgeon. He did a

rigid scope two days later.

The colorectal surgeon told me it was going to be very close but doable for me to have the cancer removed and a temporary colostomy which could later be reversed. I was afraid, but very hopeful when he told me that. Surgery was scheduled one week later.

I had a urologist, a GYN and my surgeon in on the surgery. They had decided to do a complete hysterectomy just in case the cancer had spread and they couldn't get it all. He also explained at my age, I didn't need those parts and that is one place where the cancer likes to spread. I was fine with that. The urologist was in there to insert stints and do some minor bladder surgery.

I woke to find I had a permanent colostomy and my rectum had been removed. I had one lymph node involved and would be having chemo and radiation treatments start within the next 5 weeks. I was scared but too weak at that time to think too much, which was a good thing. Seems the cancer had spread more than they had at first thought and there was no choice in what had to be done to save my life. There was no going back and no reversal to come. I'm forever with my ostomy.

I was scheduled for a PET scan a



couple of weeks before the chemo began. It showed I was clean and no signs of cancer were in my body. I was elated! My Bill was happy to hear this news too. We had both traveled a long scary road during the weeks before and I have to say, he was there for me all the way. I don't know what I would have done without him. I think sometimes it was harder on him emotionally than it was on me. I know I would rather it be me that was sick and not him, I'm pretty sure he felt the same. He is my everything!

I had a port surgically put into my shoulder and that made chemo so much easier on me. I did 5 days in a row of chemo and rested a month then did 5 more days in a row and rested a month. I then carried an IV around of continuous chemo infusion for 6 weeks while I did radiation each week day. That is the part where I really got tired and a bit weak. I rested another month and then started the 5 in a row with a months rest twice more. Then it was finally done and behind me!

I have tested clean for the last three years. So far so good. I'm so grateful to have my colostomy and to be alive and enjoying my family and friends.

Bill and I got to go to the UOA convention last summer as it was in Louisville, Kentucky just one state over from us. It was wonderful to finally meet up with so many wonderful people I had gotten to know on line at various ostomy sites. I have learned that ostomates are some of the most wonderful people in the whole



Paula Rose & husband Bill -- out on the town!

world no matter the reason for their ostomy. We are a wonderful, special breed of caring folks. I have friends all over the world now. A dear friend and her husband and young son came by for a visit last summer, they are from Australia. That is just a sample of the good things that have happened to me from being an ostomate.

If there is anything I have learned about living with an ostomy that I can share with someone, I'm so happy to do so. I remember how lost I was in the beginning as I didn't have an ET nurse, only

home health care nurses who didn't know much more than me about ostomies. I have learned how to take care of myself from those who have gone on before me. I'm so thankful to all of them.

I would be the poster girl for wanting everyone 50 and over to have a colonoscopy. I firmly believe if I had one done when I was 50, I would never have had to deal with the cancer. They would have caught it before it turned into something nasty. Don't be afraid of a colonoscopy, they don't hurt at all. The only hard thing for me was the prep the night before! Drinking all that stuff wasn't fun, but it could save your life. If there is someone you love who is over 50 and never had one done, beg them to get it if you have to. There is no history of colon cancer in my family.

I was very depressed in the beginning, it was so hard to cope with my new body image, leaks, diabetes and incontinence (that came from some permanent nerve damage done to my bladder during surgery and radiation.) I'm on a wonderful medication right now that is helping that problem a lot. It took time to find the right appliance for me but find it I did! My self confidence has come back and my self esteem along with it. I'm so grateful for my stoma, it truly did save my life. I can do about anything I want to now. Bill and I travel, go fishing, out to eat, swimming. I go shopping with my sisters and friends and stay gone all day. Those are things I wouldn't even have considered doing in the beginning. Life is good again! Better even as I look at things a lot differently than I

did before the cancer and ostomy. Gratitude is a big part of my life.

If you ever find yourself in Nashville, Tennessee, USA, come on by the house for a home cooked meal and a chat! We would love to meet you!

Editor's Note - if that's too far to go, you'll find Paula Rose on Shaz's Forum, address page 14

We wish to thank the following individuals for their kind memorial donations to the chapter:

Vi & George Puhl in memory of Katherine Lang

P. Schmuck in memory of Muriel Edgar

Marlene Longeau in memory of Roy McMinn

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HOW SHOULD A STOMA BE PROTECTED?

Stomas are fairly hardy, but some common sense rules apply. Stomas should be protected from direct physical blows, from too tight clothing, and from rigid objects (e.g. belt buckles) over them. Ostomates engaged in contact sports should protect their stomas by wearing an appliance without any rigid parts, and if desired by wearing an abdominal binder for support.

Dr. Katherine Jeter, writing about children with stomas in *These Special Children* states: "Stomas may be slept on, rolled on, and even sat upon by another child for a few minutes without undue concern."

At each pouch change, check your stoma for colour, shape, and function. Watch for any stoma problems such as swelling, retraction, stenosis, [narrowing of the passage] or prolapse [excessive protruding]. Urostomates should be on the alert for crystal formation or alkaline encrustation (gritty white deposits coating the stoma). Any stomal complications should be reported to your doctor, or ET nurse.

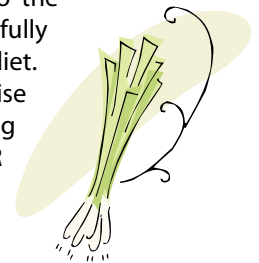
Why will the stoma bleed sometimes? Because the mucous membrane out of which the stoma is formed is so highly vascular, [full of blood vessels] some bleeding may occur if the stoma is rubbed. This bleeding should stop quickly. Prolonged bleeding and increased amount of bleeding or very easy bleeding may indicate another problem and should be reported. Can a stoma be cut? Cuts or lacerations of the stoma can occur and can be quite serious. Because a stoma has no sensory nerves (and therefore no feeling) it can be cut without you actually knowing it. Causes of stomal laceration include shifting of the wafer, too small an opening, incorrect pouch application, etc. Your medical doctor or ostomy nurse should be consulted for diagnosis and treatment in any case of stoma laceration.

Source: New Directions, Ft. Worth, TX; Stratford & District, ON; Metro Halifax News, March 2005

8 Vancouver Ostomy HighLife May/June 2005

WHAT SHOULD I EAT WITH A NEW OSTOMY?

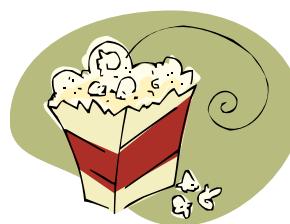
After surgery, many ostomates are able to return to their previous eating habits without much alteration. However, ostomy surgery that affects the large or small bowel may cause changes in your digestion so some caution and common sense applies when you get home and resume your normal diet. This applies doubly to those who have undergone radiation to the pelvic area, as portions of the remaining bowel can be adversely affected by this treatment. It was once thought that many types of foods were strictly off-limits, to ileostomates in particular, but this need not always be the case. You need to learn how your new body reacts to the foods you used to eat, and how to carefully introduce these items back into your diet. You need not fear mealtimes, just exercise moderation to start and (you're going to hear this repeatedly) **CHEW YOUR FOOD WELL**. Below are some common foods and hints on how to enjoy them for those recently returned home from ostomy surgery.



Fibrous Vegetables

Vegetables like celery, asparagus, and broccoli have long fibrous strands running through them. Such strands are hard to digest and can 'ball up' causing a painful blockage. When eating celery, choose the hearts, which are tender and the fibers of which are not as thick as those in the outer stalks. If you must eat the outer stalks, peel down the outside strands.

The medium-sized stalks of asparagus are usually most tender. Start at the tip and work down. As soon as the spear gets tough, stop! The same idea holds for broccoli.



Asparagus causes odor in the urine. Onions can produce odor in the stool. Broccoli, cauliflower, and turnips are gas producers.

Mushrooms, especially fresh ones, are notorious for going through the system undigested or causing blockages. Slice them thin and yes . . . chew, chew, chew.

Corn on the cob or canned corn? Popcorn? Again, notorious. Start with very small amounts.

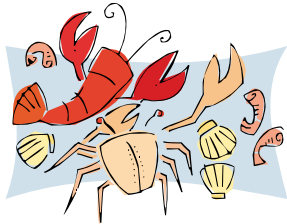
Cheese

Natural cheeses tend to be more binding than processed cheeses. Processed cheeses such as American, cottage, or cream cheeses are also easier to digest.

Fruit

Fresh fruit can, and should, be included in a well balanced diet. If you are having trouble digesting oranges or grapefruit, try

squeezing the juice and discard the skin and pulp. Try peeling apples, pears, plums and peaches to start off. Be careful with fresh coconut. You may be able to eat all of the above items right away, however, post-surgically it's best to approach any fruit with caution and moderation. Keep in mind that fruit is also a natural cathartic [laxative] that may increase bathroom visits.



Seafood

Oysters, clams, and mussels can be more difficult to digest and can cause minor blockages behind the stoma. Chew well and avoid tough morsels (the major offenders). Seafood can cause odor in the stool.

Nuts and Meats

Hard nuts such as peanuts, almonds and hazelnuts should be introduced in very small amounts and chewed well. Most meats and poultry do not present major problems but steak, chops, roasts or hamburger **MUST** be carefully chewed and consumed in moderation. Just home from hospital and hungry for your first real meat dinner, that wonderful T-bone off the BBQ? Enjoy a small portion of that steak but try not to overload your healing system with such a dense amount to digest. High fat items, heavy casings and gristle may be more difficult to digest after ostomy surgery. Try patties instead of sausage links and select hot dogs that do not have a skin. Eat slowly, avoid the gristle and limit your intake.

Spicy Foods

Heavily spiced foods and sauces can act as cathartics and gas producers.

Adapted from Regina Ostomy News, March/April 2005

ANTI-DIARRHEA AGENTS

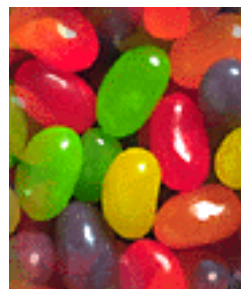
Via: Coos Bay & Metro Maryland

If you are in need of an anti-diarrhea agent, you would do well to consider Imodium, rather than Lomotil. Not particularly new, Imodium has become more and more the drug of choice in reducing the volume of discharge in ileostomies and colostomies. Its great advantage over Lomotil is that it contains no atropine and anti-cholinergic. Atropine in large amounts has several serious side effects, including difficulty in urinating and dryness of the mouth and it can increase intraocular pressure in persons with closed angle glaucoma. Lomotil requires a prescription.

CAN YOU CONTROL THE AMOUNT OF WASTE PRODUCED BY SELECTIVE DIET?

Obviously, if you stop eating, you will not have output. This is an excessive way to limit waste and hazardous to your health. Some people do restrict their food intake for certain portions of the day or evening in order to keep their stoma inactive and the bag flat, which is an acceptable method of waste control if not carried to extremes. If you choose this method of control you must balance periodic fasting with proper nutrition intake, and follow directions for taking medications. If you're starving yourself to the extent that you are dizzy, irritable, fatigued or getting headaches, you're overdoing it and possibly harming your health. (You're also not doing your friends and family any favours by being cranky because you're hungry, either!)

Some foods do produce more waste than others, for example, things that contain cellulose will produce more residue and hence, more output. Cellulose is the chief component in the cell walls of plants, so it stands to reason that consumption of most fruits and vegetables will increase output. Refined grains such as white rice or white bread produce relatively little residue, as do things like eggs, cheese or chicken. Examples of foods that thicken or slow output are oatmeal, peanut butter, marshmallows and bananas. Drinking large amounts of fluids will not affect stool output; it will increase urine output.



Got a Sweet Tooth? You'll Like this Tip!

Tired of eating applesauce, rice, peanut butter etc to thicken or slow output? Try jelly beans. That's right, jelly beans; they do work for some people. (No word on whether or not the red ones work best, though)

Can't Get Your Pouch Off?

You are ready to change your pouch but your stoma has swollen. Don't panic. Fill the pouch with ice water and swirl it around the top of the pouch. If it is a closed-pouch, hold an ice cube over the stoma on the outside of the pouch. Either way should reduce the swelling, which is usually caused by a tight fit.

- Winnipeg Ostomy Association

that life is not over just because you've been diagnosed with a chronic disease -- you can still live a great life, attain goals and do the things you like. The only thing I can't do is wear a string bikini -- but no loss there."

Motivated by her newfound friend's success, she made the difficult choice to have surgery -- a choice which she stresses time and again is not appropriate for all UC patients.

"I have never regretted my decision. I felt well enough to get back to work within two weeks, though I was lucky enough to have four weeks of vacation time. I now do whatever I want, and I eat with no problems."

As a medical student, she was already familiar with UC when she was diagnosed, though she'd never even heard of it prior to medical school. To educate people about the disease and their options for a good life, she created her own internet site. "I created this page because I want to provide helpful information to other UC patients -- things I wondered about, especially when I first got diagnosed." That helpful information includes strong words of advice on the subject of UC medication.

"The best thing to keep the disease under control is to keep taking your medications as prescribed. They are used for maintenance -- stopping them even when you feel well can lead to a more severe flare."

A true success story, this young woman has overcome

Do not do unto others as you would that they should do unto you. Their tastes may not be the same.
- George Bernard Shaw

many obstacles, including a gruelling step two medical licensing exam that she took in between multiple runs to the toilet. She's justifiably proud that she still scored in the top five percent nationwide. Now she's embarked on what she hopes will be a fulfilling and rewarding career. But "although I have received my Doctor in Medicine degree, I will always consider myself a UC patient."

Source: Belleville, Quinte West UOAC, Regina Ostomy News March/April 2005

Male Ostomates and Prostate Enlargement

In most men, the prostate begins to enlarge at about the age of 40. Normally, doctors can detect abnormal growth of this gland by the insertion of a gloved finger into the rectum where they then can feel the size, firmness or softness of the prostate. However, in the case of an ostomate who has had his rectum removed and the opening shut, this of course is not possible. Males who fit into the above category must be alert for any difficulty in urination or bleeding, and have periodic examinations by their doctor.

Examination, in my case, included a urinalysis and a blood test for starters, followed by an intravenous pyelogram (IVP) to check the kidneys and ureter by means of a dye and X-rays. The second procedure showed nothing abnormal. The third procedure was done under anesthesia by a surgeon who used a cystoscope, a long metal instrument with a magnifying lens and a light on its end. This was inserted up the urethra into the area of the bladder and prostate. The cystoscope showed some nodules growing on the prostate. An accessory device, used in conjunction with the cystoscope was used to remove the nodules, which proved to be benign. The surgeon had found the source of my bleeding. I was fortunate.

Source: Prince George Ostomy Hotline, March/April 2005

Pouch Construction and Function-

Excerpt from the British National Pouch Foundation National Seminar, October 2004, Mr. Stefan Plusa, Consultant Colorectal Surgeon, Royal Victoria Infirmary, Newcastle

The first pouch surgery in Britain was performed by Sir Alan Parks at St. Marks Hospital, London in 1978. There are different types of pouches, such as 'J' and 'S', named due to the way the small intestine is folded during the procedure.

Pouch surgery is usually done in two or three stages and it is recommended that there are at least three months healing time between pouch construction and closing the temporary ileostomy to reduce the risk of complications.

The indications usually used to decide if a patient is suitable for pouch surgery are medical history, and the effect of further surgery on the patient. The function of the pouch varies from person to person and Mr. Plusa provided data that showed 5 - 10% of the patients studied suffered from dysfunction so severe that the pouch was not successful for them.

He looked at factors such as night frequency, urgency, continence, and sexual/urinary function—quality of life versus actual function. Some of the complications that can occur post-op are abscesses, maemotoma and bowel obstruction.

Mr. Plusa concluded that the pouch operation is an established procedure, the patient must be fully informed, and that generally the outcomes are good.



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VISITOR REPORT

An active couple of months in the hospitals! Requests for patient visits for this busy reporting period came from VGH, Lion's Gate and independent inquiries.

Colostomy 6

Ileostomy 4

Urostomy 5

Pre-Op 3

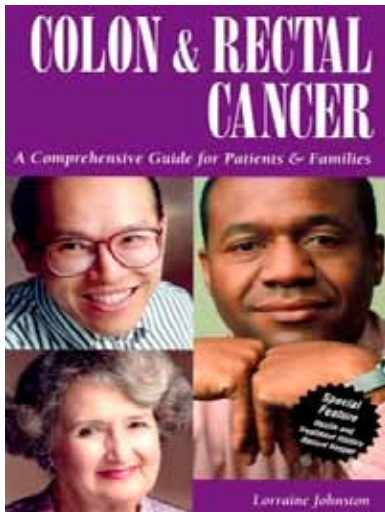
TOTAL 18

*Many thanks to my excellent crew this round:
Arlene McInnes, Merv Wright, Jenny Robulack,
Sharman King, Maxine Barclay, Elaine Dawn and
Earl Lesk.*

Reading Resources

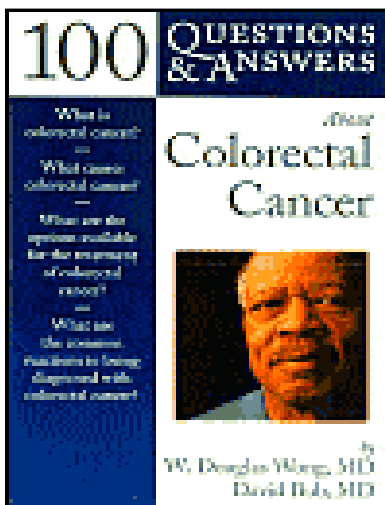
All books are available at your local bookseller or by order from same; some are available at the public library or the BC Cancer Agency. R = Reviewed. We welcome your book referrals and reviews.

COLORECTAL CANCER



Colon & Rectal Cancer: A Comprehensive Guide for Patients & Families

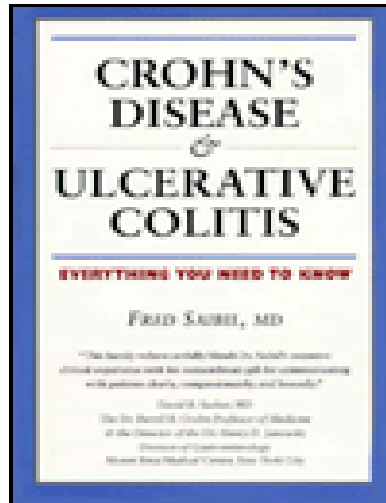
(R - Very informative and engaging book. Colorectal Cancer 101 for Beginners)
by Lorraine Johnston



100 Questions and Answers about Colorectal Cancer

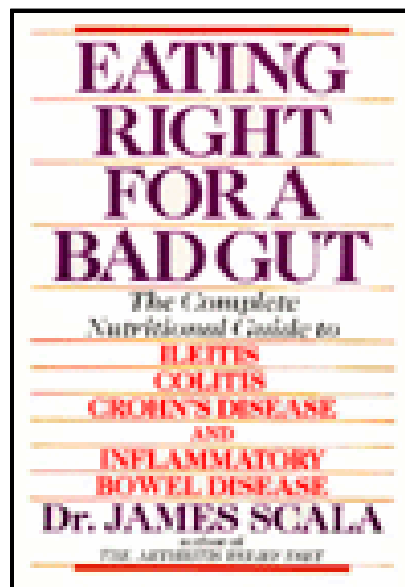
by David A. Bub, Suzanne Rose, W. Douglas Wong

CROHN'S/ULCERATIVE COLITIS



Crohn's Disease and Ulcerative Colitis

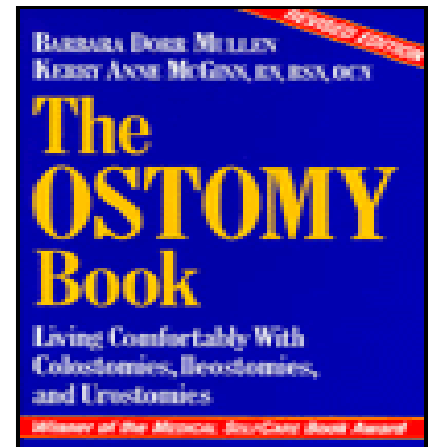
by Fred Saibil



Eating Right for a Bad Gut: The Complete Nutrition Guide to Ileitis, Colitis, Crohn's Disease and Inflammatory Bowel Disease

by Dr. James Scala

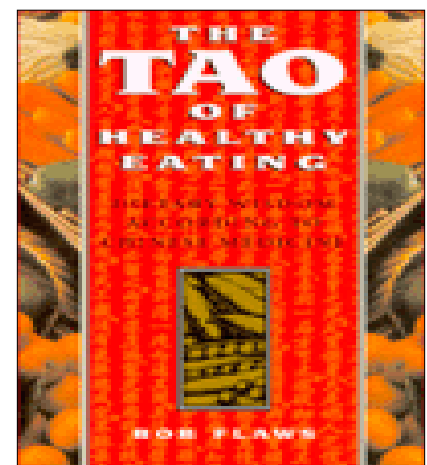
GENERAL



Ostomy Book: Living Comfortably with Colostomies, Ileostomies and Urostomies

by Barbara Dorr Mullen, Kerry Anne McGinn

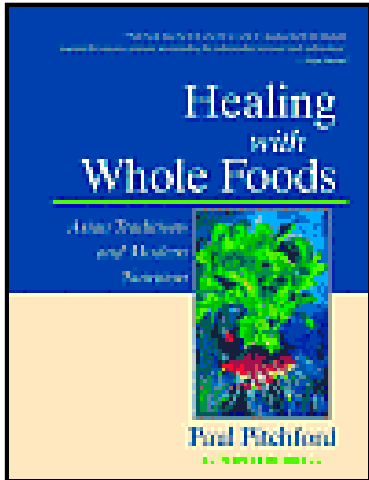
ALTERNATIVE



The Tao of Healthy Eating: Dietary Wisdom According to Traditional Chinese Medicine

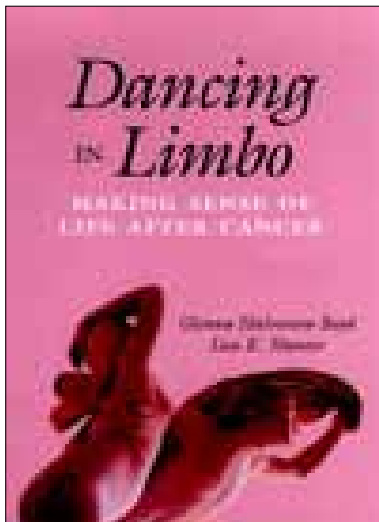
by Bob Flaws

**ALTERNATIVE
READING RESOURCES
cont.**



**Healing with Whole Foods:
Asian Traditions and Modern
Nutrition**
by Paul Pitchford

CANCER/SUPPORT



**Dancing in Limbo: Making Sense
of Life After Cancer**

*(R - An excellent resource for those
troubled by a cancer diagnosis.
Highly recommended)
by Glenna Halvorson-Boyd, Lisa K.
Hunter*

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2005".



Internet Addresses of Interest to Ostomates

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

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

UOA of Canada Inc.: www.ostomycanada.ca

http://search.ebay.ca/colostomy_W0QQfkrZ1QQfnuZ1QQfromZR8
Yes, folks, you can buy (and sell) ostomy stuff on EBay

NEW <http://www.geocities.com/ajlogue/uc.html>
Alicia Logue's personal website on ulcerative colitis

NEW <http://www.ostomy-winnipeg.ca/>
(Winnipeg Ostomy Association-- see conference information)

<http://www.geocities.com/coqcon/index.html>
(Coquitlam Ostomy Association)

NEW http://www.mindspring.com/~rrubiojr/personal_site/
(Personal site, ulcerative colitis diary. Nice design, too!)

<http://www.ostomates.org/cgi-bin/yabb/YaBB.pl>
(Shaz's Ostomy Forum --previously listed, international forum for all types, ages)



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