

# New Patient Guide

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# Colostomy New Patient Guide



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# The Phoenix

The official publication of UOAA

Dear New Ostomy Patient,

Welcome to the United Ostomy Associations of America and your free New Patient Guide. It is brought to you by UOAA, its over 300 local affiliated support groups throughout the United States, and by its official publication, *The Phoenix* magazine.

We believe that it is very important for you to have as much information about your ostomy as possible. Undoubtedly, you have heard many stories about people with an ostomy or related procedure, many of which are based on ignorance and "old-wives' tales." We are here to dispel those and help you move beyond the stigma!

In this magazine, you will find answers by medical professionals to many of your basic questions, hints about living with your ostomy and motivational stories describing quality of life accomplishments from some of the 700,000 people in the United States that have an ostomy. In fact, articles first appeared in *The Phoenix* magazine, with subscriptions being a major source of revenue for the UOAA.

UOAA is a volunteer-managed non-profit organization whose vision is the creation of a society where people with bowel and urinary diversions are universally accepted socially, in the work place, medically and psychologically. UOAA has a comprehensive website, [www.uoaa.org](http://www.uoaa.org) that includes ostomy information, support group locations and discussion boards so that people with ostomies can connect, ask questions and share advice.

UOAA staffs a national Help Line at **800-826-0826**. Call to find the affiliated support group in your area or to talk to an ostomy nurse. Another free service offered by UOAA is provided by our advocacy legal specialist. If you experience some form of discrimination as a result of your surgery, call our Help Line and they will put you in touch with our specialist.

Membership in UOAA is through its affiliated support groups, or ASGs. If you are a member of a local support group, or one of UOAA's virtual networks, you are a member of UOAA. Our local ASGs have periodic support and educational meetings where you can get answers to those questions that so many new patients have and where fellow members can share with you their experiences. You will find, upon attending, that you are greeted warmly and treated like a member of an extended family.

Be well,  
UOAA's Management Board of Directors

P.S. This free New Patient Guide is made possible by subscriptions to *The Phoenix* magazine and donations to the UOAA. Your support is appreciated.

P.S.S. Visit [www.phoenixuoaa.org](http://www.phoenixuoaa.org) to learn more about America's leading ostomy magazine.

# Ask Dr. Rafferty



Dr. Janice Rafferty is a board-certified colon and rectal surgeon, currently a professor of surgery and chief of the colon and rectal surgery division at the University of Cincinnati. She specializes in the treatment of inflammatory bowel disease, colon and rectal cancer and benign abnormalities of the pelvic floor and anorectal area. She lives in Cincinnati with her husband Don, sons Ian and Jack, one dog and two cats.

Send questions to publisher@phoenixucaa.org, or P.O. Box 3605, Mission Viejo, CA 92690

## No Appetite, Drainage, Rectal Stump

### Common Occurrence

*I had my rectum removed in last May and now have a colostomy. I am finding it uncomfortable when I sit for long periods. Is this a common occurrence and will it go away with time? Is the discomfort due to scar tissue?*

S.T.

Dear S.T.,

The anatomy of the pelvis changes significantly when the rectum is removed. You may notice a change in how most things feel, including sitting! In addition, patients often lose a bit of weight around the time of surgery and with it some of the backside "padding."

This results in placing more pressure on the coccyx, or tip of the tailbone, in certain positions and can be quite uncomfortable. If you had your rectum removed because of cancer, visit your surgeon for a thorough evaluation to make sure there is no problem with the surgical site or evidence of recurrent disease.

### Confused Plumbing

*I had a colostomy in December of 2004 and manage it quite well. The problem is hardened fecal material in the rectum. I have gas pains and also some liquid drainage there. Why do I have it if my bowel elimination has been a colostomy since my surgery? Will it cause any harm if left there? Is there another method, besides enemas, to eliminate this problem? Could I become dependent upon enemas if I do them regularly?*

T.M.

Dear T.M.,

If you had a colostomy constructed, but your rectum was left in place, you may

accumulate mucus and shed rectal lining. Over time, this may harden and then feel and pass like a bowel movement. The occasional use of a stimulant suppository or low-volume enema should be harmless.

A rectum that does not pass stool for a prolonged period of time will become mildly inflamed that will increase the amount of material ultimately passed. Certain anti-inflammatory medications applied to the lining of the rectum may decrease drainage and lead to some relief. Ask your doctor if anti-inflammatory enemas, foams or suppositories are right for you.

### Color Concern

*I've had a colostomy since June of 2006. I'm concerned about the color of stool that passes. Sometimes, it is an auburn color which makes me think it may be blood. Should I be concerned?*

C.B.

Dear C.B.,

You can certainly pass blood through a colostomy, much like you could when you had an anus. Oftentimes, the color of stool that is highly visible in a pouch is related to food that was eaten. Talk to your doctor to help decipher your risk factors and decide whether or not a colon exam is needed to address your concerns. Consider keeping a food diary to see if you can relate the color to a certain food eaten in the prior 24 hours.

### Growing Problem

*I have had my colostomy for about six months and about three months ago I had some sort of growth out of the bottom of the stoma: about the size of a jelly bean. It looks almost like intestine coming out, but*

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*it does not bother me. Then, about a month later, I had another growth. It is about the size of a piece of corn and looks almost like a wart and is hard.*

*I don't know if this is normal or not. The nurse said if it doesn't bother me then don't worry about it, but I didn't think something growing on me was normal.*

G.S.

Dear G.S.,

These are most likely nodules of excess intestinal lining (hyperplasia or pseudoverrucous change), which grow in reaction to exposure. Remember, the lining of the intestine was “designed” to be inside! Exposure to the outside can irritate the tissue and make it “grow.” While these growths are benign, they can make pouching difficult.

In fact, sometimes they are a signal that your pouching routine is traumatizing the stoma itself. Talk to your ostomy nurse about the details of your routine; perhaps a slight modification will cause less irritation.

Finally, don't leave your surgeon or gastroenterologist out of the loop. If you have a history of intestinal polyps, cancer, or Crohn's disease, these nodules may need to be biopsied.

## **No Appetite**

*I've just come home from the hospital after ostomy surgery. I have no appetite and the smell of food makes me sick. Is this normal? Do I have to eat when it makes me sick?*

L.T.

Dear L.T.,

It is completely normal to have decreased appetite and energy for a month or so after major abdominal surgery, so don't despair. The most important thing to do is stay hydrated and move around the house. Try to drink juices, water, some sports drinks and milk products. Also, try to nibble on salty crackers, pretzels, chips, scrambled eggs, toast, peanut butter and bananas – things that will calm your stomach and provide some nutrients and protein at the same time. Be patient with your body as it heals and give it the building blocks to do a good job!

## **Phantom Rectum**

*Is it normal to have rectum pain with a permanent colostomy? It's kind of like pressure, but painful. What would happen if you strained, like using the toilet, with a colostomy? I know that sounds silly, but when I feel like*

*I'm going to have a bowel movement, I want to push like before, but I tell myself not to.*

A.B.

Dear A.B.,

What you describe is very common after removal of the rectum. Since the surgeon closes the muscles of the pelvic floor after rectal removal, a pressure or sensation of tightness may result.

You should seek to insure that your discomfort is not due to malignancy, especially if your rectum was removed because of cancer. If you are male, this sensation can result from inflammation of the prostate. In men and women, a perineal hernia can also cause pelvic pressure reminiscent of an “old fashioned” bowel movement. Occasionally, a CT scan or MRI of the pelvis can help identify the cause of your sensation.

## **Mucus Drainage**

*What is the average amount of mucus drainage? Several times a day? Weekly? Monthly? I was having mucus about every six weeks, but now I'm having it several times a day. Is there a “normal” amount?*

M.D.

Dear M.D.,

I assume you are referring to draining of mucus from a defunctionalized rectal stump. If this is the case, the amount of drainage you see will be related to the length of rectum that remains and the amount of inflammation in the lining.

A certain amount of inflammation will always be present in a segment of intestine that is unused. The amount of drainage can be decreased by using an anti-inflammatory suppository that contains 5-ASA.

## **Return to Work**

*I had colostomy surgery and my rectum removed seven weeks ago. I can only sit in a chair for 5-10 minutes at a time. I was hoping to return to work in two weeks (desk job). At what point does the butt start feeling better in order to drive a car and sit in a chair?*

C.C.

Dear C.C.,

There is no single answer to this question that applies to all patients! After the rectum is removed, the surgeon closes the opening in the pelvic floor by

*continued on page 23*

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*- Kenneth R. Schena  
Inventor and fellow Ostomate*

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HAPPINESS



# Ask Nurse Muchoney



Marlene Muchoney has been an ostomy nurse for over 28 years. She is nationally board certified in wound, ostomy, and continence nursing. She has been awarded the Quality of Life Award by the American Cancer Society, was a runner-up for the Nightingale of Pennsylvania State Award and received the Cameo of Caring Award for excellence in nursing from the University of Pittsburgh School of Nursing.

Send questions to [publisher@uoaa.org](mailto:publisher@uoaa.org) or P.O. Box 3605 Mission Viejo, CA 92690

## Proper Fit, Showering, Pouch Patching

### Confused Colostomate

*I am 50 years old with a colostomy. I'm confused about nutrition. We are told to eat high-fiber foods, yet it is suggested that I avoid such foods as they cause gas and bloating. How can you control odor? What am I supposed to eat?*

N.B.

Dear N.B.,

First of all, if fiber doesn't cause you any problems and is not contra-indicated by your physician, you should continue eating a diet rich in fiber. Having a colostomy does not restrict you from fiber as a general rule. If gas (flatus) or odor is a concern, you can voluntarily avoid foods such as cabbage, beans, broccoli, cauliflower, fish, some spices, carbonated beverages (soda and beer) and some dairy products. The primary cause of flatus is from swallowing air and eating the above foods. Drinking through a straw, chewing gum or smoking also increases flatus.

Odor control is achieved by wearing an appropriate, odor-proof appliance, good hygiene, using commercial deodorants as desired, a careful diet and even oral agents. Products to control odor taken by mouth or placed into the pouch must be discussed in advance with your physician. Parsley, orange juice and yogurt may reduce odor.

Ostomates should only notice odor when emptying or changing a pouch. Spraying air freshener before and after changing or emptying is beneficial. Odor from the pouch at other times indicates a poor seal, a hole in the pouch or the need for an appliance change. See your ostomy nurse to have your appliance evaluated if this is a recurrent problem.

I have met people who experience odor problems because they were not wearing the appropriate wafer or pouching system. That was easy to fix!

Don't be afraid to eat. Try new foods one at a time. Record food intolerances. See your ostomy nurse, if indicated. Remember, there is no replacement for good hygiene and an effective odor-proof pouching system. Try some of my recommendations and get back to us on the results.

### Proper Disposal

*How should I properly dispose of used ostomy equipment?*

J.C.

Dear J.C.,

Do not flush any ostomy equipment unless it is specifically designed for that. I do not have any personal experience with "flushable" pouches, but would love to hear from someone who has used them.

The correct way (and safe for disposal) is to empty pouches, put them into one or two zip-lock style plastic bags and put them into your regular garbage. You can also tuck the discarded equipment into an opaque plastic bag or line clear ones with paper towel prior to disposal, if you desire. Appliances intended to be reused for longer periods of time should be cleansed as per the manufacturer. Washcloths and towels should be laundered in the usual fashion.

### Fitting Flanges

*What determines the flange size a person should use? I have been using the same size they gave me in the hospital and wonder if I can use something smaller that*



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*will not be so noticeable.*

H.W.

Dear H.W.,

As stoma sizes change, flanges can also change. Most companies provide guidelines advising proper flange size based on the stoma measurement. You need an adequate barrier on the flange, but remember that too small can cause stoma injury. If you are unsure, contact the company who manufactures your flanges for advice or contact your local ostomy nurse.

Larger flanges can be used for small stomas as long as the stoma pattern is correct. Some people feel more secure with a little extra adhesive backing on the flange; however, wearing the smallest appropriate size flange is most desirable.

### **Convexity**

*What exactly is a convex wafer? Mine is flat.*

S.B.

Dear S.B.,

A convex wafer has a back surface that curves in toward the abdomen; it appears slightly cup-shaped vs. flat. They are used to improve wearing time, reduce leakage problems and prevent irritated peristomal skin, when indicated. Examples of the need for a convex wafer would include retracted stomas, a soft abdomen, stomas in creases or folds or even a history of frequent leakage in some cases. Occasionally, a support belt is added to assist with the convexity.

### **Showering**

*Should I shower with my pouch on or take it off? What will give me the longest wear time?*

W.V.

Dear W.V.,

Either will work. This is a personal preference. If you shower with your pouch off, do not use excessively hot water and avoid direct contact of the water stream onto the stoma. Also, you will not have any voluntary control over the function, so shower before meals or a few hours after meals when the stoma is less active.

Do not shower with your pouch off if traveling in areas where the drinking water is not safe. This may apply to well water or stream water in rural areas. This is also true in foreign countries. Contamination of the stoma with unsafe water may cause the same infection as if you drank it.

There are products designed to be worn when showering. One is an “apron” and the other is a “cap.” See advertisers in this issue or contact your ostomy product supplier.

Showering with your pouch on or off is a personal preference, unless not allowed by your physician or when the water is not safe to drink. I do not recommend tub bathing with the pouch off. Also, be certain to dry the pouch well after bathing to reduce moisture that can cause fungal skin rashes.

### **Prescription for Supplies?**

*Every time I try something new, my distributor of products has to contact my surgeon for a new prescription. Is this true for everyone?*

D.P.

Dear D.P.,

Yes, it is my experience that you need a prescription for new products to utilize insurance coverage. I recommend obtaining a prescription from your primary care physician, not your surgeon. Have the product name, re-order numbers and number generally needed available for your physician.

When trying new products, I recommend contacting the manufacturers for samples to be certain it works for you before ordering a large supply. Your local ostomy nurse can help resolve issues of product selection too.

### **Low-Residue Diet**

*I am supposed to eat a low-residue diet after my surgery. What foods are OK?*

C.G.

Dear C.G.,

The following is a partial list of low-residue foods: milk, coffee, tea, white bread, plain crackers, cream of wheat cereal, grits, cream of rice, strained oatmeal, cooked, refined dry cereals such as corn flakes and rice crispies, macaroni noodles, puddings, ice cream, bananas, canned peaches, strained juices, tender beef, chicken, fish, cottage cheese, eggs (not fried), cooked vegetables such as potatoes, squash

Avoid highly seasoned meats or meats with casings, fried foods, whole-grain breads and cereals, raw fruits and vegetables, popcorn, pineapple, corn, nuts and seeds, to name a few foods.

As always, you should discuss your dietary plan with your physician or a registered dietician to determine what is best for you.

## Pouch Patching

*If I notice leakage under the outside edge of my wafer. Is it okay to add paste or more tape to keep it in place?*  
M.W.

Dear M.W.,

It is not advisable to “patch” wafers that are beginning to leak or undermine. The only exception might be to buy a little time until the wafer can be fully changed. Patching the edges does not stop the leakage. It only traps the drainage under the wafer possibly resulting in irritated or damaged peristomal skin.

## What's the Difference?

*Are skin prep and skin barriers the same thing?*

W.C.

Dear W.C.,

Skin prep is a type of sealant and contains a plastic agent and alcohol to help it to dry. Sealants add a protective, thin plastic film on the skin to protect it from excessive stripping when wafers or flanges are removed.

Sealants can interfere with the effectiveness of the wafer in some cases. They come in wipes, sprays, roll-on and liquid forms. Let them dry thoroughly before applying the appliance. Skin barriers include powders, pastes, wafers, rings, washers or strips made from various ingredients. Barriers can help to prevent erosion from stoma output and fill “low spots” such as creases or scars, thus providing a flat pouching surface. Barriers often improve appliance adherence and prevent irritated peristomal skin due to leakage.

If you eliminate the sealant and the wafer still lifts, your pouching system may need to be evaluated. In any case, call your ostomy nurse to clarify exactly what barrier you need.

## Over Protection

*Do I need to wear gloves when caring for my colostomy?*  
B.U.

Dear B.U.,

No, you do not need to wear gloves, but you should wash your hands before and after care. ☺

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# The Ostomy Book

## The improved and updated edition of an ostomy classic

By Cliff Kalibjian

The long-awaited third edition of *The Ostomy Book* is finally here. Prompted by a review of the second edition (published in 1992) last year in *The Phoenix* magazine entitled, "A Classic In Need of Revision," Kerry Ann McGinn rose to the challenge and delivered within a year's time.

As in the second edition, McGinn has preserved the personal stories, including those of her mother, Barbara Dorr Mullen, who passed away peacefully between the time of the first and second edition. What's new in this book is information on the latest treatments, surgical procedures, ostomy equipment and statistics. Kudos to McGinn for blending her updates so seamlessly with her mother's original stories. For example, before Mullen describes her three roommates in her hospital room, McGinn slips in a line about how most patients today have either private rooms or just one roommate, thus eliminating potential fears about staying in the hospital that one might develop if they assumed multiple roommates were still the norm.

*The Ostomy Book* is filled with wonderful personal stories, mainly those of Mullen, but of others as well. In the first several chapters, Mullen describes her cancer diagnosis, surgery and hospitalization in detail. In addition to simply sharing her experiences, Mullen shares her feelings, to which most ostomates will be able to relate. When trying to make sense of it all, Mullen asks, "Why did this happen to me? I always ate my spinach."

Mullen shares her wisdom on the grieving process, which most people with an ostomy experience when losing even the most diseased organ. She explains, very insightfully, how we really cannot see the "bright side" until we've allowed ourselves to feel all of our negative emotions, such as sorrow, anger, loss and fear.

Throughout the book, Mullen also touches on an extremely important topic: the strength and ingenuity of the human spirit. For instance, in places where

people are either unaware of or without modern ostomy supplies, she shares how people have adapted to their ostomies in ways that many would consider the most unusual in order to fully live their lives: taping a tuna fish can, waterproofed cigar box or old-fashioned rubber glove to their belly.

She also relates a story of a woman who was told she had only six months to live, but then decided to simply get busy living in the present. Six years later, she was still alive, but her surgeon was not. And sixteen years later, she was still alive and well and celebrating her 92nd birthday.

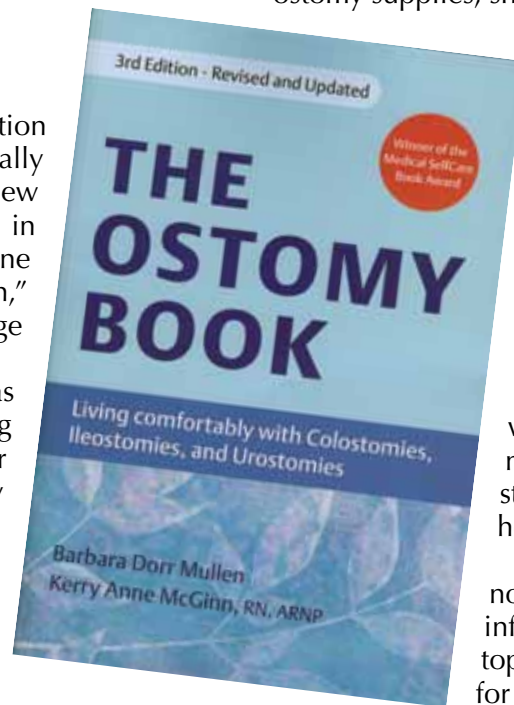
Readers of *The Ostomy Book* will not be at a loss for up-to-date, factual information regarding various ostomy topics. The book includes chapters for people undergoing colostomies, ileostomies, urostomies as well as any

continent and temporary procedure associated with them. Excellent illustrations are included as well to help readers fully understand the various surgeries. The latest on pouches, skin care and check-ups/tests following surgery is included as well.

What's nice about the book is that you can read it all the way through from start to finish, or you can just as easily read an individual chapter on its own if you are looking for specific information on a topic, such as sex, work, travel, sports, pregnancy or children and teenagers. A glossary and resources section are included, as well as a patient's bill of rights in one of the early chapters.

*The Ostomy Book* is so comprehensive that a reader, after finishing the book, would be hard pressed to think of a relevant topic it does not cover. It's simply an excellent resource that every person with an ostomy, along with their closest friends and family members, should read. Ostomy nurses and physicians who perform ostomy surgeries would be wise to recommend it to their patients as well.

On behalf of people with ostomies around the world, special thanks to Kerry Ann McGinn for taking the time to update the book. Hopefully, she won't wait so long when it comes time for the fourth edition! ☺



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# Ostomy A to Z

## Getting to know the ostomy lingo

By Cliff Kalibjian

Reviewed by Leslie Washuta, RN, BSN, CWON

If you are new to the ostomy world, it's easy to become quickly overwhelmed with new terminology when talking with your health care team or when reading about your condition. The good news is that by becoming familiar with some key terms, you will soon begin to feel much more comfortable – and fluent – with the ostomy lingo around you. This article will help you get started by briefly defining various ostomy-related terms in an easy-to-understand manner.

**Adhesions** Scar tissue from an abdominal surgery can generate adhesions, which are fibrous bands that may attach to the bowel. These can sometimes cause blockages in the intestine, though this is a rare occurrence.

**Appliance** the formal term for an ostomy pouch or ostomy bag.

**Colectomy** the surgical removal of the colon (also known as the large intestine), often due to cancer, or non-cancerous conditions such as severe inflammatory bowel disease or ruptured diverticulitis. Depending on what's necessary, a colectomy can be a partial or a total removal of the colon.

**Colostomy** a type of ostomy in which part of the colon is brought to the surface of one's abdomen, through a surgical procedure, to eliminate stool. Reasons for a colostomy include cancer of the rectum, ruptured diverticulitis, trauma to the bowel, or disease / damage to the spinal cord resulting in little or no bowel control.



A wafer with convexity

**Convexity** a type of pouching system that is typically used for stomas that are recessed into or flush with the abdominal surface.

**Crohn's Disease** one type of inflammatory bowel disease. It affects the gastrointestinal (GI) tract anywhere from mouth to anus (although the small and large intestines are the most common sites). Crohn's affects all layers of the GI tract. Symptoms can include abdominal pain, diarrhea, fever, fatigue, and weight loss. Surgery for this condition may result in one having an ostomy.



A faceplate on a one-piece pouch

**Cystectomy** the surgical removal of the bladder. A cystectomy can be partial, or, more commonly, total. The most common reason for this surgery is bladder cancer.

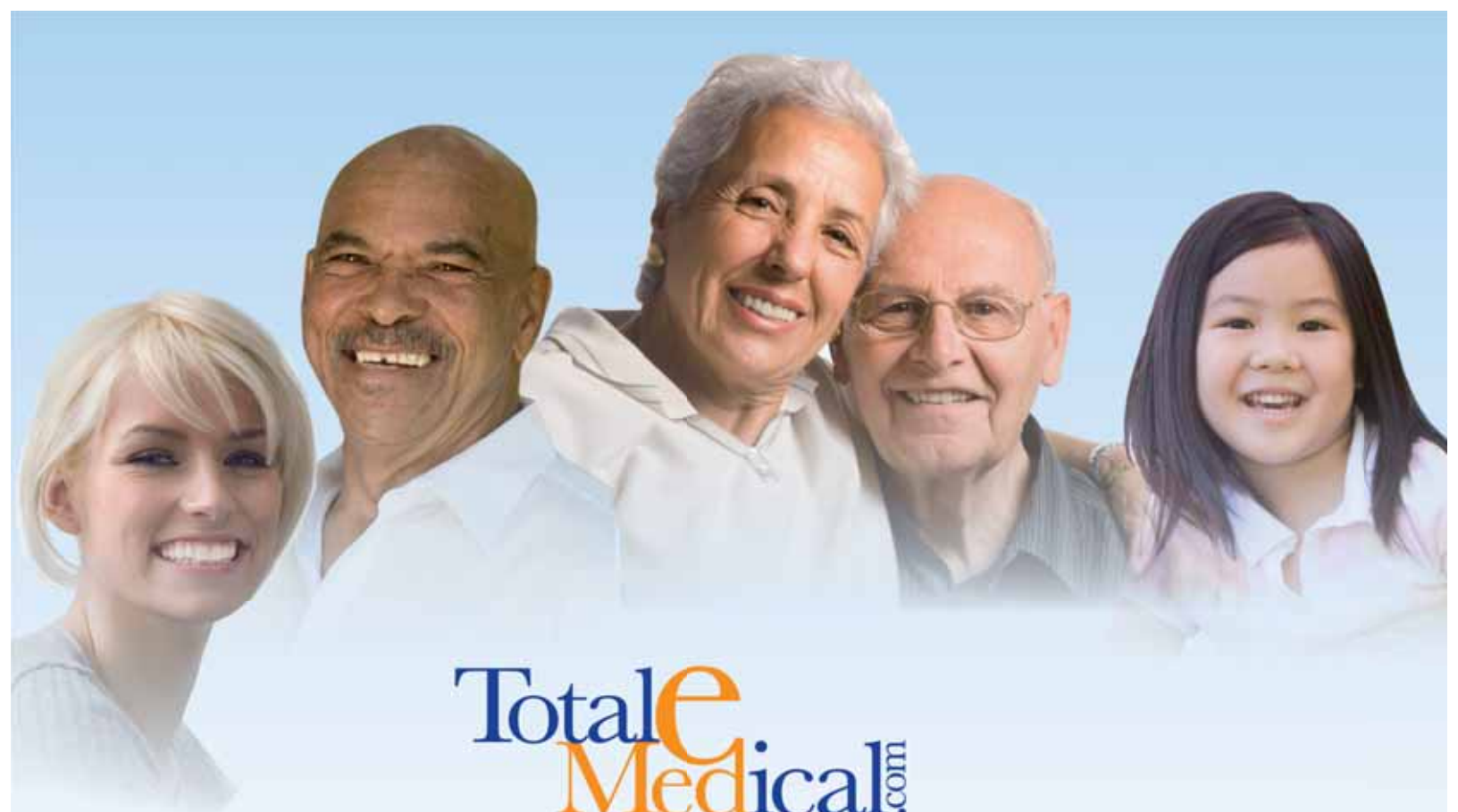
**Diverticulosis/Diverticulitis** a condition of the colon in which small sacs or pouches form in the wall of the colon, often asymptomatic. Diverticulitis occurs when these small pouches become inflamed. Ruptured or perforated diverticulitis often requires the creation of a temporary colostomy.

**Enterostomal Therapy (ET) Nurse** a nurse specializing in ostomy care. Refer to WOCN for the updated version of "ET Nurse."

**Faceplate** the part of the pouching system that adheres to the skin around the stoma. The faceplate can be separate from a pouch (two-piece system), or a pouch and faceplate can be one unit (one-piece system). See also "wafer."

**Familial Adenomatous Polyposis (FAP)** a hereditary disorder that is characterized by the development of multiple polyps (growths) in the colon that generally begin during the teenage years. There is a high risk for developing colon cancer in any of these many polyps over time. Surgery to remove the large intestine is the typical treatment for this disorder.

**Folliculitis** an inflammation of the hair follicles. This condition sometimes occurs on one's skin around his stoma due to the physical trauma involved with



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repeatedly removing ostomy appliances adhered to one's skin. It may also occur as a result of frequent shaving of the skin around the stoma, resulting in a rash or eruptions of the skin.

**Flange** a plastic ring on the faceplate (wafer) that allows a pouch to snap onto the faceplate. Some manufacturers also refer to their wafer/faceplate as a "flange."

**Hernia** occurs when the intestine "bulges" through a weak area of the abdominal muscle. When this happens next to a stoma, it's called a peristomal hernia.

The presence of a hernia may result in a fullness or prominence around or behind the stoma. Repairing a hernia requires a surgical procedure.

**Ileostomy** an ostomy in which the end of the small intestine (ileum), through a surgical procedure, is brought to the surface of one's abdomen to eliminate bodily waste. Reasons for having an ileostomy may include severe cases of inflammatory bowel disease (i.e., Crohn's Disease of the colon or ulcerative colitis), or as a method to provide a temporary diversion of the bowel while it heals from a surgical procedure.

**Inflammatory Bowel Disease (IBD)** a general term used to describe chronic inflammation (consisting of redness, swelling, and ulceration) in the digestive tract. The two major forms of IBD are Crohn's disease (inflammation anywhere in the digestive tract affecting all layers of the GI tract) and ulcerative colitis (inflammation only in the colon affecting the innermost layer of the GI tract).

**Irrigation** a procedure that people with colostomies undertake to regulate their bowel movements. Water is instilled through the stoma, which then triggers the colon to empty its contents. This process is much like taking an enema. It's typically performed every day or every other day. After irrigating regularly for about two months, the person with a colostomy may not need to wear an appliance any longer, as the colon is "trained" to only eliminate during irrigation.



*Irrigation equipment*

**J-Pouch** a surgical procedure that involves removal of the colon and creation of an internal reservoir (shaped like a "j") made out of the end portion of the small intestine. People with a j-pouch eliminate their feces the regular way through the anus, though with much greater frequency. It's most commonly an option for people with ulcerative colitis that is not responsive to medical therapy or those with familial polyposis.

**Kock Pouch** a surgical procedure that involves removal of the colon and creation of a continent internal reservoir made from the end of the small intestine. A valve is made and attached to a stoma that is sutured to and is flush with the abdominal surface. An ostomy appliance is not used. A catheter (drainage tube) empties the reservoir several times per day. A gauze dressing is generally worn over the opening.

**Laparoscopic Surgery** a surgical procedure where several small incisions (.5 to 1.5 centimeters) are made at various points on the abdomen. A harmless gas is injected into the abdominal cavity to create a large working space that the surgeon views through a tiny, inserted camera. Surgical instruments are inserted through the small incisions, which the surgeon manipulates while viewing the surgery on a video monitor.

**Obstruction** a blockage in the intestine. Obstructions can result from a variety of causes, including fibrous foods, cancerous growth, scar tissue / adhesions, or severely inflamed lining of the intestine.

Symptoms typically include abdominal pain, nausea, vomiting, or inability to pass gas or stool. Hospitalization often ensues to address the cause of the obstruction.

**One-piece Pouching system** consists of a pouch that is already bound to a faceplate (i.e., the skin barrier or wafer that sticks to your skin).

**Ostomy** a surgical creation of an abdominal opening that allows the elimination of either feces or urine.

**Ostomate** a person who has an ostomy. Another term sometimes used is ostomist (mostly in the UK).

**Patch Test** a method of determining whether one is allergic or sensitive to an ostomy product, such as a tape or adhesive barrier. It's done by placing a small amount of the product on the side of the abdomen opposite the stoma. If the skin becomes irritated within a day or

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two, then one likely has an allergy or a sensitivity to the product and should avoid using that product.

**Peristomal Skin** the skin around your stoma. Having healthy peristomal skin is important for quality of life for those with ostomies.

**Pouch** an ostomy appliance consists of a skin barrier or wafer, and a pouch, either as separate products used together, or manufactured as a one-piece system. The pouch collects the effluent from the stoma, serving as a reservoir until the pouch is emptied by the wearer.

**Pouchitis** the inflammation of an internal pouch made from small intestinal tissue (such as the j-pouch or Kock Pouch). Pouchitis is treated with either probiotics (beneficial bacteria) or antibiotics plus increased fluid intake and prompt emptying of the full internal pouch. Pouchitis is the most common long-term complication of ileal-anal reservoir surgery.

**Prolapse** occurs when the stoma no longer adheres correctly to where it comes out of the abdomen as the bowel everts itself outward. This results in the stoma protruding significantly further out than the normal one-quarter to one-half inch. This complication is most commonly seen with transverse loop colostomies. Surgery may be necessary to correct this problem.

**Short Bowel Syndrome** a malabsorption disorder, which means that there is not enough small intestine or not enough functional small intestine to adequately absorb

fluids and nutrients from the foods and beverages you eat and drink. Some define it as having more than 50 percent of your small bowel removed, while others point out that the functionality of the remaining small bowel is the key determinant.

**Skin Barriers** products, such as pastes and powders, that some people with ostomies use to protect the skin around their stoma



*Two-piece pouching system: pouch attaches to faceplate (flange or wafer) that adheres to the abdomen. Bottom: Flexible skin barrier.*

before attaching their appliance. The faceplate or the wafer of an appliance is also considered to be a skin barrier as it protects the skin from contact with the stoma's effluent.

**Stoma** the part of an ostomy that is visible on the exterior of one's abdomen where body waste exits the body. It is bright red and ideally protrudes approximately one-quarter to one-half inch above the skin surface, although some

stomas are flat or "flush" with the skin surface. The size of a stoma will decrease after surgery as the swelling goes down.

**Tail Closure/Tail Clip/Tail Spout** seals the bottom of a drainable ostomy pouch used for a colostomy or an ileostomy. Sometimes a tail closure is a separate plastic clamp that is attached to the pouch. Other pouches have a folding/Velcro® system that keeps contents from coming out from the bottom of the bag. A tail spout is the closure mechanism found on the bottom of urostomy pouches that can be opened for emptying and then closed to prevent leakage of urine.

**Two-Piece Pouching System** consists of a separate pouch and faceplate or wafer (i.e., the barrier that sticks to your skin) that comprise the ostomy appliance. Different styles of bags can be attached to the faceplate without having to remove the faceplate adhered to your skin. Using a two-piece system also allows for more frequent pouch-only changes or alternate methods of cleaning out the pouch contents while the wafer stays in place.

**Ulcerative Colitis** one form of inflammatory bowel disease. It targets the colon (also known as the large intestine) and affects its innermost lining. Symptoms can include abdominal pain, fatigue, weight loss, and bloody diarrhea. Surgery for this condition may result in one having an ostomy.

**United Ostomy Associations of America (UOAA)** an association of affiliated, non-profit support groups committed to improving the quality of life of people who have, or will have, an intestinal or

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For patients with problems with conventional (Brooke) ileostomy, failed ileo-anal J pouches, or Kock pouches, or those with ulcerative colitis or familial polyposis, the Barnett Continent Internal Reservoir (BCIR) offers a "Bag-Free Life."

urinary diversion. The UOAA can be reached at 800-826-0826 or [www.uoaa.org](http://www.uoaa.org).

**Urostomy** the surgical creation of an opening in the abdomen that allows the elimination of urine. It's usually performed on people who have had their bladder removed because of cancer, or in people with spinal cord injuries who no longer can control their bladder function.

**Wafer** a barrier or faceplate. It has adhesive on one side to stick on your skin around your stoma. The other side is designed to have a pouch attached to it.

**Wound, Ostomy and Continence Nurses Society (WOCN)** a professional, international nursing society of more than 4,200 health care professionals who are experts in the care of patients with wound, ostomy, and continence issues. WOC nursing is the sole nursing specialty in the United States that focuses on nursing management of patients with an ostomy. The WOCN can be reached at 888-224-WOCN (9626) or [www.wocn.org](http://www.wocn.org).

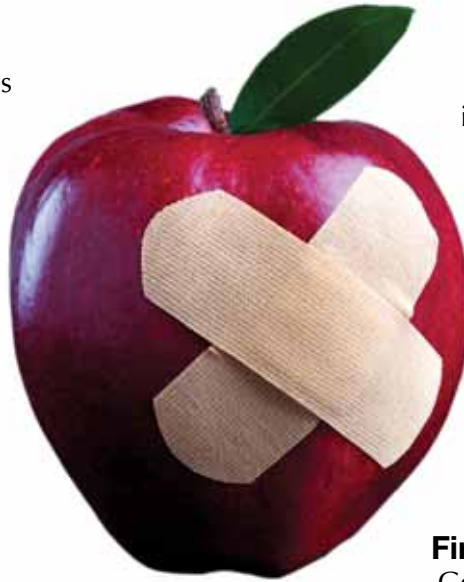
Many ostomy-related terms are defined above, but there will always be more. Whether you are new to the ostomy world or have been involved with it for some time, you will always be on a path of continuous learning. By working with your health care team and arming yourself with the right knowledge, you will learn the best ways to take care of yourself and maintain your health. For more information, see a qualified ostomy nurse, contact an ostomy supply company, or call the UOAA at 800-826-0826. ☺

# Healing from Ostomy Surgery

## Understanding the phases of recovery from the hospital to home

By Anita Prinz, RN, MSN, CWOCN

Over 120,000 people of all ages undergo ostomy surgery every year in the United States. Ulcerative colitis, Crohn's disease and colorectal cancer are the most common reasons. Many ostomies are temporary while others are permanent. Either way, having an ostomy is a life-altering experience that affects individuals physically and psychologically. Healing from an ostomy takes time and patience. Living life with an ostomy is a personal journey.



### Physical Healing

What happens when the surgeon creates a stoma? You are probably aware that the surgeon cut your intestines and brought the end through an opening in your abdomen. A simple description is that the plumbing in your body has been reworked. Where digested food was once excreted through your anus, it is now diverted through a stoma on your abdomen. Think of the gastrointestinal tract as a long tube where food goes in one end, the mouth, then nutrients are absorbed and finally your body excretes the remains of your digested food. It's amazing that food goes in one end smelling and tasting so wonderful and then comes out not so wonderful.

Stomas can be created by several different surgical techniques; the most common is the Brooke technique where the end of the intestine is brought through a surgically created hole in the rectus abdominus muscle and then through the skin on your abdomen, inverted like a turtle-neck sweater and sewn into place. The procedure takes place through a large midline incision or laparoscopically. The incision is stapled closed and an ostomy pouch is applied to the stoma.

The next day, you wake up to a very sore belly, with dressings and tubes poking into your abdomen and down your nose and a bag on your belly covering your new stoma. At this stage, you just need to rest and let your

body recover from the trauma of surgery and anesthesia. Your intestinal function has been traumatized by the surgery and effects of anesthesia and takes approximately 24-72 hours to wake up and start functioning again. The first sign of awakening intestines is flatus or gas. There might be stool in your bag already.

The doctors and nurses will be examining your stoma and checking to see if you have passed gas. You may hear sounds from the stoma area or notice that the bag is blowing up like a balloon and you didn't think you were full of hot air! After flatus returns, soon comes the stool – usually liquid with a vengeance. Now the fun begins!

### First Challenges

Getting acquainted with your stoma is one of your very first challenges. A “text-book” stoma is red, moist and protrudes about one inch with the opening pointing straight out. Stomas come in all sizes and shapes, just like belly buttons. Some are round, some oval, some innies and some outies. Looking at a stoma, touching it or seeing it expel stool are very private matters, but it seems that everyone in the hospital is now doing just that. The WOC nurse may comment on what a beautiful stoma you have and even suggest you name it, maybe Charlie or Rosy.

Anatomically, there are no nerve endings in the stoma, so when you dare to touch it for the first time you might be surprised that you don't have any sensation. Control over when and where to pass stool is lost also. The stool comes when it wants to, without any notice or control, but typically after eating. You will get to know your own patterns. Learn to love your stoma as it most likely saved your life!

Learning how to change the ostomy appliance is the next challenge. The purpose of an ostomy appliance or bag is to keep you clean, dry and smelling pretty. Everyone learns differently, but ostomy management is definitely a “hands-on” experience. Some doctors seem to think ostomy management is a no-brainer, just peel the back off the bag and stick it on. A technically simple process, but not always so easy. A WOC nurse will teach

you the basics of emptying and changing the appliance in the hospital. The less leakage problems you have in the hospital, the easier the transition to home will be.

Once you come home, you may be experiencing post-traumatic shock about what has really happened to your body and what other treatments you may be needing. Despite your hospital education, you may be bewildered by your new ostomy and its activities. Many people balk at the first change, claiming they can't see the stoma. Spouses, family members and home care nurses often help out for the first few weeks while you recover physically and emotionally. Eventually, it's time to be brave and overcome your fears or become dependent on someone else to do the "dirty work."

Generally, people learn to change their ostomy appliance standing or sitting in front of the bathroom mirror. Practice, humor and a dash of patience are essential, but no gloves are required!

Once your stoma has assumed its rightful size and shape, about six to eight weeks after surgery, you might decide to order pre-cut pouches to end the "arts and crafts" ritual of cutting a hole in the wafer. Shopping

for an ostomy appliance is another daunting task. There are so many different manufacturers and systems to choose from that it can be overwhelming. The language of ostomy care is almost foreign and confusing. Some mail order catalogues have 80 plus pages of ostomy products.

The hospital gives you a transparent, "one-size-fits-most" ostomy pouch. When you have mastered the technique of changing the ostomy appliance, you may switch to an opaque pouch so you don't have to see the stool. Let's be honest, who really likes to look at poop? Other options for colostomates are to use closed-end pouches which are removed and discarded rather than emptied. Your WOC nurse can help you find an appliance that's right for your body and lifestyle.

Irrigation is a popular choice of colostomates in Australia, but not so common in the U.S. To irrigate one's stoma is to give it a large water enema that stimulates the colon to empty all at once. Between irrigations, you wear a little stoma cap. For more information about irrigation, see "Colostomy Irrigation," in the June, 2007 issue of *The Phoenix* available at



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Stool patterns usually return to pre-surgery patterns, perhaps once or twice daily for colostomates. Ileostomates will have a more liquid or mushy stool consistency (the colon is no longer absorbing water from your diet) and will empty their pouch an average of four to eight times per day. If your anus is still intact, you will experience the urge to defecate on occasion and notice some mucous. This is quite normal as the tissue of the rectum and colon don't know that it's not being used anymore and still continue to produce mucous.

Diarrhea and constipation can still occur, but ileostomates are more prone to food blockages. All ostomates will need to relearn their bowel habits as both gas and stool pass through their stomas and they won't be using toilet paper the same way again!

Bathroom habits are just not socially acceptable topics. Some patients feel dirty all the time. Individuals who are fanatical with being clean have a very difficult time adjusting to life with an ostomy. While ostomy pouches are designed to be odor proof and waterproof, they are not self-cleaning. Some ostomates choose to rinse out their pouches after emptying, others empty and go on their way. Manufacturers do not encourage rinsing as the bags are designed to be odor proof. Accepting the fact that you will have stool in the front and not inside is another emotional hurdle to overcome. Pouch covers, specially designed underwear, binders and opaque pouches are helpful here.

### **Psychological Adaptation**

Much of your emotional healing will depend on if your surgery was planned or due to an emergency. Other factors that impact your psychological well-being are your age, relationship status, social support, the reason for your ostomy and how you view yourself. If your surgery was planned, your surgeon or Wound Ostomy Continence (WOC) nurse may have explained the surgical procedure and what an ostomy is. If your surgery was done emergently, you had no preparation and may be quite shocked when you awoke from surgery. Individuals who are physically and emotionally prepared for life with an ostomy adapt much easier to their stomas than those who are not.

Accepting and adapting to life with a stoma is an enormous task. So much has changed – the way your body looks, how you use the bathroom, maybe your clothing, diet and your self-image. You may be concerned that people look at you differently. You may

experience frequent ostomy leaks which make you very anxious about going out in public. You might feel that your body is not normal and that you don't fit in. You might also have fears that others are aware of your pouch or that you might be pooping in public!

What about your spouse? Will he or she be repulsed by your stoma? What will your children think? What about dating? Can people smell me? You may be wondering if you will ever be intimate again. Another factor in your adjustment to life with a stoma is your prior comfort level with looking at your stool and the process of defecation or toileting. Those who never looked at their stool or are very self-conscious of defecating (poo-shy) will be more challenged to accept their ostomy. Sensitive noses beware too. Body image has a profound impact on our self-esteem and social lives.

### **Altered Image**

Having a stoma requires a great deal of psychological adaptation and adjustment. Grieving the loss of your body image as it once was is a normal process. You might also be grieving the loss of a smooth abdomen, body parts, maybe even having a belly button. C.M. Parkes describes<sup>1</sup> five stages individuals go through with an altered body image:

- Realization – avoiding or denying the loss followed by experiences of unreality or blunting.
- Alarm – characterized by anxiety, restlessness, fear and insecurity.
- Searching – acute episodic feelings of anxiety and panic and a preoccupation with loss.
- Grief – feelings of internal loss and mutilation.
- Resolution – efforts to construct a new social identity.

It takes time to heal from ostomy surgery both physically and emotionally. Talking to other ostomates, your WOC nurse, attending support groups and social networking on the internet can provide the support you need to successfully adjust and adapt to life with an ostomy. Professional counseling may be helpful and antidepressants are sometimes necessary. Once you have gone through these stages of healing and education, you should be able to resume an active, rewarding and full life. Thousands of ostomates have returned to work, dating, playing sports, sexual intimacy, having babies and enjoying life to the fullest. Your ostomy will hold you back only as much as you let it.

### **References**

1. Black, P.K. (2000). *Holistic stoma care*. London: Harcourt Publishers Limited. ☺

Ask Dr. Rafferty from page 6

pulling the muscles together – imagine the letter “U” as the opening and to close it the sides of that letter are brought together.

Then, the healing process in the pelvis and perineum begins. It starts with inflammation and ends with scarring. This process continues for about a year until complete. Patients who are thin can have discomfort from the tissues being rearranged and from sitting on the tip of their tailbone. Most patients have enough fatty tissue to pad the area, but occasionally, some of the fat padding around the tailbone must be removed.

If you have a job that requires prolonged sitting, consider padding the seat with a firm cushion and try to take frequent breaks to stretch. Look into “chairs” take the pressure off your backside and shift it to your knees.

### Sleep Tight

*I have been told that you should never lay on your colostomy or that side. Is that true? Lately, I have been waking up on my colostomy side. Am I hurting my stoma*

*or doing any other harm?*

L.M.

Dear L.M.,

It is OK to sleep on the side where your stoma is located. You will not harm it in any way. Most important is that you are comfortable, have no pain, and sleep well. If your stoma appliance fills with stool while you sleep, you may be a bit more prone to have a leak, but you will not harm the stoma itself. ☺

### More Advice



The “Ostomy Information” section of the UOAA website has answers to many common ostomy questions. Seven guidebooks, a frequently asked question section, brochures, fact sheets, reference cards, irrigation information and more are all just a click away.

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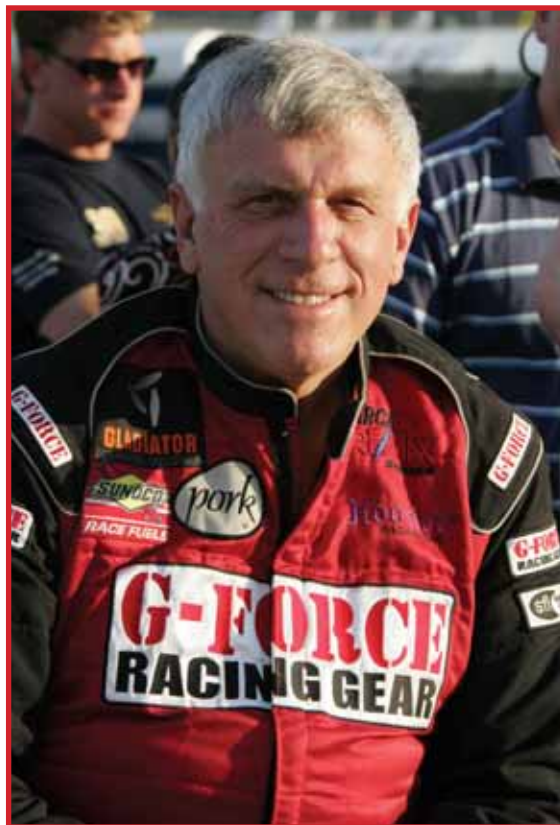
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# Tim Mitchell

## Lives His Dream Behind the Wheel



By Ilona French

Determined not to let colon cancer – or an ostomy – get him down, veteran race car driver Tim Mitchell continues to pursue his passion in his #06 race car by always striving to beat the competition and capture the checkered flag.

Mitchell's race career started at age 21, when he drove on local dirt tracks for about 15 years. While he did take a break from racing, he came back to it after the opportunity to drive part time in the renowned stock car series ARCA (Automobile Racing Club of America) in 1997. "We have always been an unsponsored team, so I have not had the best of equipment," said Mitchell. "Not having the money to buy new tires, I would race on used tires that other teams would give us."

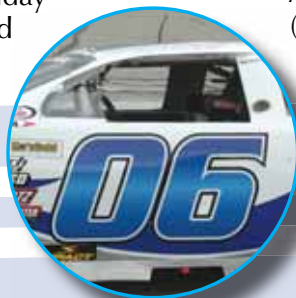
"At the Atlanta race in April of 2003, I had a good car but just did not have any good tires to race on. After finishing 19th in that race, I got out of the car and told everyone that I was quitting racing. I bought me a Harley Davidson motorcycle and rode it on Sunday afternoons to take the place of racing." And

that could have been the end of his racing pursuits, but as he later learned, the adventures were far from over.

Mitchell, who resides in Fayetteville, TN first detected something was wrong with his health when he frequently had the urge to go to the bathroom, but when he tried, nothing happened. Symptoms persisted until one night he woke up in bed drenched in blood. "My hands were covered in blood...I had to take all my bedding off and wash it immediately," said Mitchell. "It scared me, so much blood. Naturally, I went to the doctor the next day and then they scheduled me for a colonoscopy."

Mitchell soon learned that blood had built up and collected in polyps, putting pressure on his rectum, giving him a false signal that there was stool there. "After the blood passed through and whatever was holding the blood burst and I lost all that blood, I had the symptoms (of having to go to the bathroom) no more," said Mitchell. "That was how it originated."

After being diagnosed with colon cancer (seemingly without any other related health



issues in the past) Mitchell, then age 60, decided to go to the Mayo Clinic at Rochester, MN for another opinion. "Dr. Richard Devine performed an examination as well as tests and recommended that I have surgery to remove a small portion of my colon and my rectum – ostomy surgery – which meant that I would have to wear a bag for the rest of my life."

Mitchell was scheduled for surgery in November of 2003. "I remember checking out of the hotel where I was staying at about 6:00 a.m. and walking to the hospital for surgery. That was a very long walk for such a short distance," said the U.S. Army veteran. "I didn't ask God to heal me; I just asked Him to give me the strength to take whatever He had in store for me."

After surgery, Mitchell was put in a semi-private room. The first thing he did was call family and friends

to tell them he was all right. But soon thereafter, the procedure and all the emotions that came with it had taken their toll. "I was feeling down because I knew that I had been changed and would be changed for the rest of my life," he said.

Mitchell, disheartened and depressed, did not immediately pull up the hospital gown to examine the ostomy. "The ostomy nurse came in and checked to make sure everything was okay and then in a day or two, the nurse showed me how to change the wafer and the pouch," he said.

After several days in the hospital, he finally felt like he was going to live again. "About the fifth night, I turned the television on and they were interviewing Chris Reeves, Superman (then and there) live," he said. After watching the late Reeves, who had

"I pulled my hospital gown up and looked at my stomach and I just said, 'I don't have any problems.' From then on, life has been great!"





become paralyzed and confined to a wheelchair after an accident, Mitchell made a decision. "I pulled my hospital gown up and looked at my stomach and I just said, 'I don't have any problems.' From then on, life has been great!"

When people ask Mitchell how he feels, he tells them he feels good. "I tell them I feel guilty if I complain because I know there are so many people that are in worse shape than I am," said Mitchell, who does indeed have pain, though not severe, almost every day.

Mitchell, whose lifelong dream was to race for a living, doesn't make a living at it, but has had the opportunity to race with drivers such as Ryan Newman, Ken Schrader, Tony Stewart, Kyle Bush and many other well-known champs. "No one in my family races and I grew up on a farm, so I was not exposed to any type of racing, but it was just in my blood to race."

Just before surgery, Mitchell told the doctor that he had a goal to reach: to get back in a race car one more time. "In February 2004, I asked car owner Wayne Peterson if there was a chance that I could drive his race car at Nashville, TN the following April. Not only did I drive at Nashville, but finished 16th in driver points for 2004, 17th in 2005, 19th in 2006 and 17th in 2007. I also had a 20th place finish at Daytona in February 2008," he said. "I feel like a winner just being able to

race and compete at this level."

While Mitchell was concerned about his stoma the first time he jumped into a race car after surgery, he says he has no problems or challenges racing with an ostomy, since the seat belt and shoulder harness actually hold him in and keep pressure on his stomach. "It's very good therapy for a person that's in racing to get back in a car to race again," he said.

Mitchell does, however, admit that during the first year after surgery, when the racing season started up, he helped work on the race car, picking up and changing tires and performing other arduous duties involved in prepping for an event.

"I overdid myself. I started working out at the health center and lifting weights," he said. "I overexerted myself just trying to make sure that I didn't get down." This led to the formation of a large hernia that had to be removed at his one-year checkup. Now his stomach is held in by a piece of mesh and he's careful not to do any heavy lifting or strenuous work.

"Having an ostomy is not something that I would wish on anyone, but I don't let it limit me from going places or doing things that I enjoy doing," he said. "I watch the expressions on people's faces when I tell them that I have an ostomy and see a frown or an awkward expression. Then I tell them that it is not that bad. It's

just whatever you set your frame of mind to."

In addition to his racing career, Mitchell owns and operates two roller skating businesses and enjoys riding his Harley Davidson and raising a garden every year. "I have had really no hurdles to cross because I accept what I have and make the best of what I have. I look forward to living one day at a time and thank God each morning when I get up for allowing me to live another day. I have to thank Wayne Peterson for having faith in me to drive his race car and ARCA for allowing me to race and live out a dream."

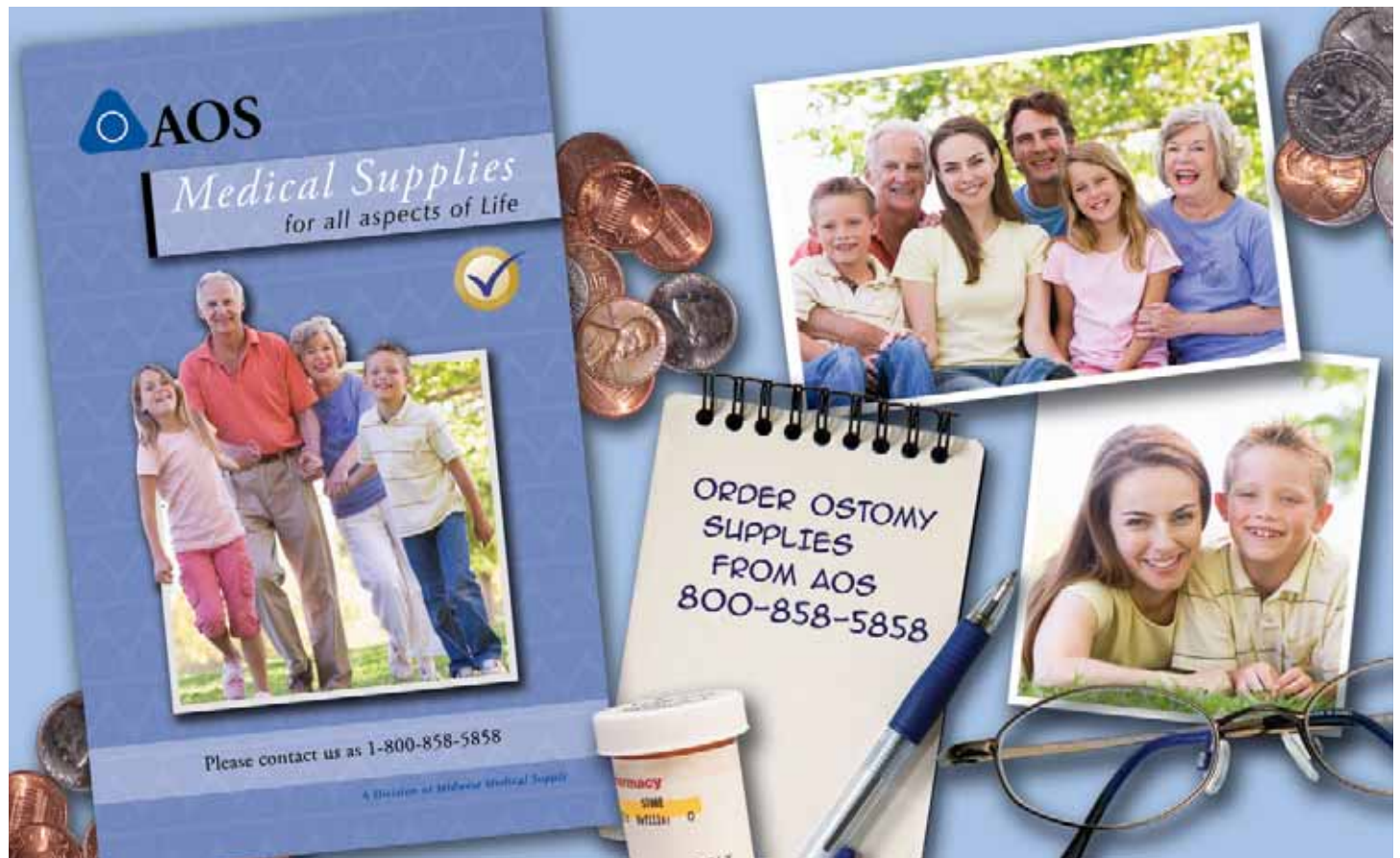
What's in store for the future? Mitchell is determined to continue racing and make it to the front of the pack. "I have a good program to offer anyone that would like to sponsor a race car for one race or for the entire season," he said. "I feel with enough sponsorship that I would be able to finish in the top 10 in driver points."

Mitchell, who received his first colonoscopy at age



60, believes everyone, especially men, should have the procedure at age 50 and thereafter every three years. "I might not have lost my rectum if I had been screened earlier," he said. "My goal is to become a motivational speaker and to help people that are facing trials in their life and to put their trust in God. Life was great before the ostomy and life is still great. I see a bright future."

Mitchell welcomes opportunities to share his story and motivate others at speaking engagements and, additionally, seeks race sponsorship. Contact him at 931/433-0111 or [TimMotorsports@bellsouth.net](mailto:TimMotorsports@bellsouth.net).



# Basic Colostomy Care

## Learning the ins and outs of basic pouch management and equipment

By Leslie Washuta,  
RN, BSN, CWON  
Certified Wound/  
Ostomy Nurse

Learning to care for your new colostomy or ileostomy can seem like a very daunting task – odds are you have no experience in this very personal care. It's definitely uncharted waters. Fear not! With the help of capable ostomy nurses and the support of family, friends, support groups and mentors, as well as your inner strengths, you'll learn the critical skills and will develop the confidence to provide your own ostomy care.

### In the Hospital

There are, of course, many things to learn in a relatively short period of time. Considering that the average hospital stay following surgery is usually five days, you cannot begin to learn it all while in the hospital. If you do, you'll surely qualify for the "new ostomate of the year" award! Realistically speaking, there are just too many topics to cover and you may not be clear mentally for several days following anesthesia.

Bowel surgery/ostomy patients are generally released from the hospital once all the tubes are out and a liquid or soft diet is tolerated. For a colostomy, it may be that your ostomy has not actually worked yet! On the other hand, an ileostomy can be expected to start "functioning" within the first few days and you will have at least passed that hurdle before going home. Be sure to talk to a discharge planner before you leave the hospital and ask to be referred to a home care nursing agency so you can continue the vital ostomy teaching that has been started by the nurses in the hospital.

Let's consider some of the daily aspects of caring for

your ostomy. These are critical to developing knowledge and confidence as you recuperate from your surgery and eventually get back into your daily routine.



### Types of Ostomies

First, learn about your type of ostomy from your physician and/or ostomy nurse. Ask, "Is it a colostomy or an ileostomy?" Learn the particular reason the ostomy was done and whether it is permanent or temporary. It is essential information that will help explain your particular situation and how long you will have it in the event that it is considered to be reversible down the road.

Because the ostomy will function unpredictably, at

least initially, virtually every person with a new ostomy will be taught to wear an "appliance" or pouching system. The pouching system serves as a collection reservoir on the outside of your body where the discharge from the stoma is stored until you empty or change the pouch. It is usually attached with adhesive to the skin surrounding the stoma (peristomal skin). A non-adhesive system is available, but it is unlikely that you will be introduced to this system initially.

Another major function of an appliance is to provide protection for your skin, as the stool that is expelled can cause irritation or soreness if it has constant contact with your skin. Using an appliance that adheres properly generally prevents skin irritation.

### Pouching Systems

Pouching systems are made of two primary components: a wafer (also called a skin barrier or faceplate) and a pouch. The back of the wafer is covered with adhesive to attach to your skin and has a hole in the center for the stoma to fit through. It is designed to protect your skin from stoma output and is an "anchor" for the pouch. The pouch can be transparent or opaque, drainable or a "closed end" and offered in different

sizes and styles.

A “closed-end” pouch, available with both systems, is considered to be disposable. Ostomates who have fairly solid stools once or twice a day can simply remove and throw out the pouch when soiled. This would be in lieu of washing out and re-using a drainable pouch.

### One-Piece or Two-Piece

Furthermore, all pouching systems are either one-piece or two-piece systems. With a one-piece system, the skin barrier and pouch are manufactured as one unit. A two-piece system consists of a skin barrier and pouch that are joined together. Usually, a snap-on ring or Tupperware® style seal is used, but a newer style uses an adhesive coupling method.

Each style has its advantages and disadvantages, so let’s take a look at each style to learn more about each of these choices. The steps to changing the appliance will be detailed later in this article.

A two-piece appliance offers a few more variables when being applied and also during the course of wear-time. The first piece, the wafer, is placed on the skin and can stay there for several days. The pouch can be snapped on and left in place for the duration of the wafer wear-time, essentially using it like a one-piece system. Or, as is fairly common practice, you can remove the pouch from the wafer as often as necessary to empty, clean, or change it, leaving the wafer in place until it is ready to be changed. With a two-piece system, you can also vary the style of pouch you use; some people will use a drainable pouch most of the time, but change to a small closed pouch or cap that can snap onto the wafer during special times or intimate moments.

Probably the biggest disadvantage of a two-piece system is making sure that the two rings (on the wafer and on the pouch) are lined up and properly snapped together; if not done properly, the pouch could unexpectedly come off. Fortunately, this rarely happens though the possibility exists. If you choose to use a two-piece system, the pouching options can give you a little more versatility because of the fact that you can mix-and-match the pouches to the wafer to suit your lifestyle.



*Ostomy pouch wafers, also called skin barriers or faceplates.*

The one-piece appliances tend to be simpler to use since there is one less step to the application procedure than a two-piece system. This can be an advantage in terms of time and simplicity; the fewer pieces to handle, the quicker and simpler to use. A disadvantage is it may be a little challenging to “line up” the opening of the skin barrier exactly with the stoma.

This may be more difficult if your appliance is opaque and prevents you from seeing through the front of the pouch. However, this can be overcome with practice. With a one-piece system, you cannot remove the pouch without removing the skin barrier, which is possible with a two-piece appliance. Some people might consider this to be a disadvantage in the pouch-cleaning process; others aren’t bothered by this aspect.

### Changing Systems

Your initial choice in an appliance style will be guided by the products available at the hospital where your surgery was performed and by the knowledge of the nurses that are teaching you. As you become more knowledgeable about living with your ostomy, chances are that you may want to change to an appliance that offers different features from your original product. Look to your ostomy nurse, product manufacturer or UOAA affiliated support group for help in fine-tuning your selections in order to determine what’s just right for you.

### Accessories

In addition to the basic pouching system, ostomy accessories may be a part of the fine-tuning process to enhance wear-time, comfort or stoma management. These accessories include skin prep, stoma paste or strip paste, adhesive rings/sprays and convex rings.

These products are designed to improve skin barrier adherence if you have dimples, folds, a flat stoma or problems with leakage. Stoma powder is also available for use under the wafer for sore skin; see an ostomy nurse if you think you need any of these products.

Other accessories include items such as an ostomy belt, ostomy deodorant drops or spray and oral deodorant tablets. The belt, if needed, attaches to tabs on either



*From left: Schena one-piece pouches (left has a convex wafer) – note the built-in flushing mechanism; ConvaTec drainable, two-piece pouch. Hollister one-piece, closed end pouch.*

side of the pouch, snugly but comfortably encircles the body, and helps lend support to the appliance. The deodorizing products help to cut down on the odor in the pouch or those formed in the gut.

Adjustments in your product choices may be needed based on the characteristics of your stoma and stoma site. One look at any ostomy product catalog will tell you that there is an overwhelming number of ostomy products and accessories to choose from! Making a choice or product change is best done with the advice of a professional, such as your ostomy nurse, who has experience in fine-tuning product selection to meet your specific needs and will be glad to offer you guidance in this area.

### **Wear Time**

How often you change the appliance will depend on personal preference as well as your stoma characteristics. It's best to set up a regular schedule. Think in terms of a four-to-five day wear-time and make notes on your calendar that will keep you on schedule. Your wear time may be reduced to perhaps three-to-four days if the stoma is flat or is located in a recessed or dimpled area or if your stool is watery as with a new ileostomy.

Build some flexibility into your schedule and err on the side of caution, changing earlier rather than later if at all in doubt. As you gain more experience with your stoma, you will develop a routine that suits you best.

When getting ready to change your ostomy appliance, prepare your new appliance and any accessories for quick and easy handling. Lay out all your products before the actual change to make certain you have everything you need and to expedite the process.

### **Changing Your Pouch**

Your basic products will include a towel and washcloth, soap (optional), new appliance, scissors if cutting the wafer opening, any accessories you are using and a garbage bag for disposal of soiled products. Don't

forget your pouch clip if needed. Toilet tissue is also handy for wiping around the stoma should any fecal matter be expelled as you work. Gloves generally are not necessary for ostomy care, just good handwashing before and after are sufficient.

Then, prepare your new wafer. Wafers come either pre-cut or what we call "cut-to-fit," which requires a little craftiness with the scissors on your part. Chances are you will be using a cut-to-fit wafer for the first four-to-six weeks after surgery while your stoma is shrinking or if your stoma is oval rather than relatively round. Most pre-cut wafers have round holes, although custom cut products can be ordered from several manufacturers. If you're cutting your wafer opening, do so ahead of time.

Use the size markings on the wafer backing or trace the proper measuring guide circle or your own pattern onto your wafer, then cut with your scissors. Be sure to use a pattern no more than 1/8" larger than your measured stoma size. Remove the paper backing and then add any stoma paste, adhesive strip paste or adhesive rings used as a part of your routine care to the back of the wafer/skin barrier. Then set that wafer aside with the sticky side facing up.

Ready your new pouch now, too. Attach the clip or fold the tail end of your appliance if using a drainable product and insert deodorant drops into the opening of the pouch, if you use them. Then proceed with your appliance change, knowing that you are well-organized and well-prepared. If the phone or doorbell rings, ignore it! They'll call or come back!

As you remove your old wafer or skin barrier, you may find that using an adhesive remover wipe will help break the adhesive seal and is a little gentler and kinder to your skin. Those fine hairs under your wafer may also thank you for it! This product also helps to remove any wafer or paste residue left behind on the skin. Be certain to wash all the remover solution off before proceeding with adhering your new wafer or appliance.

### **Skin Care**

The next and very important step is proper skin cleansing of the ostomy site. You can do this either sitting or standing near the sink or in the shower with your

appliance off, using a soft wash cloth. Soap and water are often recommended for routine care of the skin surrounding the stoma; however, a small percentage of people with ostomies use clear water only (without soap) for their skin care routine.

My preference is to use a non-creamy bar soap that will not leave any residue on the skin. Next, pat your skin dry using a soft cloth or paper towel. Exercise caution if opting to use disposable, pre-moistened wipes for your skin cleansing as many of these products contain lanolin that can interfere with the adherence of your new appliance – check the label. Please note that the stoma itself does not require cleaning; just wipe off any stool with toilet tissue and you're all set.

Inspect your skin around the stoma, noting any redness or sore areas that will require extra attention or treatment. A hand mirror will help you look along the lower border of the stoma if unable to visualize it otherwise. The skin under your wafer/skin barrier should look like the skin elsewhere on your abdomen. If you notice increased redness or sore skin, examine the back of the appliance or wafer you just removed to look for

signs of leakage.

Peristomal skin will most likely stay “healthy” if your appliance is sticking well and you change it on a routine schedule before the adhesive gives way. Please don't wait until it leaks to decide it's time to change it – chances are you'll have reddened or even sore skin if you procrastinate! Not fun!

### Solving Skin Irritation

If skin irritation does occur, try to figure out why. Your stoma site may have irregularities as mentioned above and the stool undermines the adhesive seal. You may need to add accessories such as paste, barrier rings or strip paste or a convex wafer with a belt to compensate. It would be best to discuss this with your ostomy nurse or call the product hotline of the supplies you are using for advice if facing such a problem. Ignoring it won't make it go away! Remember that old adage about an ounce of prevention...

Treat a skin irritation by dusting the irritated skin, once washed and dried, with a stoma powder designed specifically for use around the stoma. Once you have

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**Comparing Pouching Systems** (adapted from Pouching Systems Patient Educational Sheet July 2009)

One-Piece	Two-Piece	Two-Piece Adhesive Coupling
Barrier and pouch are one unit	Barrier and pouch are two units	Barrier and pouch are two units
		
Minimal hand strength and dexterity needed	Some hand strength and dexterity is needed	Minimal hand strength and dexterity needed
Fewer steps are required as the pouch and barrier are already attached	May be easier to apply as you can see the stoma during application	May be easier to apply as you can see the stoma during application
Lower profile may be less noticeable under clothing and is flexible	The pouch can be changed more frequently than the barrier	The pouch can be changed more frequently than the barrier and is flexible and less noticeable
Unless you remove the entire system, you will be unable to: * Readjust your pouch * Interchange between various types of pouches	You can interchange the type and/or size of the pouch (drainable/closed-end, etc.) without removing the barrier	You can interchange the type and/or size of the pouch (drainable/closed-end, etc.) without removing the barrier
The barrier is flexible (no rigid plastic ring). Flexibility may be needed for uneven abdomens and more comfortable	The barrier is less flexible Less flexibility may help support loose skin around the stoma	The barrier is flexible (no rigid plastic ring). Flexibility may be needed for uneven abdomens and more comfortable
Offers a lower profile than the standard two-piece system A drainable pouch or closed-end pouch is available	The two-piece system can be "burped" to let the gas out from the pouch by briefly releasing a small section of the pouch from the barrier	Offers a lower profile than the standard two-piece system The two-piece adhesive coupling system can be "burped" to let the gas out from the pouch
This may be an option for the school age child or adolescent who is more aware of "body image" and visibility of their pouch under their clothing. Consider for under a bathing suit or other tight fitting clothes where discretion is the main concern.	Consider in infants or children who experience a lot of gas	Consider in infants or children who experience a lot of gas This may be an option for the school age child or adolescent who is more aware of "body image" and visibility of their pouch under their clothing

*Product photos courtesy of Coloplast*

created a dry surface with the powder, seal it to the skin by patting with a “no-sting” skin prep and allow to dry. Then proceed with your ostomy appliance products as usual. Plan to change the appliance a little sooner than usual to check the status of your skin.

In some cases, if a rash occurs around the stoma that is red, raised, and itchy, it may be a yeast infection that will require a special anti-fungal powder application, sealed by skin prep. Actual allergic reactions to ostomy products are rare, but should be suspected if other causes are not found. Seek advice from your ostomy nurse or your doctor regarding any ongoing skin redness, rash or irritation, particularly if it has not resolved after one or two appliance changes.

## Colostomy

Pouch care and cleansing will vary with the type of ostomy you have. If you have a colostomy, the possibility exists that you may have fairly regular bowel movements each day depending on your surgery, how much colon was removed, eating habits, and your previous usual bowel habits before surgery. If your bowels move once or twice a day, you may choose either a closed-end or a drainable pouch. Closed-end pouches are usually discarded when changed after a bowel movement, whereas drainable pouches are almost always emptied, cleaned out and used again for several more days.

## Pouching Tips

Another option is using a filter. Many, though not all, pouches are designed with a small filter placed near the top. The filter will allow expelled gas to escape from the pouch through a small, pin-sized opening that is backed by an odor-absorbent product, such as charcoal. If your pouch does not have a filter, you will need to let gas out either by opening the tail (if a one-piece) or by “burping” your wafer and pouch where the two-pieces snap together. Be sure to do this in the bathroom where fecal odors are expected; use an air freshener out of consideration for the next user.



*From top: Coloplast strip paste; Nu-Hope support belt; ConvaTec Eakin Seal; Hollister pouch lubricating deodorant; Nu-hope adhesive.*

Adding a pouch deodorant is considered an optional step, but one practiced by many people with a colostomy and some with an ileostomy. Special liquid, droplet or spray deodorizing products can be added to the inside of the clean pouch that will help cut down or eliminate the odor.

This makes it a little nicer for you, too, if you are queasy about certain smells. One side benefit of deodorant drops or sprays is that they often “lubricate” the inside of the pouch, making for easier cleaning if you opt to re-use your pouches. Orally-ingested products are also available to help deodorize the stool internally before it gets to the pouch. Your ostomy nurse can advise you further about using these products.

## Controlling Odor

It’s important to know that nearly all ostomy pouches are now designed to be odor-proof, that is, they will not allow odor to escape when properly closed and adhered to your body. Of course, once you open the pouch, any odor present will escape. If you detect fecal odor when you don’t expect it, you should examine your appliance for any signs of leakage and change

it accordingly. This can be the first clue that a leak is imminent, so investigate before an “accident” happens.

For additional information regarding all aspects of ostomy care, product selection, dietary concerns, activities, social and employment considerations, and many other topics, check out the many resources available to you. These will include your ostomy nurse, teaching pamphlets and videos provided by ostomy product manufacturers, your local ostomy support group members, and many ostomy information and networking sites on the internet or available by phone.

The United Ostomy Associations of America ([www.uoaa.org/800-826-0826](http://www.uoaa.org/800-826-0826)) is just one example of a wonderful resource where you will find basic ostomy information, on-line discussion forums, find local support group information, watch ostomy videos and much, much more. ☺

# Peristomal Skin Care

## Tips and techniques for adhering a pouch over red and moist skin

By Joan Junkin, MSN,  
APRN-CNS, CWOCN

Crusts are good for more than keeping bread fresh! Making a “crust” around your stoma can provide a better seal, especially if your skin is red and a bit moist. The crust involves a special powder and liquid skin barrier. It is simple to do and a skill that is handy to have in case you ever have a rash, sore or red area near your stoma that makes it hard to get a pouch wafer to stick very well.

### First Step

Consider consulting your ostomy nurse if you are not confident about stoma care yet. It is possible that the skin contours near the stoma have changed and you may need a different type of wafer. If you are experienced and know what changes to watch for and what to do about it, please read on.

However, even if you are experienced and you notice that your solutions are not working, please contact your ostomy nurse for a second opinion. Many nurses do not have a stoma, yet we have been taught what to watch for and how to deal with most situations. The best way we have learned is from people who do have a stoma! That’s the favorite part of an ostomy nurse’s job – to see your great problem solving techniques and then pass them on to others!

### Moist Skin

When skin gets sore or red it often oozes a bit of moisture. That is what prevents the wafer from sealing well. If the wafer seal is not good, stool or urine causes more soreness and a vicious cycle can occur! In this situation, there are two techniques that can help. The first method costs more, so if your insurance will not pay for the product discussed, or you don’t mind trying

the second method, you might consider that instead.

The first method involves using an ostomy ring or strip over the moist area. There are many to choose from including Coloplast, ConvaTec, Genairex, Hollister and Marlen. These are all a putty type material, a lot like clay. You can squish it and form it to whatever you need. It helps to take a piece of it, flatten it between your fingers and place it directly over the red area. This material is able to soak up the moisture so you can keep a better seal. You may also try adding a ring of the material all the



Photo courtesy of Hollister Incorporated.

way around the stoma. Think of caulking a window so wind doesn’t get in, only this time we’re trying to keep something from leaking out instead!

### Crusting

The second method takes a bit more time, but is also quite effective and usually costs less. It is called ‘crusting.’ Crusting involves lightly covering the sore or red area with a powder, moistening the powder, letting it dry, then repeating the process a couple more times. Which powder you use depends on the type of rash or sore you have. If the rash is spotty (see photo #1) it may be a fungus, like heat rash.

This is especially likely if the rash area is also itchy. These rashes are quite common, especially when it is hot and humid or if your skin around the stoma tends to get sweaty often.

For a spotty rash suspected to be fungus you may want to speak with your ostomy nurse or doctor, especially if this is the first time you’ve gotten it or it’s not getting better within a week. Crusting for a spotty rash like fungus involves getting an antifungal powder – there are many non-prescription products available. It will say ‘anti-fungal’ on the package.

After discussing this with your ostomy nurse or doctor, gently cleanse the area by soaking it for a few minutes with warm water. It is not recommended to use

soap since most soaps are alkaline and fungus actually thrives on alkaline skin.

### Skin Barrier

After cleaning the area around the stoma gently, let it dry well. A hair dryer on a cool setting may be useful. Then, lightly dust the rash area with the anti-fungal powder and moisten the powder with a liquid skin barrier. Most liquid skin barriers contain alcohol, although you can find “no sting” barriers without alcohol. It is preferred to use the non-alcohol type when you have a rash or sore because regular ‘skin prep’ with alcohol will sting and is harsh on the injured skin.

Apply the non-alcohol liquid skin barrier by either spraying it over the powder or gently pat the powder with the wipe or swab containing the liquid. After you have moistened the powder, allow it to dry. You will know it is dry when the color lightens. When dry, lightly dust the area again with more powder and moisten that layer of powder the same way. Many people add a third layer of powder moistened with liquid skin barrier.

For a red area or sore near the stoma that does not look like a fungal rash, you can use the same process as above, but use an ostomy powder instead of anti-fungal powder. There are many ostomy powders – they all can absorb a little bit of moisture and they all get sticky when moist.

Some of the more common brands include ConvaTec Stomahesive Powder; Hollister Adapt Powder and Coloplast Ostomy Powder. You can also use pectin powder which is similar. The process is the same: lightly dust with the ostomy powder, moisten it with a non-alcohol liquid skin barrier, let it dry and repeat once or twice. This process takes just a few minutes after you become comfortable doing it. You might want to try it on easy-to-access skin first to get the hang of it before trying it on the tender skin near your stoma.

This process, known as ‘crusting’, provides a layer of powder/dried barrier that can absorb a bit of moisture from the sore skin so you can maintain your seal. Remember, neither of these methods, crusting or using an ostomy ring or strip takes the place of a properly fitting appliance. It is always important to make sure the hole in the wafer is the right size and that the appliance is fitting into any contours of your belly. If the appliance doesn’t fit well there is no amount of crusting that will help. In that case, it is important to seek help from an expert such as a certified ostomy nurse.☺

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