LIFE'S DIVERSIONS

Ostomy Association of South Texas
WWW.ostomysouthtx.org

Affiliated with... UOAA United Ostomy Associations of America, Inc.

February2015

American Cancer Society®

Support Groups Meeting The Needs of all Ostomates

~~~~~MEETINGS~~~~~

American Cancer Society **8115 Data Point Drive**

Last Monday of the month @7:00 pm

Contact: Cecilia Lynn, President (228)-217-6106

*****PROGRAM THIS MONTH*****

RAP SESSION
Opportunity to discuss problems, innovations, and ask questions

~~~REFRESHMENTS~~~

!!!! A BAKED POTATO BAR !!!! WOW ! !

(Need someone to bring a couple of salads and dressings and Some plastic (silverware))

NEW CHAPTER

SAMMC Chapter of the Ostomy Association of South Texas
WHEN: Then the 4th Tuesday of each month at 6PM
WHERE: 2551 Roger Brooks Rd (COTO Bldg)
Pediatrics Resident Conf Rm (TN122)
Leader: Shanna Fraser, WOCN, RN (Pager 210 513 4360)

Meetings 2nd Sunday of the month @ 3:00PM
Peterson Regional Medical Hospital Kerrville, Texas
Molly McCoy, RN, ET 830 258 7891

OSTOMY ASSOCIATION OF SOUTH TEXAS holds its meetings and produce this newsletter under the kind sponsorship of the American Cancer Society.

The Prez Sez

We had such an amazing turnout last month with our guest speaker Dr. Connaughton speaking about peristomal hernias. I am looking forward to this month's rap session, as it is always a great time to learn from one another. We are trying something different for the refreshment this month. If you see Cecilia Guitierrez give her a big thank you as her and Izzy provided the baked potatoes, we just have to provide the toppings! We are planning a visitor training in March, if you are interested in being a visitor please contact one of us on the board.

Last month, Shield Healthcare generously donated $300 to our group. Thank you for your support Shield Healthcare and as always we always appreciate the outreach your company has for Ostomates.

If you were unable to attend last month's meeting, it was announced that the group will sponsor a member to attend the 2015 United Ostomy Association of America's National Conference. The conference is hosted in St. Louis, MO and will be from Sept 1-6! This a wonderful experience and I encourage everyone who is able to go to attend as you will make lifelong friends and gain great advice.

Thank you for your support and I look forward to seeing everyone in February!

Cecilia

BE A LIFESAVER

Encourage your friends and relatives to have a Colonoscopy

From the Editors Corner Medical, Treatment, or Technical items contained in this newsletter are not intended to be the last and final word. Any medical or technical information is included as information to pique someone's memory or help recognize a situation present with someone's family or friend. Remember, the final word on medical or ostomy conditions will be with your doctor and/or your E.T. Nurse.

If you have any information you think our membership might be interested in, such as a news article, a publication, a good recipe, an incident or a personal experience please let me know. Contact me via e-mail at: RalphPitt@gmail.com or "snail mail", Ralph Pittenger---9914 W Military Dr. Apt 1303— Phone 210 674 0295

New Ostomy Support Group

You are invited to Join the Newest Chapter of the Ostomy Association of South Texas at SAMMC. This group is open to the general public and is led by Shanna Fraser WOCN, RN. The meeting will be held in the Pediatric Resident's Conference Room (TN-122) inside the COTO building. The physical address is 3551 Roger Brooke Drive. San Antonio, TX 78234

Directions:
Enter into the gate and follow the road around until the stop sign. At the stop sign continue through the stop sign; Turn into the parking lot at the first right. Once in the parking lot turn right and park in Parking Lot D. (Left will be the ED parking lot and you are not allowed to park there)
When you look at the hospital you will see double doors and a sidewalk that lead to "Pediatric Entrance", enter through these doors and the conference room is the second door on the right.

***********If You Have Internet Access…**
AND YOU are still receiving the newsletter in hard copy? You can save us money by joining our electronic distribution list. Just send an e-mail request to artrod@aol.com
We appreciate your efforts to keep costs down while also being more eco-friendly!

Surplus Ostomy Supplies

Ostomy supplies have been donated by chapter members or their families when an ostomate has had a revision surgery or passed away. These supplies are available to our chapter members or individuals in need of supplies. Please contact Cecilia Lynn if you have supplies you would like to donate. Our reservoir is VERY low right now, so we are counting on our members to help us replenish it!

New Visitors— Mayra Goodman

New Members
Welcome ! ! !

Pouchitis Inside Us: Learning to Listen to Our Guts

By Ali Lambert Voron

Hypochondriacs always think they're sick. I always think I'm healthy. But sometimes – I'm just wrong.

It's no wonder I'd rather see the glass half full. I was diagnosed with alopecia areata when I was sixteen years old and wound up losing all of my hair. Dealing with that ordeal prepared me quite well for the brutal battle I fought against ulcerative colitis in my twenties.

After navigating both of these health challenges, I never (ever) want to face another illness. I prefer to assume all is fine, all of the time.

But I've realized I may be a bit "too strong" for my own good.

Quick Health History

After four horrible colitis-ridden years with non-stop diarrhea, urgency, stomach pain, and miserable side effects from steroids, having my colon removed in a two-part surgery in 2011 was a carefully thought out decision that ultimately saved my life.

My surgeon vowed that I would still need to go to the bathroom often (probably 6-10 times per day) but that I would not have urgency, discomfort or diarrhea. After I recovered, his words proved true and I was thrilled!

I was able to get pregnant a year later and delivered a healthy baby girl in March of 2013. Today things are just as I hoped they would be. I'm a happy and healthy wife and mother to my two favorite people in the world.

Denial

My health started to go downhill sometime this past September. I began having urgency, diarrhea, and I just felt sick all of the time. I honestly didn't notice (or chose not to notice) any of these signs, but my health was slowly slipping away right before my eyes.

A few odd symptoms followed. I developed dry skin on both hands, and eventually saw a dermatologist who diagnosed me with a "psoriasis-like" condition.

My back started bothering me and after an X-ray ruled out anything significant, I began bi-weekly physical therapy sessions.

Whenever I pointed my left foot, I felt a shooting pain through the top of it. I finally saw a podiatrist who concluded that I had injured a nerve.

Reality Check

A few weeks ago the joints in my fingers felt uncharacteristically stiff and I decided, with all of these weird things happening to my body, it was time to touch base with my gastroenterologist at Mt. Sinai Hospital, because in my opinion, Dr. Jim George always has the answer.

I texted Dr. George and quickly laid out my strange symptoms – dry skin, back pain, foot pain, sore joints – and asked if he could refer me to a good internist. Dr. George immediately texted back with two names.

Twenty minutes passed and he texted me again. "Wait. Do you have diarrhea?" he asked.

"Yes." I typed.

"Urgency?" he questioned.

, "Yes," I responded, "most of the time." Interesting that I failed to report these two symptoms to my gastroenterologist.

"You have pouchitis. Come see me." He texted.

And that was that. After four months of dealing with discomfort and making numerous visits to various doctors, in twenty minutes, over text, Dr. George diagnosed me with pouchitis, something I never even considered a possibility.

Pouchitis

Pouchitis is inflammation of the j-pouch, which is the artificial colon that was surgically created out of my small intestine after I had my colon removed. Pouchitis occurs in roughly 50% of people who have had a colectomy so the fact that I didn't even think of it exemplifies the degree of my denial.

I made an appointment to see Dr. George and was curious to see how he connected my odd symptoms with pouchitis.

A few days later Dr. George examined me and prescribed a 30-day course of Cipro, which would make me feel better within a few days. He also suggested a follow up pouchoscopy, which is essentially a colonoscopy in my j-pouch to examine the condition of the tissue.

He explained that pouchitis is much like a colitis flare up, but because there is no colon to attack, the inflammation starts in the j-pouch and then affects other parts of the body. He agreed that my symptoms were strange, but they made sense.

The Lesson

Thankfully the Cipro did the job and I felt much better within a few days, but I can't ignore the fact that I failed to recognize that I had pouchitis. I know I need to be honest with myself when it comes to my health. After all I have been through, failing to react to any signs or symptoms is ignorant and potentially dangerous.

In my heart, I know I'm just reverting back to the uber-strong mindset I sustained to muscle through those awful years when I was sick. I should stop trying to be so tough, and accept that I might have an occasional setback.

A Healthy Report

I'm writing this post from my living room couch, forty-five minutes after returning from my follow up pouchoscopy. Turns out my "pouch looks great!" and Dr. George confirmed that even though I did have pouchitis, I am now essentially free of inflammation and should be good to go.

Cheers to that! And after thirty-six hours of fasting, I'm heading straight to the kitchen to make myself a sandwich.

A Physician, Who Is Also a Cancer Patient, Talks about Medical Errors

By Ronald Piana

It is important to perform regular records review to detect and correct errors, and it is equally important to counsel, reprimand and educate staff who make errors. You need to be straightforward about this problem, to the point of dismissing those who habitually make medical errors.

Itzhak Brook, MD, MSc

In a whispered but resolute voice, Itzhak Brook, MD, MSc, led off his presentation at the 2012 ASCO Annual Meeting by telling the audience his voice is weak because he doesn't have vocal cords. He spoke with the aid of a tracheoesophageal voice prosthesis. "I have practiced medicine for more than 40 years. After I was diagnosed with neck cancer, I was left shaken, seeing firsthand how common medical errors are," Dr. Brook said, adding that as a cancer patient, he encountered at least one or two errors a day, running the gamut from minor to life-threatening.

*****When Doctor Becomes Patient**

Dr. Brook, Professor of Pediatrics and Medicine, Georgetown University School of Medicine, said that after the hospitalization following his laryngectomy, he was emotionally unprepared to change roles from doctor to patient. "I had to deal with pain and weakness and being completely dependent on others. On top of that, I couldn't speak, which compounds anxiety because I couldn't convey the extent of the problems I was having," Dr. Brook said.

Dr. Brook pointed out that timely and thoughtful patient-doctor communication is a vital component in preventing medical errors that, as he witnessed, occur with similar frequency at all levels, from nurses to physicians. Moreover, patients are often reluctant to complain to the people they are dependent on. "Laryngectomees are even more vulnerable because they are less able to abort medical errors, given their inability to speak," Dr. Brook said.

In Dr. Brook's case, the first, and arguably most serious medical error he encountered was a failure to detect his cancer. "This serious error was probably the result of a failure to do the correct ENT examination that would have revealed the cancer. It was a resident who finally found the cancer," Dr. Brook said.

"The surgeon also made a serious error when he attempted to remove the cancer," he added. "During the surgery, he inadvertently removed scar tissue, mistaking it for the tumor. And by not checking the tissue in the OR with a frozen section, it was a week later before the pathology lab identified it to be scar tissue and not cancer," Dr. Brook noted.

***Nursing Errors

According to Dr. Brook's experience, nursing errors can include not responding to calls, not washing hands or using gloves, not placing the oral thermometer in a plastic cover, or administering an incorrect medication dose.

"As a patient—especially one who is a doctor—it is very frustrating to realize that errors occur so frequently. I actually needed to become my own watchdog, waiting to catch mistakes, which meant I could never relax. I also realized that in most cases, there was no self-recognition of these errors.… Once, when I was in the ICU, the nurse forgot to connect me to the call button and I was choking, helpless because of her oversight. I was in plain sight of a nursing station—yet no one came to my help until my wife walked in," Dr. Brook said.

"Instead of administering my medication through the NG tube," Dr. Brook continued, "sometimes the nurse would try to give me the meds orally, causing me to choke, or administer medication that was dissolved in hot water, burning my esophagus."

*****Preventing Medical Errors**

As common as medical errors are, Dr. Brook's observations as a patient left him confident that better and more uniform training and adherence to established standards of hospital care could avert the majority of harms from errors. "It is important to perform regular records review to detect and correct errors, and it is equally important to counsel, reprimand and educate staff who make errors. You need to be straightforward about this problem, to the point of dismissing those who habitually make medical errors," Dr. Brook said.

He pointed to recent data indicating that developing and following algorithms, use of set procedures, and meticulously following a bedside checklist for all procedures markedly decreases the chance of errors. Dr. Brook commented, "Increased supervision and communication between health-care providers serves as a firewall to errors. Moreover, we need to spend more time educating patients and caregivers about medical conditions and treatment plans. This way they can participate in preventing medical errors."

*****Be Your Own Advocate**

Dr. Brook's travails within the hospital system reinforced the need for self-reliance on the part of the patient. In other words, it's your health—be an assertive advocate for yourself. "You decrease the chances of being the victim of a medical error by being informed and not hesitating to challenge health-care providers and ask for explanations. Become an expert on your condition and how the care should be delivered," he said.

According to Dr. Brook, an area that needs special attention is postsurgical care. "Educating the patient and family about the short- and long-term implications of surgical procedures is vital. To that end, make sure that the surgical team provides personal attention and spends time giving patients and caregivers information," he said.

Dr. Brook continued, "I would say to very busy surgeons, as challenged for time as you are, you need greater vigilance and communication among the staff to avoid medical errors. Plus, it's important to understand the need for better medical and psychological postsurgical care, especially for patients who have had major surgery."

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Dr. Brook concluded his presentation with a brief note about a book he wrote, My Voice—A Physician's Personal Experience With Throat Cancer, detailing the physical and emotional difficulties of vulnerable cancer patients, especially when their care is compromised by a slew of preventable medical errors. "I would stress to all clinicians that the solution to dangerous medical errors is in their hands. By increasing their awareness and vigilance, they will radically decrease the likelihood of medical errors."

ODOR MANAGEMENT

By Rosemary Van Ingen

Isn't it interesting that people with normal intact bowel tracts and urinary systems manage odor problems in an acceptable manner in our society? But when disease or trauma strike, and the person is the owner of an ostomy, the one big concern is the fear of offending society with an odor.

Basically, and simply, an ostomy is a man-made exit site that changes the point of exit from the bottom of our body to the front. Our eyes and nose are obviously on the front of our body, which leads us to be more aware of our changed body image and our odor producing products.

You've heard the statement "You've come a long way, baby." Yes, ostomy management has come a long way--considering that as little as ten years ago we had very few 100 percent odor-free pouches. When ostomy surgery was first developed, ostomates wore anything to collect output. Tin cans, rubber gloves, cups of all sizes, bread wrappers, and plastic margarine cups, just to mention a few, were standard supplies for the ostomate. Not only the feasibility, but odor problems these type of supplies produced, was enough to give ostomy surgery and people with ostomies a deplorable place in our society. Presently, almost all ostomy supplies available to us today are made of odor-barrier materials. Therefore, if an ostomate does have a fecal or urinary odor about them, some detective work should be done: Check out the application of the pouch to the body-is it leaking?

Check out the closure of the pouch-is it closed properly so that no fecal matter oozing out after the closure is applied? Do not put holes in the pouch as gas will seep out continuously.

A Urostomate should rinse or wipe off the spout of the pouch with a bathroom tissue after emptying. Those few drops left in the spout after closing the pouch can cause a urine odor under clothing. It's interesting to note that most urostomy pouches on the market are odor-proof, but the connector tubing and bedside and leg bags are not. You must dispose of and replace these products when they take on odors, or else your entire living quarters will smell.

Emptying an ostomy pouch is comparable to a person with an intact bowel or urinary tract having a bowel movement or emptying their bladder. How does the non-ostomate handle the odor produced by this normal function of their body? Room deodorizing sprays are popular; a quick flush of the toilet when defecation occurs, and striking a match or opening a window are some acceptable methods that have been used for odor management since the invention of indoor plumbing.

Why then are we Ostomates so "up-tight" about the odor produced when our pouches are emptied? This complaint has encouraged ostomy supplies manufacturers to create products to meet this need of "odor control." The trouble is, the ostomy deodorants do not work for everyone, and they are expensive.

Can we then consider ourselves "as normal as blueberry pie" so far as waste odors are concerned? Just remember, there is not a man or woman on this earth whose wastes do not smell. If someone tells you their waste products are odorless, then a nose overhaul is in order.

LIFE ISN'T THE SAME WITH A POUCH

While the pouch is nice and handy to collect whatever comes out, it can come loose as a result of certain body movements and leave us with quite a mess; abruptly sitting up straight from a flat-on-your-back position, bending over to pick up something, or stretching to reach something too high up.
Learn the proper ways to get into bed and how to get out of bed without putting strain on your pouch. Learn to use tools to help you with some of the chores requiring bending over and reaching those high items. Don't, for instance, bend over to clean the bathtub. Use a broom and a cleanser, or carefully. kneel down at the side of the tub. To pickup something up, or to reach high shelves, get a clamp-type "reacher" or "grabber". They also make "grabbers" with suction cups, in place of the standard "fingers", for screwing/un-screwing light bulbs or picking up small round objects.
Learn to lift and/or carry objects on the side of your leg or hip, or drag it or better yet, get someone to help you; don't be too proud to ask for help. Not only do you prevent the pouch from coming loose, you might also prevent a hernia -ostomates get hernias easier than anyone else.

POINT TO PONDER

I am driven by two main philosophies: Know more today about the world than I knew yesterday, and lessen the suffering of others. You'd be surprised how far that gets you.
NEIL DEGRASSE TYSON, Astrophysicist

CARAMEL-GLAZED APPLE CRESCENT ROLLS:

1 cup peeled, finelv chopped apple
1/3 cup chopped nuts
1/4 cup sugar
1 tsp. flour
1 tsp. cinnamon
2 (8-oz.) cans Pillsburv refrigerated crescent dinner rolls
2 tbs. butter or *margarine, melted*

Glaze:

1/2 cup firmly *packed brown sugar*
1/2 cup sour cream
1/4 cup butter or *margarine*
1/4 cup chopped nuts

1. Preheat oven to 375°F. To make rolls: Combine first five ingredients; mix well.
2. Separate crescent dough into 16 triangles; brush each with melted butter. Spoon rounded tablespoons of apple mixture onto wide end of each triangle. Roll up, starting at shortest side of triangle and moving to opposite point.
3. Arrange rolls seam side down on ungreased cookie sheet; curve into crescent shape. Bake 25 to 30 minutes or until golden brown.
4. To make glaze: In medium saucepan, combine first three ingredients. Bring to a boil; boil 3 minutes, stirring occasionally. Pour over rolls; sprinkle with chopped nuts. Serve warm or cool.

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Note: Just your name needed for renewals.

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DATE OF SURGERY_____

CIRCLE ONE: COLOSTOMY ILEOSTOMY UROSTOMY OTHER_____

Please make checks payable to Ostomy Association of South Texas and mail completed application with payment of $9.00 to: Ostomy Association of South Texas, San Antonio, Tx .

In addition to my membership I am enclosing a donation of $_____.

You are welcome to pay your dues at the monthly meeting. The newsletter is included in the cost of membership.

Newsletter VIA E-mail (Circle one)YES NO (E-mail saves almost 50¢ postage and it's in color)