Vancouver Ostomy
HIGH Life

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

INSIDE

2008 MEETING SCHEDULE:

Feb. 17 (Disability Tax Credit)
April 27 TBA
June 22 TBA
Sept. 21 (AGM)

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

ANNUAL CHRISTMAS LUNCHEON:
SUNDAY, DECEMBER 2

at the Holiday Inn on Broadway!
Reserve now!
Call:
604-738-7065
to reserve and mail in your admission!

UOA ANNUAL CHRISTMAS PARTY!

Once again we will be hosting our Annual Christmas Luncheon to be held:

Sunday, December 02, 2007
at the Holiday Inn, 711
West Broadway, Vancouver, BC

Doors Open: 12:00 Noon
Lunch Buffet 12:45

The Buffet includes:
Waldorf, Caesar and potato salads
Roast Turkey, potatoes, dressing
Cranberry sauce, glazed carrots and green beans
Chef's Dessert Table
Coffee, Tea, Orange Juice and Wine

ADMISSION

Member	$20.00
One Guest per Member	21.00
Additional guests	22.00
Children (4 to 11 years)	10.00
Children (under 4 years)	free

Please make your reservations **no later than Sunday, November 25** by contacting Nora Turner in the evening at 604-738-7065. In order to decrease paperwork at the door we prefer that you mail your buffet and raffle ticket money; however you may pay at the door as well. Please make your cheque out to UOA Vancouver Chapter and mail your cheque to:

Nora Turner
110 - 1551 West 11th Avenue
Vancouver, BC V6J 2B5

RAFFLE TICKETS are included in this newsletter. CASH PRIZES!! Six for $5, or one for $1. Complete these and and mail them, along with a cheque, to Nora. We've had many out of town CASH winners in past years. If you are able to, we ask that you bring a small gift for the door prizes. All donations will be acknowledged in the January newsletter.

From the President

TIME IS OF THE ESSENCE

It is hard to believe that 2007 is drawing to a close already. It seems like just yesterday my family and I were gathered at my cousins' Myron and Lorna's home to celebrate the new Millennium. There was a great deal of uncertainty as to whether when the clock struck midnight on December 31, 1999, airplanes would fall out of the sky, ATMs would stop dispensing money and whether, in fact, commerce in the Western World as we knew it would grind to a halt!

Much has happened in my life since then, and since much has happened to me, I assume much has happened to everyone else. On the "plus" side, some of the wonderful things that happened to me include my marriage to Sandy, the weddings of two sons and the birth of two grandchildren. On the "minus" side, I had cancer and became an ostomate and my cousin Myron had cancer and also became an ostomate. Worse than that, we lost several friends including Wendy Irvine (in whose memory we have named our Chapter's Youth Fund). Wendy passed away in 2005. She was 35 years old. In April of this year, Wendy's father, Dr. William (Bill) Irvine, a very good friend of our Chapter, died of cancer.

As a lawyer I am familiar with the phrase "Time is of the essence." It is a phrase commonly found in contracts. It means that the parties to the contract have agreed that time is a very important element of their agreement. In particular, if something is to be carried out on a particular day, it must be carried out on that day. The absence of that phrase can create uncertainty, because often the courts will conclude that time was not an important element, and therefore will allow a "reasonable" amount of time for the action to be taken. How much time is reasonable will vary with the circumstances.

In looking back and assessing what is really important in life, I have concluded that time is really important, but only if we use it to help others. A life of 90 years squandered on self pity or in only acquiring material possessions is an empty wasted life. That type of life, even though 90 years, does not hold a candle to a much shorter life devoted to helping others and trying to make the world a better place. Albert Schweitzer once said, "I do not know what your destiny will be. But one thing I do know, is that the only ones among you who will be truly happy are those who have sought and found how to help

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From the Editor

Sometimes a change in wardrobe can conceal an ostomy

Do you remember -- think waaay back, some of you -- before you had your ostomy and the subject came up, what you thought or said about the prospect of having an ostomy? No doubt the topic came up in relation to someone's aunt or colleague or child who'd had to have ostomy surgery. Your reaction was probably similar to mine which was along the lines of "That poor man/woman/kid -- I'd rather DIE than live like that, ANYTHING but a colostomy!" (substitute urostomy/ileostomy-- who knew those terms pre-surgery?) We were all once blamelessly ignorant.

I recently had the unexpected opportunity to test that old attitude, the 'anything but an ostomy" one. [More on the "I'd rather die" one in a later editorial) I woke up mid-October with a sore foot. A sore big toe, to be exact. I thought no big deal, this will go away, arthritis runs in the family after all, perhaps I aggravated something while gardening etc. etc. Within two days the foot was swelled to the point where getting a shoe on was an exercise in bad language skills and I was hopping about work in great discomfort. It wasn't so much that the damn thing hurt, but it was maddening to have to move so slowly and be constantly distracted. By day three it was obvious that Advil, ice and elevation were having little effect and it was time to see the doctor. I hobbled into her office on borrowed crutches. Long story short: she thinks I have gout. Gout!! I thought only people like King Henry VIII got gout. You know, those who ate a side of venision and drank a bucket of wine every night got gout. Right? Not so. It doesn't take a profligate lifestyle to produce too much uric acid which can collect in the toe joint (or other joints, but the big toe is a favourite) and give you a condition that while not life-threatening, can be most painful and aggravating. It occurred to me, while waiting to have my nice doctor sort this out, what if I was given a choice between permanent gout and a permanent colostomy? (don't tell me none of you ever have these idle speculations) I realized with a start that I'd pick my colostomy. Seriously. It doesn't

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Letters & News

RESEARCH STARTING TO CATCH UP WITH CROHN'S

- The Vancouver Sun, September 22, 07/LA Times

Two new drugs are poised to hit the market in the United States, and if all goes well, things should soon improve for sufferers of Chrohn's disease, a chronic inflammation of the bowel and intestines that affects an estimated 1,000,000 people world-wide. On July 31, the Food and Drug Administration advisory committee recommended approval of the drug Tysabri as a medication for Crohn's. Tysabri is already in use for treatment of about 14,000 patients with multiple sclerosis, another autoimmune disease. Although the committe's decision is non-binding, it will allow the FDA to move toward approval of Tysabri for Crohn's.

And in two studies published in the July 19 issue of the New England Journal of Medicine, researchers reported that another drug, Cimzia, was effective at treating about one-third of the studies' 1,330 patients with moderate to severe Crohn's. UCB, the Belgium-based maker of Cimzia, has begun filing paperwork with the FDA and plans to seek formal aproval soon.

In treating Crohn's, patients frequently start out with anti-inflammatory drugs such as Azulfidine and Rowasa, then progress to steroids, which are stonger but toxic and can be taken only for a short time. The long-term solution is to suppress the immune system even further.

Since 1998, many Crohn's patients have been helped by medications called TNF blockers, which stymie the action of a molecule called TNF. TNF is produced by immune cells and activates further inflammation. Two of these drugs, Remicade and Humira, are antibodies that bind to TNF, interfering with its function and helping to prevent symptoms.

Remicade and Humira are the first drugs to make a noticeable dent in the rates of hospitalization and surgery for Crohn's patients, says Dr. Stephen Hanauer, Chief of Gastroenterology at the University of Chicago. But they don't work for everyone. Although the antibodies block TNF, they can induce a damaging immune response of their own. Some patients are allergic. For others, the drugs work and then stop being effective.

Cimzia is also a TNF blocker, but unlike the others, it contains only part of the anti-body. The rest of the antibody is replaced with a compound called PEG which stabliizes the drug, allowing it to stay in the patinet's body much longer. That means patients would require treatment only every other month, as opposed to every other week with Humira. Continuing studies are assessing Cimzia's efficacy. Preliminary data indicate that it can remain effective for at least 18 months.

Tysabri, the second new approach to Crohn's works by interfering with a different part of the immune response. During inflammation, infection-fighting white blood cells cruise through capillaries, searching for infection. When tissues are infected, they put out signals to slow the blood cells and coax them to enter the tissue. "They're kind of like the exit signs on the expressway", Dr. Hanauer says.

Tysabri binds to those exit signs -- blocking them from recognition by the immune cells that are causing the Crohn's. So the white blood cells keep on moving, and the course of inflammation is stopped.

Two clinical trials involving 848 patients published in the *New England Journal of Medicine* in 2005 and 2007 reported that Tysabri was effective for about one-third of Crohn's patients, and 59 per cent of those patients continued to see benefits after a year. However, three patients out of 3,000 in clinical trials for Crohn's or MS developed a viral infection in the brain -- and two died. Because of this, Tysabri use is closely monitored.

The exact cause of Crohn's disease is unclear, but there appears to be a genetic link. A person is 10 times more likely to have Crohn's if a relative has it.

- contributed by Sean Mair

QUALITY OF LIFE IS KEY TO CANCER SURVIVAL: STUDY

CHICAGO (Reuters) - Having someone to drive you to cancer treatments or make sure you are eating may be even more important than tumor size or other medical factors in predicting cancer survival, U.S. researchers said on Tuesday.

They found patients with a below-average quality of life before getting treatment for lung cancer -- those in poor health or with inadequate support networks -- had nearly a 70 percent higher death rate than those with a better one.

"It's intuitive that someone who is in better physical shape and has a support system will do better than someone who comes in already debilitated and doesn't really have anyone to help them go through treatment," said Dr. Nicos Nicolaou of Fox Chase Cancer Center in Philadelphia in a telephone interview.

"We have now shown this," said Nicolaou, whose study was presented on Tuesday at the American Society of Therapeutic Radiology and Oncology meeting in Los Angeles.

Doctors routinely consider factors such as tumor size, stage of the disease and other measures to predict how long a patient with cancer will survive.

But factors that make up a patient's quality of life -- overall health, mobility, emotional stability, social support and financial resources -- may make the most difference, Nicolaou and colleagues found.

"If you have someone to help you with your meals, transportation, give you your medications and take care of your daily needs, both physical and emotional, you will be able to get through the treatment better," he said.

Researchers at Fox Chase and Henry Ford Hospital in Detroit studied 239 patients with lung cancer enrolled in a treatment trial involving both radiation and chemotherapy.

Report on 10th Annual UOAC Conference - *by Alan MacMillan*

(Alan was our voting delegate at the Calgary conference; the following is an excerpt from his presentation at the AGM September 16)

I would like to express my appreciation of the chapter's support of my appointment as your delegate at this Conference. I'm sure that I speak not only for myself in this matter, but also for the other delegate, Graham Drew. It was a very well organized gathering of almost 200 attendees from Canada and the United States plus two international delegates (Mexico) with 33 chapters being represented. Speakers and introducers were all very informative and well-versed in their particular field of expertise. Time was allowed for questions from the audience as well as time to fill out the evaluation sheets re starting and finishing times, effectiveness of handouts (if any) status of the P.A. system, satisfaction with room temperature etc. etc. at the end of each workshop. Workshop notes and content will be published in the next issue of "Ostomy Canada".

THURSDAY MORNING Following the Grand Opening, the keynote address was given by Dr. W. Donald Buie, Clinical Associate Professor in the Divisions of General Surgery at the University of Calgary. His subject was "Changing Times: Ostomy Surgery Past, Present and Future". He began by expanding the question -- "Who are we?" -- noting that 'we' are 100,000 ostomates in Canada and 1,000,000 ostomates in the United States, a rather astounding figure considering that so many of us feel so alone with our affliction. He then went on to describe the chronology of ostomy history from the early 1800's to today, the advent of staged operations, the introduction of ileostomy oerations, ostomy management systems, through to what we have today to help us in managing ostomies, i.e. a network of knowledgeable nurses, excellent support, and multiple pouching systems. Along with this, we have ostomy Support groups, better technology and an ever expanding body of knowledge. As to the future, Dr. Buie thought we should be able to look forward to better screening procedures, newer techniques and improvements re ostomies vis-à-vis Crohn's disease.

THURSDAY AFTERNOON Various Support Groups based on each delegate's particular interest -- colostomy, ileostomy, urostomy, pelvic pouch, 20/40 group and SASO (Spouses and Significant Others). As I am a urostomy ostomate, I attended that particular workshop conducted by a registered ET nurse from a Calgary hospital as our group leader. Although it was a small group, it was very informative, with each attendee contributing, and questions were expertly handled by our resource person.

THURSDAY EVENING The banquet was sponsored by Coloplast, with a Western theme.

FRIDAY MORNING I attended a lecture on "Marrying Best Practice With Financial Resource" by Ms. Lauran Chitton, RN, BScN, NCA, who has been a manager for the Alberta Aids to Daily Living Program (AADL) since 2000. Currently she is responsible for the management of $22 million of the AADL programme providing ostomy supplies to those Albertans who live in their home or a home-like setting and who have long-term ostomies.AADL helps Albertans maintain independence in their residence by providing medical equipment and supplies to meet medically-assessed needs.

FRIDAY AFTERNOON This workshop was with Ms. Heather Orsted, RN, BN, ET, MS., speaking on "Psychological Effects of Ostomy Surgery on You and Your Family". A qualified and accomplished clinical and educational consultant in her own right, she focused on quality of life issues not just for persons with an ostomy, but also for their family. Chronic illness or recovery from surgery affects so much more than just physical functioning: it may also affect emotional, social and occupational functioning. She lead us to discover how someone with a colostomy, ileostomy or urostomy can face new tasks in order to adapt to altered body image an altered body function. She also dealt with the results of a recent poll using the British Happiness Index showing the breakdown in percentages between various ostomies. As an objective, ostomates should explore and reflect that having an ostomy is more than just learning all about a pouch change, and that an altered body image and altered body function is a fact of life. All ostomates are not the same and each person brings a different quality of life. The physical, social and psychological boundaries are intertwined with development, health and related factors. Empowering factors include stoma location, stoma structure, access to support, assessment, fear and anxiety. What is important is this: "If you can't get a seal, nothing much else matters".

FRIDAY'S BANQUET was sponsored by Convatec and included presentation of the Renaissance Award (our own Debra Rooney/ Vancouver)

SATURDAY MORNING I attended the national Council Meeting presided over by Ms. Pat Cimmeck, Past President of UOAC, wherein business relating to UOAC was conducted as per the guidelines set out in the Policies and Procedures Manual. Various reports, motions, etc. etc. presented, with the meeting being adjourned at 11:45 am.

SATURDAY AFTERNOON The early afternoon was taken up with attending the Bertha Susan Okun Lectureship where speaker Frances Wright, Founding Director, President and CEO, Famous 5 Foundation highlighted the strategies and lessons learned from five remarkable Canadian women-- Emily Murphy, Henrietta Edwars, Louise McKinney, Irene Parlby and Nelly McLung -- all who have become known simply as the Famous 5. They fought for the recognition of women as "persons" under the British North America Act while achieving various "firsts" in their own right -- ie: establishing the YWCA, the VON, formation of the United Church, the first woman senator, women's right to vote etc.

The **FAREWELL BANQUET** was sponsored by Hollister Inc. and included presentation of the President's Award (Les Kehoe/Ottawa), the Maple Leaf award (Betty Woolridge/Halifax) and ET of the Year (Jean Grignon/Sudbury)

Next year's UOAC conference will be held in Hamilton, Ontario, August 14 - 17, 2008.

GUT REACTION:

The Candida Story

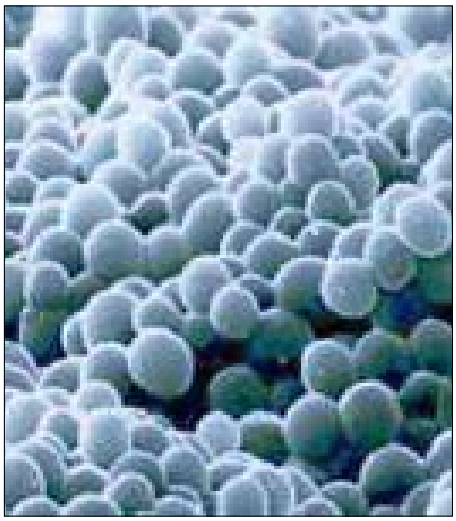
What do heartburn, morning aches, creaky joints, depression, PMS, headaches, dandruff, excessive perspiration and memory loss have in common? You might think it's a list of symptoms that define aging, but these seemingly unrelated complaints have been linked to problems in the digestive tract caused by a single-celled bacteria (yeast) called 'Candida albicans". And it's the same bacteria that can cause an irritating, itchy rash on the peristomal skin.

Your intestines are home to trillions of creatures -- and unpleasant as that may sound, you want most of them to be there. Beneficial bacteria help to break down food, metabolize hormones, create vitamins, and prevent yeast and disease causing bacteria from taking over your system. On the other hand, bacteria like Candida can take advantage of your hospitality; living in your intestines without offering any positive payback -- but as long as the beneficial bacteria outweigh the freeloaders, there is harmony in your digestive tract. If the environment shifts in favour of Candida they quickly take control and the results can be felt far from your digestive tract.

Shifting the Balance

The most obvious trigger for intestinal impalance is antibiotic medications, which disable or kill bacteria when you have an infection. Unfortunately, antibiotics don't discriminate. Not only do they kill bacteria causing an infection, they also eliminate those that serve and protect you. Because opportunistic bacteria like Candida tend to recover more quickly than the beneficial varieties, your internal landscape shifts.

Chlorinated water is another common cause of intestinal imbalance, as is pregnancy, AIDS, high alcohol intake, pesticides, herbicides, and too much



processed or packaged food. Lacking digestive enzymes found in fresh fruits and vegetables, prepared foods are more difficult for the body to digest, causing a slow-down in the intestines that leads to a feast for freeloading bacteria. The feasting allows bacteria like Candida to reproduce and create waste, which is toxic to us. The walls of the digestive tract become irritated and inflamed, and susceptible to damage. Candida cells then produce root-like structures that penetrate the lining of the gut in a condition called 'porous bowel' or 'leaky gut' syndrome.' Tiny holes in the digestive tract allow two things to happen. Firstly, undigested food proteins can directly enter the bloodstream, triggering an immune system reaction as your body tries to eliminate a perceived threat. As a result, food allergies and sensitivities frequently develop.

Secondly, Candida itself leaves the digestive tract and travels through the bloodstream until it finds an available organ to call home. In fact, a 2002 study found that 15% of sinus infections were caused by Candida albicans. Candida is also involved in many vaginal yeast infections, nail infections and skin conditions like eczema.

Yikes! Is there no escape?!

Since the great majority of us have used antibiotics, been exposed to chlorinated water, live with stress and don't always eat a perfect diet, you might think Candida infections are inevitable. Not so. Our bodies and immune systems are adaptable and usually do a good job of maintaining inner harmony despite our bad habits. But there are some things you can do to help your body keep Candida in line.

What Can You Do?

One of the most effective ways to eliminate Candida is to stop feeding it. As a yeast, Candida needs sugar to survive. Reduce your intake of refined sugar and white foods like bread and pasta that quickly convert to sugar in the body. If you want to be really serious about starving Candida, eliminate fruit from your diet for a short while. Although otherwise good for you, fruit also provides plenty of sugar to feed yeast. Other foods to avoid include red meat and processed foods, which are difficult to digest, cause your system to slow down and Candida to dine. Wheat is also a problem for many people to digest, so experiment with other grains such as quinoa, kamut and millet. To change your internal environment, you'lll also want to eliminate fungus foods such as mushrooms (hey -- easy choice for some of us!) as well as yeast-containing foods and nuts. Nuts often contain mold. Avoid alcohol and dairy, which are high in sugar, also limit your intake of coffee.

If you're starting to wonder WHAT you're allowed to eat, take heart. Vegetables, lean protein such as eggs, chicken, turkey, fish and legumes as well as whole grains like brown rice are fair game. Enjoy green tea and drink plenty of water. To build up your beneficial bacteria, consider using supplemental probiotics containing live bacteria. These can be consumed in either capsule form from the health food section of stores, or in specific yogurt brands.

- adapted from Canadian Health & Lifestyle, Summer, 2007

Management of a Flush or Retracted Stoma

- Charlotte, NC Cheers & Tears & Hemet-San Jacinto, CA; Evansville Ostomy News; Okanagan Mainline

The ideal stoma is one that protrudes above the skin, but this is not always possible and a flush (or skin level) or retracted (below the skin level) stoma may result. The surgeon may be unable to mobilize the bowel and mesentary adequately or be able to strip the mesentery enough without casing necrosis or death to the stoma. Some causes of stoma retraction after surgery may be weight gain, infection, malnutrition, steroids or scar tissue formation. Stomas that are flush or retracted can lead to undermining of the pouch by the effluent (drainage). This continued exposure can lead to irritated and denuded skin as well as frequent pouch changes. These problems can be very stressful and expensive. The inability to maintain a pouch seal for an acceptable length of time is the most common indication for a product with convexity. Shallow convexity may be indicated for minor skin irritations and occasional leakage. Medium convexity may be indicated for a stoma in a deep fold, with severe undermining and frequent leakage. Deep convexity is used when medium convexity is not sufficient, stoma is retracted, in deep folds or leakage is frequent and the skin is denuded.

WAYS TO ACHIEVE CONVEXITY:

CONVEX INSERTS: can be applied to a 2 piece system by snapping a convex insert into the ring of the flange. Outer diameter must match the flange size. this can be cost effective as this insert can be removed, cleaned and re-used.

CONVEX POUCHES: are available in both one and two piece systems. These can be shallow, medium or deep. they come as either pre-cut or cut-to-fit.

ADDITION OF SKIN BARRIER GASKETS AROUND THE STOMA: can be cut or purchased pre-cut. You can use one layer or several layers. Products such as the Convatec Eakin Seal, Hollister Adapt Convex Barrier Rings, or Coloplast Strip Paste can be pressed into shape around the stoma to protect and seal.

OTHER WAYS TO INCREASE WEAR TIME AND PREVENT LEAKAGE: An ostomy belt may be helpful. Cut the barrier opening so it clears the stoma at most by 1/8" only, to give skin maximum protection.

OSTOMY PASTE FOR "CAULKING" Apply a string of paste (like squeezing toothpaste out of a tube) closely around the opening of the barrier (the adhesive side of course!) Do not flatten; rather, allow it to shape itself around the stoma as you press the pouch on.

PRODUCT INFORMATION: Pay attention to what the ostomy appliance manufacturers have to offer! Most make appliances with convexity and carry convex inserts as well as belts. Barriers can vary in design and function from one brand or model to the next. Call your supplier or ET nurse for-up-to date information or samples.

HOW TO SHAVE AROUND YOUR STOMA

- Kathy Dalin, RN, Riverside HealthCare, Kankakee; Metro Halifax News

Many men find they must shave the peristomal skin with each change of their skin barrier. In the past, ostomy literature has usually recommended using an electric razor. I personally have never had great success with this method, although I have heard that some folks do very well with the newer small razors that are designed for trimming mustaches and sideburns.

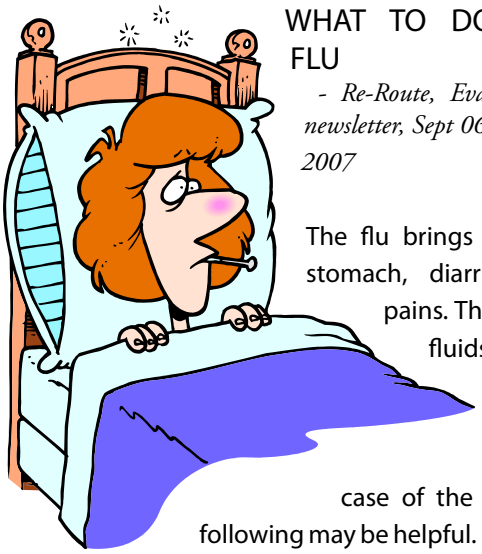
If you use a safety razor, as we do in the hospital, be sure to apply sufficient shave cream so that this is not a dry shave.

In addition, be gentle. Most shave creams have emollients so you will need to wash the skin with plain soap and water afterwards. Rinse your skin well so no cream or soap residue remains.

If your skin is very irritated and itchy, we have found that Kenalog spray or Desonide lotion is extremely helpful. This is a steroid (cortisone) solution, which decreases the itching and irritation dramatically. Apply these lightly, and then allow to dry completely prior to placing on your new skin barrier. These medications have a slightly oily base, which means your skin barrier probably will not stay on as long as you are accustomed. This procedure will relieve the itching and

promote healing. Skin heals better covered by a skin barrier than it would if aired out. Do not use any steroidal spray as part of your regular changing routine. Steroids are absorbed into your system through the skin. Moreover, steroids will thin the skin compounding peristomal skin issues.

If there are actual pustules around the irritated hair follicules, you may need to use an antibiotic powder such as Polysporin powder to clear this up. All the products mentioned require a prescription to obtain.



WHAT TO DO IF YOU GET THE FLU

- Re-Route, Evansville, IN Niagara chapter newsletter, Sept 06; Halton-Peel Newsletter, Feb, 2007

The flu brings with it headaches, upset stomach, diarrhea, muscle aches and pains. The advice to drink plenty of fluids and rest in bed remains sound medical advice for your general attack of the virus. But if your case of the flu includes diarrhea, the following may be helpful. For those with a colostomy, it is usually wise not to irrigate during this time. Your intestine is really washing itself out. After diarrhea, you have a sluggish colon for a few days, so leave it alone. Start irrigation again after a few days when your colon has had a chance to return to normal. In colostomy patients, drugs or certain foods can cause constipation, prevented during a cold by drinking plenty of liquids. For those with an ileostomy, diarrhea is a greater hazard. Along with the excess water discharge, there is a loss of electrolytes and vitamins that are necessary in maintaining good health. This loss is usually referred to as a loss of fluid, which in turn, brings a state of dehydration. Therefore, you must restore electrolyte balance. First, eliminate all solid food. Second, obtain potassium safely and effectively from tea, bouillon and ginger ale. Third, obtain sodium from saltine crackers or salted pretzels. Fourth, drink a lot of fluids, including water. Cranberry juice and orange juice also contain potassium, while bouillon and tomato juice are good sources of sodium. Increased water intake in the ileostomy patient results in increased urine output rather than increased water discharge through the appliance. Vomiting also brings the threat of dehydration. If it is severe and continuing, your doctor should be notified. You should know also that diarrhea may be symptomatic of partial obstruction or acute gastroenteritis. Since the treatment of these two entities is entirely different, a proper diagnosis should be sought immediately. It is very important to determine whether the diarrhea is caused by obstruction or gastroenteritis. If you do not know, check with your doctor. Do not guess – always call your doctor.

Flu shots:
Important if you have heart disease

Larry Baddour, M.D.

Flu shots are recommended for anyone with heart disease. Find out why from a Mayo Clinic specialist who helped develop the flu shot recommendations.

If you have heart disease, you should get an annual flu shot. That's the message put out by the American Heart Association and the American College of Cardiology.

Studies have shown that death from the flu (influenza) is more common among people with cardiovascular disease than among people with any other chronic condition. Doctors have long recommended that older adults and other high-risk groups get flu shots, but have recently placed more emphasis on the importance of flu shots for those with heart disease. The flu shot could prevent thousands of flu-related complications and deaths every year in people who have heart disease.

Larry M. Baddour, M.D., an infectious diseases specialist at Mayo Clinic, Rochester, Minn., and professor of medicine at Mayo Clinic College of Medicine, was on a joint American Heart Association and American College of Cardiology advisory panel that developed the flu shot recommendation for those with heart disease. He shares his insight about the group's recommendation.

Why are flu shots important for those with heart disease?

According to the Centers for Disease Control and Prevention (CDC), the flu is estimated to cause more than 36,000 deaths annually in the United States. In addition, it sends 225,000 people to the hospital. The rate of flu-related complications is even higher for people with heart disease.

If you have heart disease, you are at increased risk of complications from the flu — including pneumonia, respiratory failure, heart attack and death. Having the flu can also cause dehydration and worsen heart failure, diabetes or asthma.

Most scientific evidence indicates that flu shots are associated with a reduced risk of cardiovascular events — such as heart attack — in people with known cardiovascular disease.

Is it safe to get a flu shot if I have heart disease?

Flu shots are safe for most people who have heart disease. Get your flu vaccine injected by needle, usually in the arm. Some people develop mild arm soreness at the injection site. The flu vaccine that is given by nasal spray isn't recommended for people with heart disease because it's made with live virus that can trigger flu symptoms in people with heart disease.

When should I get a flu shot?

If you have heart disease, get the flu shot each fall when it becomes available, usually late September through November. However, if flu shots are still available and you haven't yet received a vaccination, you'd still benefit from getting a flu shot in January or later. That's because the flu season doesn't typically peak until January, February or March.

Do I have to get a flu shot from my cardiologist?

You don't have to get your flu shot from your cardiologist. However, the American Heart Association recommends that cardiologists have the flu shot available at their clinics. The flu shot is also available through primary care doctors, some specialists and cardiology clinics, public health departments and some pharmacies. It's best to call ahead to determine if vaccine is available and when. Some places may require an appointment.

Mayo Clinic Online

Garlic Doesn't Improve Cholesterol

Don't depend on garlic supplements to lower cholesterol. In two independent and controlled studies, one using Kwai garlic powder the other using Tegra garlic-oil preparation, there was no evidence that garlic made any difference in total cholesterol, LDL cholesterl or HDL cholesterol.

The first study reported no significant differences between the garlic-taking group and those taking placebos.

The second study found that garlic had no influence on "serum lipids, cholesterol absorption, or cholesterol synthesis."

Source: Archives of Internal Medicine; Aviation Medical Bulletin, April 2007, Metro Halifax News, May 2007

BLADDER CANCER

T.R. Van Dellan, MD, Greater St. Louis chapter, Columbia, MO;
Metro Halifax News, September 2007

Most tumors of the urinary bladder are malignant. They are likely to develop after the age of 50, and men ar more susceptible than women. At least 95 percent of these tumors are carcinomas or papillomas. These cancers are unique, especially papillomas. When the first tumour is removed, another develops months or years later. It is a new lesion and likely to be more malignant than the first. And this type of recurrence may happen over and over again. This is why urologists insist on looking into the bladder every three to six months after the first neoplasm is removed. The incidence of bladder tumours is increasing among our population. In 2002, it was estimated that 56,000 (US) new cases would be reported. Overall, bladder cancer incidence is about four times higher in men than in women. On the other hand, the death rate has not risen due, perhaps, to improvement in early diagnosis and treatment. Cancers of the bladder may grow for varying periods of time without producing any symptoms. They are always suspected when the individual suddenly, and for no apparent reason, urinates blood. Should this painless, but serious, sign develop, consult with your physician without delay. He may recommend an urologist who will try to find the source of the bleeding. If nothing is done about the sudden bleeding, it may stop spontaneously. However, signs of bladder irritations and infection may soon ensue with queasy urgency, and difficult and painful urination. Diagnosis is made by looking into the bladder with a cystoscope and doing a biopsy. With this procedure, the surgeon determines the size, shape and location of the tumour. In some instances, the top of the lesion may have sloughed off, leaving a bleeding ulcer. A pap test of the urine may reveal cancer cells. X-rays of the kidneys and an examinatin of the prostate gland in men, complete the study. Some vesical tumours can be removed with electro coagulations or cutting electric currents inserted through the opening in the scope. Radon seeds can be inserted in the same way. Serious lesions require abdominal surgery, which involves removal of part of, or the entire, bladder.

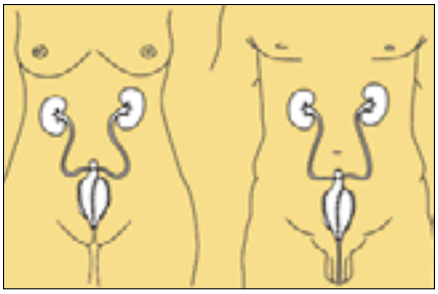
"Resolve to be tender with the young, compassionate with the aged, sympathetic with the striving, and tolerent with the weak and wrong...because sometime in your life you will have been all of these"

- Anon

Procedure Minimizes Lifestyle Changes after Bladder Cancer Surgery

Neobladder Urinary Diversion

(Female patient pictured left, male patient pictured right)



For patients with invasive bladder cancer, surgical removal of the bladder, called a cystectomy, provides the best chance for a long-term cure. In the past, following bladder removal all patients were required to wear a bag on the outside of their body to collect urine, a permanent condition that necessitated significant lifestyle adjustments. Today, many of these patients qualify for what is known as a neobladder -- an internal urine-storing pouch that is attached to the urethra, which allows patients to regain control of urination and to void much as they would with their natural bladders. Thanks to recent advances in the procedure, the majority of patients undergoing bladder removal surgery at Memorial Sloan-Kettering Cancer Center are able to receive neobladders.

Invasive Bladder Cancer and Cystectomy

Of the estimated 61,000 Americans who will be diagnosed with bladder cancer this year, nearly 90 percent will have what is known as transitional cell carcinoma (TCC). While about 75 percent of TCC cases are confined to the lining of the bladder, the remaining 25 percent of cases are invasive, meaning that the cancer has penetrated the bladder lining, invading the muscular wall of the bladder and possibly other nearby organs. For these patients, a surgical procedure known as a cystectomy is performed to remove the bladder along with surrounding affected structures. (For men, this procedure also entails the removal of the prostate, seminal vesicles, lymph nodes, and part of the vas deferentia. For women, surgeons also remove the uterus, fallopian tubes, ovaries, lymph nodes, and possibly part of the vagina.) Once the bladder has been removed, surgeons must create a new way for the body to store and eliminate urine.

Urine is produced in the body's two kidneys, both of which are connected to tubes called ureters. Ureters carry urine to the bladder, where urine is stored until it is expelled through a tube called the urethra. In a traditional cystectomy (also called an ileal conduit diversion), the surgeon performs what is known as a cutaneous diversion, a procedure in which a conduit, or passageway, for urine is created using a segment of the patient's small intestine. This conduit transfers urine directly from the kidneys and ureters to a surgically created opening in the abdomen, called a stoma, which funnels the urine into a collection bag worn on the abdomen.

Neobladder Urinary Diversion

In the neobladder procedure, an internal pouch is formed using a section of small intestine and the new "neobladder" is attached to both the ureters and the urethra, effectively serving as a substitute bladder that allows patients to urinate using the urethra. After surgery, patients with neobladders are instructed to follow a course of exercises, which helps strengthen pelvic muscles, in order to regain urinary control, or continence. Some incontinence will remain until the neobladder pouch is adequately stretched and the pelvic muscles are strengthened. With regular exercise, significant improvement in urinary control usually begins about two months following surgery. Nighttime control may take longer.

"Our surgical techniques have progressed to a point where the vast majority of men and women receiving neobladder diversions will have near-normal urinary control that allows for an excellent quality of life after surgery," says Bernard Bochner, a urologic surgeon at Memorial Sloan-Kettering.

Treatment Hesitation and Surgical Skill

In the past, Dr. Bochner notes, concerns over the need to wear a urine collection bag caused some invasive bladder cancer patients to put off the procedure. The resulting delay in treatment may have affected their long-term outcomes. Recent research has suggested that urinary-function-preserving neobladder surgery encourages individuals to receive treatment sooner, when the likelihood of a positive treatment outcome is greatest.

Dr. Bochner cautions that the neobladder technique does require greater surgical skill than the traditional ileal conduit diversion. Qualified patients are advised to seek out a center that has successfully performed a large number of these procedures. Of the more than 200 radical cystectomies with urinary tract reconstruction procedures that are performed each year at Memorial Sloan-Kettering, more than half will include neobladder reconstruction.

Nerve-Sparing Technique Preserves Sexual Function for Men

While men account for three out of every four cases of bladder cancer in the US, the traditional cystectomy often includes the removal of the nerve bundle that controls erections. In many cases, cystectomy with a neobladder urinary diversion allows surgeons to spare this nerve bundle, thereby preserving a man's sexual function.

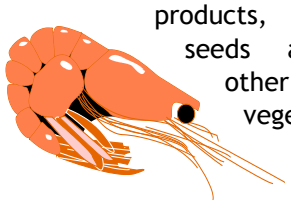
"Removing all the cancer remains the primary goal for bladder cancer surgery," Dr. Bochner explains. "But in male patients who qualify for nerve-sparing and urethra-sparing surgery, the majority of these men will benefit and achieve spontaneous erections after surgery."

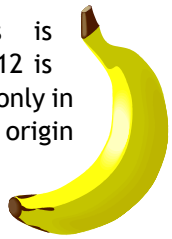
- Mayo Clinic Online

ILEOSTOMATES -- VITAMIN B12, FOLIC ACID AND POTASSIUM

Only a small section of the intestines absorbs vitamin B12. It is located near the joining of the small and large intestines. In the ileostomate, especially if there have been revisions, too much of the small intestine may have been used up and the area which absorbs B12 may be gone. The ileostomate can then no longer absorb it from food or even from supplements. The answer to this problem is B12 shots, given anywhere from each week to once a month, depending upon how the patient feels. The "worn out" feeling that one has occasionally can develop into a constant thing that is a good indication of vitamin deficiency.

In the case of a suspected deficiency, there are three elements the doctor should check: vitamin B12, folic acid, and potassium. The shortage of any one or all three can keep us down and without any pep or ambition even to do our daily chores. B12 and folic acid interact to the point that a deficiency of either might be mistaken without complete tests for a deficiency of the other. Everyone needs each to make the other one work right. There is no danger of taking too much B12; the body throws off what it does not need. Folic acid should not be taken in large doses. Studies are not complete but it seems that the maximum is 0.4 mg a day. Potassium in natural foods cannot be overdone. The greatest sources of potassium is bananas, with orange juice and potatoes also being very good. However, if you have a shortage of potassium, you probably cannot get enough from foods without gaining weight. Leaf vegetables such as spinach and turnip greens, dried beans and peas, fortified cereal products, sunflower seeds and certain other fruits and vegetables are rich sources of folate, as is liver. Vitamin B12 is naturally found only in foods of animal origin including meat (especially liver and shellfish) and milk products. Eggs are often mentioned as a good source, however they also contain a factor that blocks absorption. Fortified breakfast cereals are a particularly valuable source of vitamin B12 for vegetarians and vegans





An ileostomate who cannot absorb enough vitamin B12 from food or from pills must take shots. Folic acid and potassium can usually be absorbed in pill form, but the ileostomate should watch that the pills are not passing through the digestive tract and being expelled. If an ileostomate feels tired all the time, he/she should consult a physician.

From the President

cont. from page 2

others." Henry Drummond said, "You will find, as you look back upon your life, that the moments that stand out are the moments when you have done things for others."

Bill Irvine and his daughter Wendy were truly people who found how to help others. We were fortunate to have known them, although all too briefly. May their lives inspire us to help others just as they did. Emerson wrote, "You can never do a kindness too soon, for you never know how soon will be too late."

Time is of the essence! Happy Holidays to all.

Martin Donner,
President

From the Editor

cont. from page 2

hurt, nobody can tell anything is different about me, I can move and dress normally and do everything I used to do and I don't think about it that much. If I had gout for the rest of my life I'd have a heavy limp, be unable to do most of the physical activites I enjoy doing now, have to take painkillers and be constantly aware of one part of my body. I realized, with mild surprise, that I was heartily sick of this very sore foot and just wanted to be back to normal. Normal. With a colostomy. Who knew?

The foot cleared up with some medication and rest but you know what the moral of this story is. ANYTHING but an ostomy? Hardly. Getting and living with an ostomy is no day at the beach, but there are far worse and more debilitating conditions to live with, even something as prepostorous as gout. Remember that, if you ever get one of 'those' days.

Oh yes, and take it easy on that venison and wine.

VISITOR REPORT

Requests for patient visits this reporting period came from Vancouver General, Lion's Gate, and St. Paul's hospitals, as well as from individual inquiries.

Colostomies:	5
Ileostomies:	3
Urostomies:	2
Pre-op	1
Other:	1
TOTAL:	12

Many thanks to my excellent crew this round: Ron Dowson, Lisa Saunders, Rob Hill, John Jensen, Lennea Malmas and Al Ashcroft. ***Thanks AGAIN to Maxine for taking over the referrals while I was on holiday!***

2008 MEMBERSHIP RENEWAL TIME!

Membership dues of $30.00 (unchanged from last year) are due by **December 1, 2007.** It would be greatly appreciated if members could send in their renewal promptly so all names can be forwarded to the head office in Toronto in one mailing. This saves us postage and is more efficient for the hardworking volunteers in the head office to process all renewals at one time. Please make sure to indicate if there are any changes in name or address from last year. Those members who are new as of July 1, 2007, or who have already renewed please disregard this notice. A renewal form is on the back page of this newsletter. Please remember to make your cheques out to the Vancouver Chapter UOA. We look forward to having all our members back for another year!
Please contact me if you have any questions - Arlene McInnis 604-929-8208

Welcome to Our Treasurer

Fred Lesiuk hunted up the Visitor Program phone number not long after his colostomy surgery 2 years ago and joined our chapter soon after. He has faithfully attended almost all meetings since! Fred has kindly stepped up to the plate to take over the position of Treasurer from Myron Donner, who has had to retire from the position due to health issues.

Fred was born in good old Moose Jaw, Saskatchewan in the early 30's. He completed high school at Central Collegiate in that town, bounced around for a few years as a miner in the Headly Gold mine and then back to Moose Jaw to sign up for an accounting program. He articled for a Moose Jaw accounting firm, R.L. Bamford and Co. Fred officially retired from the accounting world ten years ago, although, in his own words, "I still dabble in accounting, unofficially using the Simply Accounting software program, which is the program I am using to record financial data for my own affairs and my family and now for the Vancouver UOA Chapter."

Fred lives in Richmond and is [quoting again] "the father of a handsome son, 5 beautiful daughters, 4 equally beautiful granddaughters and 4 equally handsome grandsons and one great grandson who is the 'best looker of all.' That to me is my proudest accomplishment."

the Lighter Side . . .

BEER TROUBLESHOOTING

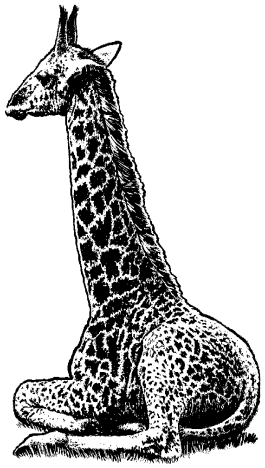
SYMPTOM	FAULT	ACTION
Feet cold and wet.	Glass being held at incorrect angle.	Rotate glass so that open end points toward ceiling.
Feet warm and wet.	Improper bladder control.	Stand next to nearest dog, complain about house training.
Beer unusually pale and tasteless.	Glass empty.	Get someone to buy you another beer.
Opposite wall covered with fluorescent lights.	You have fallen over backward.	Have yourself leashed to bar.
Mouth contains cigarette butts.	You have fallen forward.	See above.
Beer tasteless, front of your shirt is wet.	Mouth not open, or glass applied to wrong part of face.	Retire to restroom, practice in mirror.
Floor blurred.	You are looking through bottom of empty glass.	Get someone to buy you another beer.
Floor moving.	You are being carried out.	Find out if you are being taken to another bar.
Room seems unusually dark.	Bar has closed.	Confirm home address with bartender.
Taxi suddenly takes on colorful aspect and textures.	Beer consumption has exceeded personal limitations.	Cover mouth.
Everyone looks up to you and smiles.	You are dancing on the table.	Fall on somebody cushy-looking.
Beer is crystal-clear.	It's water. Somebody is trying to sober you up.	Punch him.
Hands hurt, nose hurts, mind unusually clear.	You have been in a fight.	Apologize to everyone you see, just in case it was them.
Don't recognize anyone, don't recognize the room you're in.	You've wandered into the wrong party.	See if they have free beer.
Your singing sounds distorted.	The beer is too weak.	Have more beer until your voice improves.
Don't remember the words to the song.	Beer is just right.	Play air guitar.

A boy was assigned a paper on childbirth and asked his parents "How was I born?"
"Well honey ..." said the slightly prudish parent, "the stork brought you to us."
"OH," said the boy. "Well, how did you and daddy get born?" he asked.
"Oh, the stork brought us too."
"Well how were grandpa and grandma born?" he persisted.
"Well darling, the stork brought them too!" said the parent, by now starting to squirm a little in the Lazy Boy recliner.
Several days later, the boy handed in his paper to the teacher who read with confusion the opening sentence:

"This report has been very difficult to write due to the fact that there hasn't been a natural childbirth in my family for three generations."

Oddities from the Animal World

DID YOU KNOW . . . ?



- Dogs do not have different blood types
- The giraffe has the highest blood pressure of any mammal
- Dogs are the only animal, besides humans, that have a prostate
- Cheetahs do not have collarbones
- Horses cannot vomit
- A cow cannot (or will not) walk down stairs

A warm welcome is extended to new Vancouver chapter members:

M. Ingeborg Claus
Ruth Pestell

Many thanks to:

June Matheson
Mrs. Willy Plantinga
Angela Akkerman
Shirley Kelleher
Paris Tomei
Ruth Pestell
Graham Drew

for their kind donation to the chapter!

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. To quickly access these, open our website*, go to the newsletters, and cut and paste the addresses directly from there.

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

UOA of Canada Inc.: www.ostomycanada.ca

Appliance Hole Punch
www.stomico.com

NEW A better way to cut stoma openings in wafers and appliances. Punch pliers are easy to use, versatile.

Life After Surgery (video - also available from our library at meetings)
http://www.us.coloplast.com

NEW Join Coloplast Clinical Project Manager, Sharon Evans, and five people with ostomies as they discuss the basic survival skills for life after surgery. Topics include: what to expect after surgery, emptying/changing the pouch, day-to-day living.

Ostomy Software
http://ostomysoftware.com/Software.htm

NEW This is a software program you download into your own computer. It will allow you to find and compare different appliance brands to suit your particular needs. The best part is you can see what the various appliances look like. Recommended for anyone who wants to learn more about what's out there. Cool site.

Protective Ostomy Belt and Mini Skirts
www.ostomycares.com

NEW Canadian company (Quebec) specializing in lightweight protective belts, wraps, and miniskirts. Sizes X small to XXX large. Men and women.

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Cindy Hartmann 604-731-6671

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Lottie Calli 604-988-7962
Joy Jones 604-926-9075

REFRESHMENTS
Lisa Saunders/Arlene McInnis

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

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

STOMA CLINICS IN VANCOUVER / MAINLAND AREA

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

VANCOUVER
UBC Hospital 2211 Westbrook Mall
Vancouver General Hospital 855 West 12th Avenue
Deb Cutting, RN, ET. Tel (604) 875-5788
Candy Gubbles, RN, ET.

St. Paul's Hospital 1081 Burrard Street
Elizabeth Yip, RN. Tel (604) 682-2344
(Anne Marie Gordon on mat leave) Ext. 62917 Pager 54049
Lisa Hegler, RN., ET.

Children's Hospital 4480 Oak Street
Amie Nowak, BSN., RN. Tel (604) 875-2345
Local 7658

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

NEW WESTMINSTER Royal Columbian Hospital
Lucy Lang, RN, ET Tel (604) 520-4292
Laurie Cox, RN, ET.

Ostomy Care and Supply Centre
Andrea (Andy) Manson, RN. ET. Tel (604) 522-4265
Muriel Larsen, RN. ET.

SURREY Surrey Memorial Hospital
Elke Bauer, RN. ET. Tel (604) 588-3328

LANGLEY Langley Memorial Hospital
Maureen Moster, RN. BSN. ET. Tel (604) 514-6000 ext 5216

ABBOTSFORD M.S.A. General Hospital
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Extension 7453

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

RICHMOND Richmond General Hospital
Lauren Wolfe, RN, ET Tel 604-244-5235

WHITE ROCK/RICHMOND E. T. Resources, Ltd.
Elaine Antifaeve, RN. ET. CWOCN Tel (604) 536-4061

KEIR SURGICAL AND OSTOMY SUPPLIES Tel 604-879-9101
Eva Sham, WOCN
Tuesdays & Thursdays 8 am to 4 pm

IMPORTANT NOTICE

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

DONATIONS AND BEQUESTS

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

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

ADVERTISERS!

Promote your products and services in High*Life!*

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

Size:	1/6 page	1 issue	$30.00	6 issues	$100.00
Size:	1/4 page	1 issue	40.00	6 issues	150.00
Size:	1/2 page	1 issue	60.00	6 issues	200.00
Size	full page	1 issue	100.00	6 issues	300.00

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

MOVING?

Don't go missing!! Please phone or send us your new address.

MEMBERSHIP APPLICATION

Vancouver Chapter United Ostomy Association

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

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

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

Name _____ Phone _____

Address _____

City _____ Postal Code _____ Year of Birth _____

email (if applicable): _____

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

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

UOA, Vancouver Chapter

and mail to: Membership Coordinator, 34 - 4055 Indian River Drive, North Vancouver, BC V7G 2R7