



Vancouver Ostomy **HIGH**Life

Volume 36 - Issue 5 **SEPTEMBER /OCTOBER 2004**

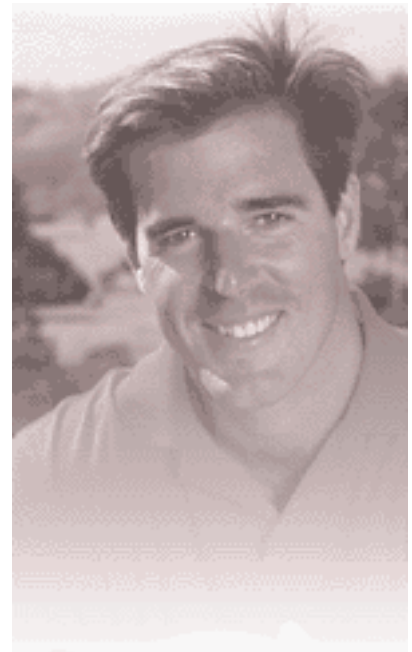
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ALIVE & KICKING

When Rolf Benirschke was taken as the second-to-last pick in the 1977 NFL draft, few people could have imagined the football career that would unfold. He became the placekicker for the San Diego Chargers for the next 10 years and set 16 team records before retiring as the third-most accurate kicker in NFL history. But what makes Rolf's career so remarkable is that he played while battling Inflammatory Bowel Disease (ulcerative colitis) and after undergoing ostomy surgery midway through his third season.



Severe abdominal cramps and bouts of diarrhea were the first signs of trouble. When the symptoms persisted, he finally went to the doctor and was diagnosed with Inflammatory Bowel Disease. He played "sick" for the entire 1978 season while trying everything and anything to get rid of his little-understood illness. During the final month of the season, he was forced to check into the hospital immediately following each game and have an IV placed into his neck so he could be fed intravenously for the entire week before being released in time to play the next game. It was a miserable existence, but Rolf didn't know what else to do.

Trying to press on, Rolf began the 1979 season by kicking four field goals in a Charger win against Seattle. Unfortunately, his success on the field masked the worsening of his disease.

Three weeks later, he collapsed on the team plane on a flight home and required emergency surgery that removed most of his large intestine and left him wearing two ostomy appliances. After a month in the intensive care unit and his weight a frail 123 pounds, he was devastated - not just about football - but about adjusting to life with an ileostomy.

NEXT MEETING:
SUNDAY, SEPT 19
Jewish Cultural Centre
950 West 41st Avenue
1:30 pm

Speaker: Andrea (Andy) Manson, ET, RN

*Executive meeting:
Saturday, September 11,
1:30 at Joan Williams'*

COMING EVENTS! *Our very successful Annual Christmas Party in December -- date to be confirmed in November issue!*



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President's Message

We have had a most wonderful summer; I hope that you all had a great time during the holidays. I have been kept busy with watering the plants and lawns, only on approved days of the

week of course.

We were successful with our grant application for sending the kids to summer camp this year. I received a cheque for \$1430.00 from the Vancouver Sun Newspaper. I shall be sending a copy of this newsletter with my final report to Eve Cheung Robinson the Program Director. I would like to send a big THANK YOU to Eva and all at the Vancouver Foundation from all of the members of the Vancouver Chapter. Also a very big Thank You from the children.

We have received a letter from FOW Canada, thanking us for all our donations sent during the last few months. May I take time to thank our very good friend Earl Lesk for organising all the collections from members etc and sending to the Oakville collection centre, without your hard work Earl we would not achieve these results.

Where are these volunteers that we need to assist the committee?

Keep cool and well.

Ron



From the Editor

Thank you to all those members who responded to our call for membership renewals in the past couple of issues -- we are now almost up to date with most of the AWOLs run to earth and accounted for. Good work, Arlene and Mien.

I had the great pleasure of travelling to Ireland and England for three weeks this summer. Lest you think all I did was purchase souvenir tea towels and compare pubs, I WAS doing some research at the same time. Namely, how do people buy supplies over there? What do they cost? I always travel with far more than I need and invariably wind up returning home with much of it so my hunt was out of curiosity rather than necessity. Suppliers here generally have the the word 'ostomy' somewhere out front on the signage but I never saw this at any point during our travels. Pharmacies are easy to find though so I went into a number and inquired, "Do you sell ostomy supplies?" Most didn't but would direct me to larger stores; eventually I wound up in one off the beaten track in Dublin. First I had to convince the clerk I didn't actually want to buy anything, I just wanted to know how much standard items cost. It took rather a long time to get this point across but eventually she disappeared d-e-e-p into the back of the store where presumably such nasty products are kept hidden, and came back with a price: about 7 euros for a Coloplast one-piece drainable which translates to about \$12 Cdn. I never did see the actual product and wasn't sure if this was for a single item or a box of several! Complicated business, buying supplies in Dublin.

And congratulations to UOA Canada on their new website design!

Debra

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:



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Vancouver, BC V6K 4P4



EDUCATION AND LIBRARY AVAILABLE

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

Post-Surgical Depression and the Older Ostomy Patient



Ostomy surgery performed on seniors is most often due to a cancer diagnosis. Patients find themselves coping with not only a frightening disease but with a major change in their bodies as well. After a lifetime of 'normal'

bathroom habits, suddenly they are no longer in control and must use unwelcome artificial means to contain body waste. Although they may no longer have issues such as how to continue working at a job, or how to date with an ostomy, they have concerns and body image issues the same as those much younger. Let's face it, we're all vain and have our pride, no matter how old we are!

Depression, sadness or anger are common emotions for older ostomy patients to feel upon their return home. They may fear loss of independence -- how will I care for myself? How am I going to buy these supplies and how will I afford them? They may resent loss of dignity. They may resent family members who do not have to cope with an ostomy. They may resist going out or resuming former activities. They may feel -- "What's the use? I'm near the end of my life and now I'm stuck with this thing. I can't go out like this. I'll never be happy again." Does any of this sound like YOU?

You're not alone.

The first thing you should remember is you have been given many drugs during your stay in hospital -- pain-killers, antibiotics, and general anesthesia, all of which can affect your emotional state. General anesthetic in particular is known for triggering post surgical depressions lasting days or several weeks after a procedure. So if you're feeling pretty low, you're just like a lot of new patients after surgery. Go ahead and let yourself have a good cry when you want. Better to let things out than bottle them up inside. But what if the bad feelings aren't going away? You need to take a look at what might be making your sadness worse.

First -- is the ostomy itself causing problems? Is the appliance not fitting you, are you getting leaks, is there an odour you dislike? If you answered 'yes' to any of these, get yourself to the nearest ET at once. You don't have to put up with poorly functioning appliances -- make sure you are applying things correctly and have the nurse review this with you. Ask for different samples of different brands and be specific about your needs and problems. Ask for

manufacturer's toll-free numbers and call for free samples. Get the names of suppliers in town, the ones who understand ostomates' needs and who keep abreast of new products and trends. Don't rule out health food stores, either. Knowledgeable staff in these stores can recommend herbal supplements or foods that promote bowel health and suppress odour.

Are you hiding at home? The simple act of getting dressed and going outside for a walk, even if it's just up the street gets you out of a gloomy house and away from gloomy thoughts. You need to be as active as your old body will let you. Get some fresh air everyday, look at some scenery. Walk the dog if you have one! He doesn't know you have an ostomy and wouldn't care anyway. If you can walk you can go places and if you can go places you can do different things. Don't lie around the house in your pajamas. It's bad for the body and terrible for the soul.

Are you spending too much time alone? Many seniors live alone, and their families may live far away. If you are one of these it's even more important that you have something to do and people to do it with while you're coping with an ostomy. Call up your friends and get together with them. Get yourself to the nearest seniors' centre and sign up for something -- a writing class, music, bird-watching, whatever grabs your fancy that gets you out and gets your mind off that ostomy. (by the way, chances are you could meet someone ELSE who has an ostomy at a senior centre!) Volunteer -- helping other people makes you feel good and you meet new people. And you may meet those who are worse off than you. Find your local United Ostomy Association Chapter and attend a meeting. Many UOA chapters offer volunteer counsellors, people with ostomies like YOU who understand your feelings and worries. Call them up.

What if the depression will not lift no matter how hard you try? If you can honestly say you've tried to keep busy, tried to interact with others and take care of your body and you STILL have hopeless feelings, if you are still constantly sad without much change after six months you may need to see your doctor and explain the situation. Ask him or her if they can refer you to a counsellor or therapist -- cancer treatment centers often have such professionals on staff. Sometimes just talking things out with such a person can help set you back on track.

What kinds of medications are you taking? Again you should review and discuss with your doctor what prescriptions you have, which may have changed and if any combinations have become harmful to your health.

Should you take anti-depressant medication? Sometimes anti-depressants can help but they take time to have



A few weeks after surgery -- teammate Louie Kelcher leads Rolf onfield

As he wrote in his inspirational autobiography, "Alive & Kicking" (Firefly Press, 1996), Rolf found strength in his faith, the love of family, friends, and teammates, and the support of his doctors and nurses.

One of the most dramatic moments in Rolf's recovery

from ostomy surgery came on Sunday, November 18, 1979, at San Diego Stadium a few weeks after he had been released from the hospital. Rolf returned to the cheers of his teammates and a standing ovation from the sell-out crowd of 52,000 Charger fans. He was named honorary co-captain for the day and asked to walk to midfield for the pre-game coin flip with teammate Louie Kelcher. Uncertain if he could walk that far because of the painful wire sutures still in his abdomen, Rolf was reassured by Louie, "If you can't make it, I'll just have to carry you!" Louie didn't have to lift Rolf that day, but the big lineman held his hand. That afternoon, the Chargers walked all over the Steelers and Rolf took a giant step forward on his road to good health.

Wearing two ostomy appliances, Rolf amazingly returned to professional football the following season healthier and stronger than ever. He played seven more seasons and retired as the team's leading scorer with 766 points. His field goal in a 1982 playoff game in Miami lifted the Chargers

to a 41-38 overtime victory against the Dolphins - a game that many sportswriters still consider the most exciting NFL game ever played. In addition to being named "NFL Man of the Year," Benirschke received such honors as "Comeback Player of the Year," the Philadelphia Sportswriters Association's "Most Courageous



Setting up again -- alive and kicking

Athlete," the NFL Players Association's "Hero of the Year" and the NFL "Justice Byron 'Whizzer' White Award." In 1997, he became the 20th player inducted into the San Diego Chargers Hall of Fame.

Today, Rolf is president of Rolf Benirschke Enterprises and a partner in the Eastman Benirschke Financial Group. He is an author, TV personality, and frequent motivational speaker for companies across the country. As an advocate for people with IBD or those who have experienced ostomy surgery, Rolf is actively involved in the Crohn's & Colitis Foundation of America and with ConvaTec, a Bristol-Myers Squibb company and a leading provider of ostomy and stoma care products. Married with four children, he enjoys golf, tennis, skiing, roller hockey, and scuba-diving, and he volunteers his time for numerous organizations, including the San Diego Zoo, Scripps Hospital, and the United Way.

Source: ConvaTec and the Crohn's & Colitis Foundation of America, Inc. (CCFA) created the Great Comebacks® Award program to recognize people such as Rolf Benirschke and to show others that life with IBD and/or ostomy surgery can still be rich and rewarding.



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Our Stories

Josh Fraser was a 17 year old Ontario student when he underwent ileostomy surgery after years of ulcerative colitis. He writes of his experiences of undergoing ostomy surgery, his recovery and second surgery to create a J-pouch.

Lights Up.

Staring up at the clock, only five minutes has passed; will this guy ever be quiet? Will this class ever end? The cramps are getting worse and break isn't getting any closer. This is a scenario that played out throughout my teenage life growing up with Ulcerative Colitis. I was diagnosed with Ulcerative Colitis at the age of 12, by a gastroenterologist at CHEO in Ottawa. At the beginning of it all medication controlled the cramps, the diarrhea and made me feel "normal" again. As I grew up, my disease grew too, at the age of 16 I was taking high doses of prednisone with limited success. It hit me like a brick being hurled at my colon, I was having cramps and flare ups on a regular basis. Having outgrown my pediatric GI I found a new doctor at the Ottawa General Hospital, who presented me with the options, medication or surgery. I was referred to Dr. Hartley Stern of the Ottawa General Hospital for my surgical consultation. Being 17 years old and having to make my first major decision, a life changing one, I chose the surgery. It was to be performed as a two stage surgery, due to my prednisone dependency. The week that led up to my surgery was a stressful one, nerves had gotten the best of me, two days before my surgery I had to fast, a near impossible thing for a teenager to do, having eaten nothing but clear fluids, and Jello to tide myself over I nervously waited for the day to come. March



Me -- deep in thought (HA)

27th 2001 arrived, the hour long drive from Cornwall to Ottawa seemed to drag out like an eternity, after checking in to pre-op and prepping for the surgery it was a go. After spending the remainder of that day recovering in post-op and my hospital room, I remember being dragged out of bed the next day by a physiotherapist and her assistant, "the key to recovery is exercise" despite the drugs and the pain I had to walk, if only for a little. That day I got a visit from a man, who had just had the second stage of the same surgery I was having. He spoke to me a little bit about how he came to terms with it and helped me out. The hospital staff was amazing, making me feel comfortable. The big deal at the hospital was the

first time I passed gas and bile through the stoma, a bit of bile meant I could start to eat again, first with clear broth and then, you guessed it jello. There were the days that seemed to drag on, and others that made me want to bawl, I remember being upset one Saturday while in the hospital, not because of the pain, not because of the ostomy, I wanted to go home. That night my friends from high school drove up to visit, boy that was a welcome relief, true friends are definitely hard to come by. After eight days of being in the hospital I was able to go home and begin my recovery. I began to eat, gain weight, and regain my strength. I was walking everyday, around the house, and outside a little bit when the weather was nice, I got out as much as I could. Slowly but surely I was getting my life back to the way it was before ulcerative colitis, I had energy, I wanted to do things, heck my parents had trouble keeping me at home most of the time.

About 4 weeks after my surgery I began to go back to school part time, 2 classes a day on a very limited basis. Dad would drive me to school and pick me up. I was nervous the first day, what happens is my ostomy leaks, or I have to run out of class to fix it. Living with an ostomy is a challenge for anybody, and as I

cont. next page

got used to it I was more willing to do things in public. Being a long time drama student, I was heavily involved with our high school drama club. It just happened that a month after my surgery they were performing at a local theatre. It was the first time; I went through a performance without worrying about bathroom breaks, missing cues or getting sick.

June 2001, aprox, 3 months post op, my reconnection surgery is scheduled. Back to the hospital with the awesome Jello, this was a simple task for the surgeon, close the stoma up and be on the way, in and out and home in 6 days. It is now August 8, 2004 and I have been living with my J-pouch for almost 3 years, and have not regretted a thing since. I am now 20 years old, in good health, and working towards my Computer Engineering Technologist diploma. Without my surgery, I believe I would have never had the courage to go away for college. Living with a Jpouch is not unlike living with a full colon, there are a few foods I tend to steer away from, popcorn being one of them, and I have to be certain that I chew my food really well. My mom said the doctor “gave me my life back” and I tend to agree, being free from medication and worrying about flare ups has been a life changing experience. Looking back at the experience, my family, my girlfriend Stacey and my friends helped pull me through and I thank each and every one of them. If anything, the one thing that has changed since my surgery is I will no longer eat Jello.

- Josh Fraser, August 8, 2004.



Stacey and me at her senior prom

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

**Anne Kline
Inge Gutzmann
Sheila Stephen
Elaine Green
Joan Ingo**

ADHESIONS

and Other things that Cramp Your Style

- from GyneCare Network, Johnson & Johnson

Q. What are adhesions?

A. As the name implies, adhesions are fibrous bands of scar tissue (that can form after surgery, infection or other trauma) that adhere or bind together organs or tissue that are normally separate. Adhesions are common and can potentially lead to serious complications. Adhesions that form after surgery in the pelvic area are often the cause of post-operative pelvic pain, small bowel obstruction, and infertility.

Q.How common are adhesions?

A. Adhesions are a common occurrence after pelvic or abdominal surgery. Adhesions are also common in women who suffer from pelvic inflammatory disease (PID), endometriosis, or sexually transmitted diseases. The likelihood of adhesion formation and the seriousness of their consequences vary based on multiple factors (e.g., type of surgery, number of previous surgeries, surgical technique, and the predisposition of individual patients). However, studies have consistently shown that a majority of women who have gynecologic surgery will experience some degree of adhesion formation.

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Q.How do adhesions form?

A. All of the abdominal and pelvic organs except the ovaries are at least partially wrapped in a clear membrane called the peritoneum. When this membrane is traumatized during surgery, the site of the trauma becomes inflamed. Inflammation is normal and in fact is part of the healing process, but it also contributes to adhesion formation by encouraging the development of fibrous bands of scar tissue. Normally, these fibrin bands eventually dissolve through a biochemical process called “fibrinolysis,” and the traumatized site continues to heal. But sometimes the nature of the surgery results in decreased blood flow to these areas (ischemia). This ischemic condition can suppress the fibrinolysis. If the fibrin bands do not dissolve, they may develop into adhesions that connect pelvic organs or tissues that normally are separate.

Q. What problems can adhesions cause?

A. Pelvic Pain - Adhesions are commonly associated with pelvic pain. Adhesions cause pelvic pain because they bind normally separate organs and tissues together - essentially “tying them down” - so that the stretching and pulling of everyday movements can irritate the nerves involved. Adhesions can also cause pain during intercourse.

Infertility - Adhesions resulting from certain types of gynecologic surgery, especially ovarian and tubal surgeries and surgeries to remove fibroids, are a common cause of infertility. Adhesions involving the ovaries or fallopian tubes can block the passage of the ovum (egg) from the ovaries into and through the fallopian tubes. Adhesions around the fallopian tubes can also interfere with sperm transport to the ovum.

Bowel Obstruction - Adhesion formation involving the bowel is particularly common following a hysterectomy. While these adhesions don't normally result in any problems, there is one serious problem that can develop. It is called intestinal or bowel obstruction, and it can occur a few days or many years after surgery. Symptoms of bowel obstruction may include pain, nausea, and vomiting.

Q. How are adhesions treated?

A. The only way to treat adhesions is to remove or separate them surgically. This procedure is called adhesiolysis. Studies have shown that patients with pelvic pain and severe adhesions can experience a marked reduction in symptoms after adhesiolysis. However, even following adhesiolysis, adhesions reform more than 70 percent of the time. That's why adhesion prevention is so important.

Q. What can be done to prevent adhesions?

A. Meticulous surgical technique - Careful surgical technique can help minimize trauma, minimize the interference with the blood supply, prevent the introduction of foreign bodies, minimize bleeding, lessen the incidence of raw surfaces and decrease the incidence of infection - all

of which help reduce adhesion formation. **Barriers** - Fabric or liquid barriers create a physical separation between raw tissue surfaces while they heal. Thin tissue-like fabric barriers may be used to try to reduce adhesion formation at specific sites, while liquid solution barriers can help prevent adhesions over broad areas of the abdominal and pelvic region.

Vitamin B12 - You Can't B2 Sure!

There have been recent articles in the urology literature about Vitamin B12 deficiency appearing in patients who had surgery involving the terminal ileum — a portion of small bowel, which is commonly used in continent urinary diversions. Most of the Vitamin B12 we ingest is absorbed by the blood vessels in this particular area of the colon.

Initial symptoms that suggest B12 deficiency include: fatigue, weakness, numbness, sore tongue, muscle spasms, appetite loss, weight loss, and forgetfulness. Over a period of time, Vitamin B12 deficiency can cause some illnesses, including anemia and neuropathics. A deficiency is easily corrected by monthly injection in your local physician's office, or you can be taught to give it at home.

Your Vitamin B12 level is checked through a simple blood test. Talk with your doctor to see if this test is part of your regular and annual follow-up. If not, see to it immediately.

A new product, Nascobal, delivers B12 by nose instead of by needle. After the blood level has been stabilized by injection therapy, many people can maintain the proper level of B12 with this intra nasal product.

The odourless, flavourless gel comes in a nasal squeeze bottle. This convenient, inject-free method delivers a precise 500 mg. once weekly dose. It is available by prescription only.

Vitamin B12 blood levels and peripheral blood counts must be monitored initially at one month after the start of treatment and then at intervals of 3 -6 months. A decline in levels after one month of treatment may indicate that the dose may need to be adjusted upward.

There are contradictions for people sensitive to cobalt and/or B12. Those with a hereditary form of Leber's disease suffered severe and swift optic atrophy. Beware! Folic acid is not a substitute for Vitamin B12, and can result in progressive and irreversible neurological damage.

Source: Continent Diversions, Shawnee Mission, KS; via Belleville, ON, Metro Halifax News, via Inside Out On-line May/June 2003

DEHYDRATION AND THE ILEOSTOMATE

BY TERRY GALLAGHER



(The author has just had first hand experience of the effects of this following an emergency admission to hospital!)

Why we are at risk:

When we had our ileostomy surgery, our colon was removed or disconnected. In the 'normal' person (that is, a person with a working colon), the colon is responsible for absorbing most of the water we drink and is contained in our food. In addition, electrolytes such as sodium and potassium, essential to maintain good health, are absorbed there. Removal or disconnection of the colon immediately causes the first problem because of the removal of the ileo-caecal valve (I'm writing from the UK, so am using the UK spellings!). This valve is between the ileum or small intestine and the colon where the appendix is attached. Its purpose is to hold back the food in the ileum to enable it to be absorbed better. When we lose this valve, food, and water, pass through our digestive system faster so less is absorbed, often accounting for weight loss when a person first recovers from the surgery before the body responds by encouraging the person to eat more to compensate. The second problem is with the loss of the colon itself. The ileum does absorb more water to compensate, but still absorbs much less than the colon did (Waste from the ileum normally has about 30% of the water remaining whilst waste from a colon has 10% remaining – quite a difference!) In addition, we lose ten times as much sodium and potassium as someone with a colon.

Because of all this, anything which upsets the balance in our bodies has a much faster effect, as well as happening much quicker than in a person with a colon. A typical example is gastroenteritis: for the same degree of infection, a 'normal' person will have perhaps a spell of sickness and diarrhoea with a couple of days feeling unwell whereas we may well end up in hospital as an emergency! I shall be dealing mainly with gastroenteritis, but the principle applies to other problems which upset the digestive balance.

Recognising the Problem:

A 'normal' person will experience some or all of these symptoms:

- Nausea, vomiting, fever, abdominal cramps, with possibly a bloated feeling
- Diarrhoea, sometimes bloody
- Signs of dehydration (including the veins on the back of the hands and elsewhere becoming invisible)

However, we will experience the second somewhat differently. Let me tell you what happened to me. My ileostomy filled up very rapidly with fluid as well as solid waste floating in it. On emptying, the pouch refilled in minutes, becoming ever more liquid each time I emptied. I felt nauseous and developed abdominal discomfort. I rapidly began to experience the symptoms of dehydration which include a dry mouth, decreased or virtually non-existent urine output, heart irregularities (tachycardia)

and dry skin. In my case, I could see my urine output had ceased as I have a urostomy as well.

What to do:

This is a medical emergency! You need to be taken either by car, or better, by ambulance to the nearest Accident & Emergency Department of your local hospital (ER in Canada?). In the UK, the ambulances have a paramedic who can set up an IV. in the vehicle to start rehydration immediately. Dehydration can be rapid and very, very frightening. In a less than 15 minute trip to the hospital, the ambulance driver remarked that I had visibly deteriorated during this journey, even with an IV. of saline being run rapidly into me. Lest it be thought that she was unkind to say this, I had been, through a very dry mouth, apologising for having to call them: her comment was that I very definitely needed to have done so!

Do not waste time: this is a serious emergency as dehydration is rapid and severe. There is no use thinking "I can treat this myself" with electrolyte drinks such as Gatorade: you can't as you will dehydrate faster than the fluid is absorbed, if the fluid is absorbed (and it may not be).

What are the consequences of delay? You may well go into shock due to lack of circulating volume in your blood. Unconsciousness quickly follows, leading to death.

I'm not kidding, folks. That is the official statement from a UK Government health advice site for doctors. If we avoid the worst of this, the low blood volume may cause permanent and serious damage to our kidneys.

What should I expect at the hospital?

First of all, you should be put on an IV. of saline initially if this hasn't been started in the ambulance. In my case, two hours after the first symptoms (and, yes, as rapidly as that) I arrived at the hospital so dehydrated, despite the IV. from the ambulance, that the doctor set up a second one immediately so I had one in each arm running as fast as possible. Expect an ECG to check for heart problems, bloods to be taken, stool and urine samples (to check for infection, although 50% of cases do not show an infecting agent on culture – one theory to explain this is that the bug has done its damage and passed through already!) and X-rays of chest and abdomen lying and sitting or standing to check that there isn't a bowel perforation or obstruction causing the symptoms. Once surgical problems have been ruled out, you'll be handed over to the medics who will look after you and make sure you are well hydrated. The fluid given will be saline, potassium (or potassium and saline or potassium and glucose) and glucose. The glucose is to provide energy lost by the body, whereas the saline and potassium are to replace those essential electrolytes we mentioned earlier. Latest research shows that you can eat and drink normally (if it stays down!) as starving doesn't affect the length of time you will be ill. You may well be placed in isolation in case you are infectious. You will stay until you can maintain your own fluid levels without the need for IV hydration and your urine output

is normal with no excessive output from your stoma with the output being of 'normal' constituency for you.

What are the problems if I delay?

Let's go through this again: dehydration leads to shock, unconsciousness then death if not treated soon enough. Delaying treatment can also lead to kidney damage which may be permanent, requiring life long dialysis or a transplant. Heart damage is a possibility caused by the severe dehydration and loss of the electrolytes, especially potassium. In addition, the longer you leave treatment, the more difficult treatment becomes. There are two obvious problems:

- As the peripheral veins (backs of hands etc.) collapse with the dehydration, the more difficult it is to actually insert a cannula to begin the rehydration process.

- There are limits as to how fast fluids can be run into the body through a cannula. Because of my collapsed veins, the ambulance paramedic and doctor could only get a child sized cannula in, reducing the rate at which the fluid can be run into the person.

Summary:

You find yourself with a pouch which is filling and refilling with fluid very rapidly. You may feel unwell, start to develop a dry mouth, and/or have abdominal pains. Get to hospital as soon as possible, and preferably by ambulance in case you collapse on the way. The ambulance has the equipment to deal with this. 'Normal' people may sneer that we're making a lot of fuss for a simple 'tummy bug' – we're not! It is very much more serious for us than for people with a colon.

Don't wait – get to hospital straight away!





What is the Right Way to Use Skin Barrier Paste?

- www.convatec.com & Hemet-San Jacinto, CA, Evansville Re-Route, July '04

There are a variety of types and brands of skin barrier pastes, so check with the manufacturer of the brand you're using for specific instructions. Skin barrier pastes are used as "caulking" to fill in the space between the stoma and the opening in the skin barrier. Skin barrier pastes are not "glue", and should not be used to keep the pouch on the abdomen. The pastes fill in gaps or uneven areas, protect the skin around the stoma, and can increase wear-time. Generally, this is the procedure you should follow if skin barrier paste has been recommended to you:

1. Remove the soiled wafer and gently clean the skin around your stoma in the usual way. Pat the skin dry.
2. Apply a bead of skin barrier paste around the stomal opening on the body side (sticky side) of the skin barrier/wafer or apply the paste to the skin immediately surrounding the stoma.
3. Let the paste air dry for about one minute.
4. Gently place the wafer over the stoma and on to the skin. Hold in place for a few minutes, allowing the warmth of your hand to mold it to your abdomen.
5. Attach your pouch to the flange on the skin barrier.

Whoa!

- It's easier than you think to drop a clip in the toilet! Tuck a spare clip in a pocket or purse in case.
- If you stand up too quickly you can catch the clip on the edge of the toilet seat. (Ow!)
- Food dye in GatorAde and PowerAde can colour your stool green. Beets can make you look like you're passing blood.
- Take care to angle the pouch towards your leg to keep the clip away from private parts (Ow! again)
- Accidentally leaning against hot stoves, BBQ's, or fireplaces can melt a hole in your appliance in an instant.

DON'T SWEAT IT!

By Christine Newberry, RN, WOCN; Cymed Via: The Greater Cincinnati Chapter; Evansville Re-Route, July '04.

Does sweating cause you pouching problems? If you work or live in a warm environment, if you are an athlete or just prone to sweating, you may have problems keeping your pouch barrier on. Here are three approaches to solving your problem:

Sweat less! Some antiperspirants can be used underneath an ostomy barrier. Many antiperspirants dry after application and leave little residue that would affect the adherence of a pouch. C.C., a cyclist in Maryland, uses Tussy 5-day Antiperspirant that is sold in packets. Mitchum and Crystal, among others, have been used successfully by ostomates to diminish perspiration. Do your own research and find one that works for you.

Increase Adhesion! If your barrier is floating off, consider increasing the quantity of adhesive. SKINTAC has recently been produced in a new wipe-on form. This is a thin clear adhesive that is easily removed with alcohol; Torbot manufactures it. Hollister makes a medical adhesive spray. And for the truly needy, there are paint-on adhesives that, though more cumbersome, can make a dramatic difference in adherence. Two of these are NuHope Adhesive and Skin Bond by Smith and Nephew. All of these products are available at most ostomy product dealers.

Try a Breathable Barrier. The MicroSkin adhesive barrier on all Cymed pouches is moisture-vapor permeable and allows perspiration to flow through the barrier rather than being trapped beneath it. John Dermengian recently wore a Cymed pouch through the grueling Iron-Man Triathlon. His pouch held up through 16 hours of extreme physical exertion and lasted a total of 6 days. A sample of these pouches is available from Cymed Ostomy Company at **800-582-0707**.

Depression, cont. from page 3

an affect. Just don't let your doc shove a bottle of pills at you and hurry you out the door. That isn't addressing the problem, only masking it.

It's important that you know ALL ostomy patients experience sadness, depression and anger in the beginning. Some sort themselves out on their own. Some need a little more help -- don't be too proud to ask. You don't have to do this alone!

- Della Solclaro, age 74, Los Angeles



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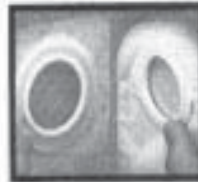
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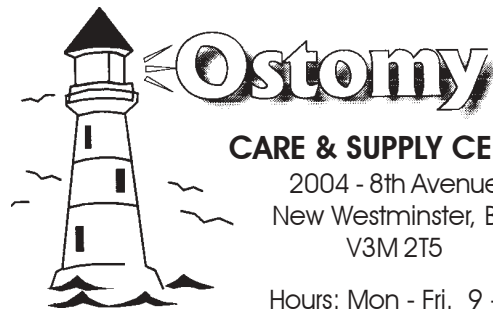
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*Andy (Andrea) Manson, R.N., B.S.N., E.T.
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UROSTOMATES AND FLUIDS

by Juliana Eldridge, RNET

People with urinary diversions no longer have a storage area, a bladder, for urine. Therefore urine should flow from the stoma as fast as the kidneys can make it. In fact, if your urinary stoma has no drainage for even an hour, it is time for serious concern. The distance from the stoma to the kidney is markedly reduced after urinary diversion surgery. Any external bacteria have a short route to the kidneys. Since kidney infection can occur rapidly and be devastating, prevention is essential. Wearing clean appliances and frequent emptying are vital. Equally important is adequate fluid intake, particularly fluids which acidify the urine and decrease problems of odor. In warm weather, with increased activity, or with fever, fluids should be increased to make up for body losses due to perspiration and increased metabolism. It is important that you be aware of the symptoms of a kidney infection:



- elevated temperature
- chills
- low back pain
- cloudy, bloody urine
- decreased urine output

All ileal conduits normally produce mucous threads in the urine which give it a cloudy appearance. Bloody urine is a danger signal. Thirst is a great index of fluid needs. If you are thirsty, drink up. Also develop the habit of sampling every time you pass a drinking fountain. Important . . . if urine is collected for urinalysis, called C & S, sterile specimen, checking urine for infection, etc. be sure your doctor and nurse know a sterile specimen must be taken directly from your stoma and not from the pouch. Bacteria builds up in the pouch immediately. It will give false test results. If they are not sure how to do this, do the following.

- remove your pouch
- clear the stoma
- bend over
- catch the urine in a sterile cup

If there is a slow flow of urine being expelled, drink a glass or two of water . . . the kidneys will work.

Urostomates who do not use a night drainage system are running a big risk of puddling and the backing up of urine into the conduit up to the kidneys. This may cause not only irritation but serious infection.

Source: Metro Halifax News; Coquitlam Connection; Ostomy Toronto; Prince George Ostomy Hotline

Slow Down for a Change!

Eat a couple of marshmallows up to 30 minutes before changing. One ostomate says, "I eat a couple of marshmallows just as I go into the shower which takes me 10 to 15 minutes to complete. I also skip a meal before changing my appliance. Combining the marshmallow, lack of food and a blast of cold water for about 20 seconds directly on the stoma does a pretty good job of shutting me down before the process of changing." Another tip is put an icecube in a thin washcloth and circle the stoma for about 20 seconds. This will shock the stoma into delaying output for a little while.

Evansville Re-Route, Oct. 99

Lapbelts vs 3-point system

There is a 50% greater chance of serious spinal or abdominal injury using lapbelts as opposed to 3-point seatbelt system.

- (CBC Morningside, Jan, 15/2004)





DID YOU KNOW?

Dr. John Harvey Kellogg and his brother invented the forerunner of ready-to-eat cereal by accident.

Dr. John Harvey Kellogg was chief surgeon at the Battle Creek Sanitarium in Michigan where his brother William Keith Kellogg was business manager. As Seventh Day Adventists, the Kelloggs and all hospital patients observed a strict vegetarian diet. In an effort to make the meatless fare more palatable, the brothers often experimented with different foods in the sanitarium kitchen. In 1894, during one such experiment they were placing boiled wheat on a baking tin when Dr. Kellogg was called away by an emergency operation. When they returned to the kitchen the following day and ran the wheat through a roller, they expected it to come out in sheets. Individual wheat flakes emerged instead.

Dr. Kellogg's patients and all who tasted them loved the wheat flakes. The Battle Creek Toasted Corn Flake Co. (later renamed Kellogg's) was started soon after and produced wheat flakes, rice flakes, and corn flakes using the same process.

Source: the back of a cereal box. Really.

VISITOR REPORT

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

Colostomy -	4
Ileostomy -	1
Urostomy -	3
Pre-op -	1

Total - 9

Many thanks to my excellent crew this round: Maxine Barclay, Al Ashcroft, Charman King, Joan Williams, Linda Jensen, Bob Millman.

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ORIGINS OF SAYINGS

For almost 300 years up until the 1700's The Tyburn Tree in London was the scene of public hangings. The condemned individual would travel from prison to the hanging square in a wagon, accompanied by their executioner. The trip could take hours and in order to keep the prisoner's nerve up they would stop at a tavern where both the condemned and his executioner would share a drink before continuing their grim journey. Hence the term:

"One for the road"

After being hanged, the dead would be loaded back onto the wagon, to be taken away, never to drink again. Hence the phrase:

"On the wagon"

Source: *The Big Bus Tour, London, England*



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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/>

UPDATED

UOA of Canada Inc.: www.ostomycanada.ca

<http://www.geocities.com/mr-ostomy/Foodblockage1.htm>

(food blockages & hernias)

International Ostomy Association: www.ostomyinternational.org

NEW

<http://flat-d.com/ostomyproducts.html>

(odour control accessory products for ileos, colos)

NEW

www.bchealthguide.org

(BC government general health information, education, news and developments)

Friends of Ostomates Worldwide: www.fowcanada.org/

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

NEW

<http://www.quackwatch.org/>

(your guide to quackery, health fraud and intelligent decisions)

<http://www.windsorostomy.info/hints.html>

(general information, Windsor, Ontario)



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