



*A Handbook
for New
Ostomy
Patients*

*Produced by the Vancouver United
Ostomy Association Chapter Inc., a
chapter of Ostomy Canada Society Inc.”*

seventh edition, 2017



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Thank you!

IMPORTANT NOTICE:

This publication is written and compiled by people who have had the same surgery as you. It contains practical advice and tips for managing and learning to live with an ostomy, and is meant to supplement, but not replace, the information given to you by your doctor, ET nurse or other health care professional.

The information in this publication is of a general nature, not specific medical, or other professional, advice. If you need medical, or other professional advice or assistance, consult your doctor or ET nurse as soon as possible.

We believe the information in this publication is correct and will be useful, but by using this publication you agree that the Vancouver Chapter of the United Ostomy Association of Canada, its members, directors and officers will not be liable to you for any injury or loss caused by your use of this information.

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In Canada alone, there are approximately 13,000 new ostomy surgeries performed every year, with an estimated population of 750,000 North Americans living with an ostomy. If you are reading this, chances are you have already had ostomy surgery or are about to.

Colostomies, ileostomies and urostomies are performed on people ranging in age from infants to the elderly, for a wide variety of causes. Disease, complications from other surgeries or childbirth, birth defects and severe injury are all reasons why ostomy surgery may be necessary. Whether the ostomy is permanent or temporary, it can be a difficult adjustment for the patient, and for their family and loved ones.

This handbook is based on the experiences of those who have had ostomy surgery and/or live with an ostomy. We've been through what you may be experiencing and understand the frustrations and fears you may have. It is our hope that this handbook can help answer your questions and reassure you that there is much good life to be lived after ostomy surgery.

Do you have an ET nurse?



Regular follow-up in the first year after surgery is essential to prevent and address possible complications.

ALL ostomy patients should see an Enterostomal Nurse Specialist (ET) six to eight weeks after surgery.

It is strongly recommended that you then see an ET nurse specialist three months and then six months after surgery to monitor your ostomy and skin health.

If the hospital where you had your surgery does not offer out-patient follow-up, ask your pharmacy or clinic where you buy your supplies if they offer ET nurse consultations.



For listings of clinics or pharmacies that offer ET nurse consultation go to:
www.uoacvanicouver.weebly.com

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*Choosing
the Right
Appliance*



CHOOSING THE RIGHT APPLIANCE

First of all, a bit of clarification on terminology. You may have already heard different terms and are confused about just what exactly they refer to. 'Bag' or 'pouch' refers to the part that collects waste. 'Flange', 'barrier', 'wafer' or 'faceplate' all refer to the part that sticks to your body. The general term 'pouching system' refers to the entire system (one or two-piece) that is used. The general term 'appliance' is also sometimes used.

Pouches (or bags), whether they are one or two-piece can also come in 'closed end' or 'drainable' models. A drainable pouch has a clip or velcro closing on the end that can be undone to release waste. A closed-end pouch has no opening or clip, and is removed and discarded instead of emptied. Many pouches are now made with filters near the top which allow gas to escape without odour.

The material that the barrier (or flange) is made out of can come in different types, too. Some are called standard wear and other are extended wear. In general, a standard wear barrier is used when stool is semi-formed or formed. An extended wear barrier is usually used when a stoma drains urine or stool that is loose or liquid. The extended wear barrier does not break down like a standard wear barrier when it comes in contact with liquid waste.

Most hospitals in the lower mainland employ one or more ET nurses, who are also referred to as Enterostomal Therapy/WOC (Wound, Ostomy and Continence) nurses. These are nurses who have taken specialized training in ostomy care. You will be discharged from the hospital with a supply of ostomy products recommended by your ET nurse to get you started. (You will be billed for this first batch of appliances.) After that you must purchase your own. But where to start and what to buy? The variety of appliances available can seem bewildering at first. Two-piece, one piece, closed, drainable, different sizes, different brands -- how does one choose? No one expects you to learn it all at once. You may find that the product introduced to you by your ET nurse or hospital works well and stay with that, or you may not be satisfied with the look or performance of your first type of appliance. We encourage all new patients to learn about different

brands and types and to try new appliances. Your ostomy may be permanent or it may be temporary -- either way you owe it to yourself to find and wear the best possible choice for you for as long as you will have the ostomy.

The Ostomy Canada Society does not endorse one brand or type over another -- all have merit. What works well for one patient may not suit another, and what one person swears by others don't like. Everyone has different needs and preferences. The most prevalent brands in our area are Coloplast, Convatec, Hollister, Marlen, SALTS, B Braun and Cymed. Your ET nurse is the best source to ask to try different product samples if something isn't quite working for you as she or he will know your ostomy and skin characteristics. If this isn't possible you can contact the manufacturers directly. All have websites and toll-free numbers you can access for free samples. Call the manufacturers, tell them what sort of ostomy you have, and what your particular concerns are. It can take several weeks for samples to arrive, so be patient. If you don't care for what was sent, you can ask for more samples. Companies want you to try their products! It's definitely worth your time to check out what they have to offer. You can also attend open houses sponsored by various pharmacies or community ostomy clinics to talk directly with ostomy sales representatives and get samples. It is beyond the scope of this publication to discuss all systems and brands, but this is a short guideline. For numbers to call, see manufacturers' listings in the back of this handbook.

TWO-PIECE VS ONE-PIECE POUCHING SYSTEMS

A two-piece appliance is composed of two parts: the flange, which sticks to your skin, and the pouch, which snaps or sticks onto the flange. A one-piece appliance has the flange combined with the pouch. There are advantages and disadvantages to both:

Two-Piece Advantages

- most are easier to 'burp', that is, allow gas to escape. This is a useful feature for ileostomates/colostomates who find that filters work poorly once dampened
- a smaller or larger pouch can be substituted without having to change the entire flange
- some have a 'floating flange' which is a type of flange that has an extra flexible joint at the circular ring. This can be an advantage for those with poorer hand dexterity who have difficulty snapping a pouch onto

a flange, or for those whose abdomen is very tender and pressing down to attach a pouch is uncomfortable.

Two-piece disadvantages

- tend to be bulkier and more visible under clothing, although with the newer thin and flexible flanges this is less of a problem than in years past
- the convex models are somewhat rigid and can be more difficult to couple
- more appliance 'inventory' to purchase, match and keep track of

One-piece advantages

- fewer components to apply
- soft convex is now available
- feel lighter, more flexible and have a lower profile under clothing

One-piece disadvantages

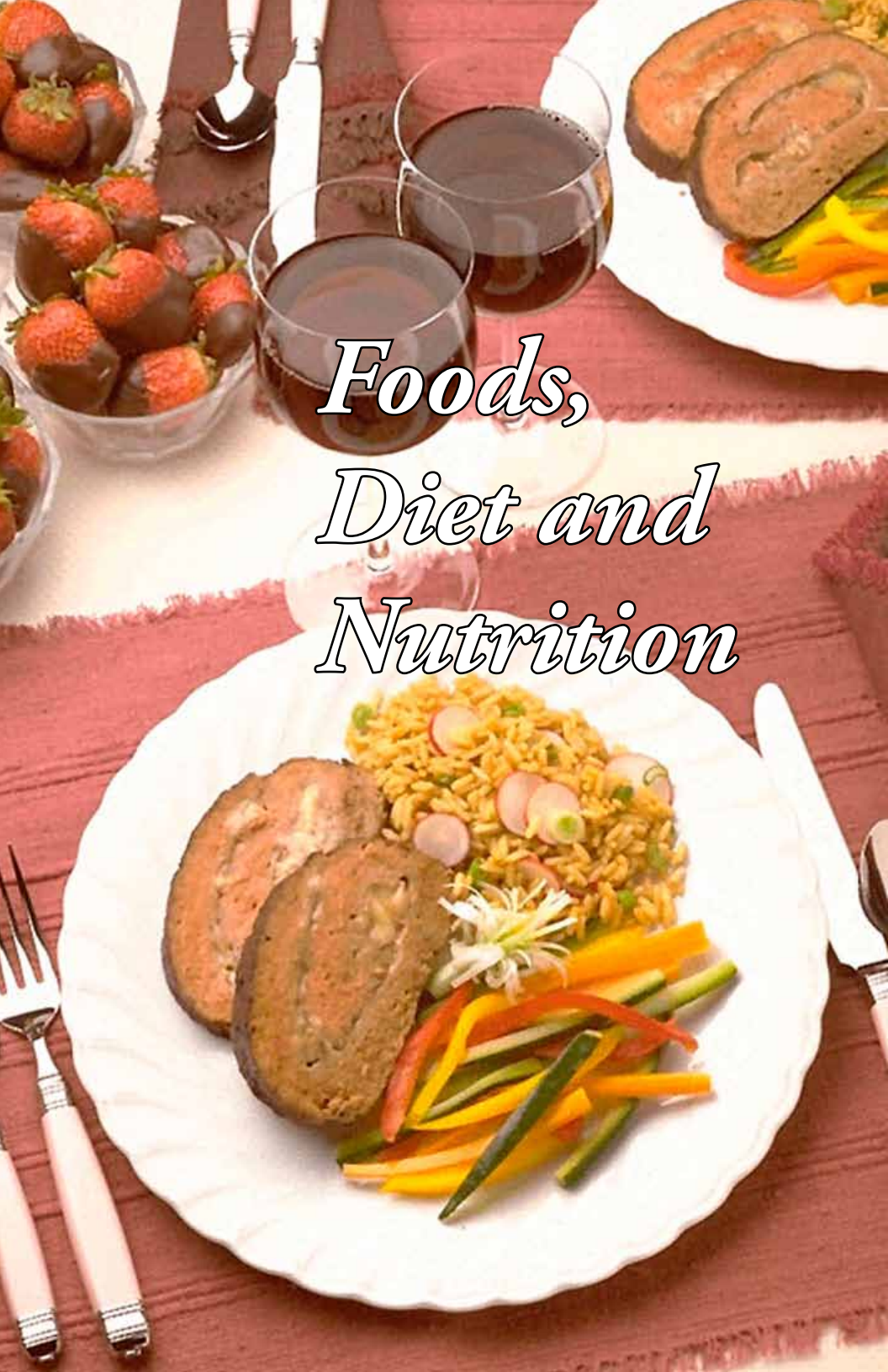
- can't be 'burped'
- some can cost more if you are using closed-end models (you'll need to throw them away every time you empty)

CONVEX APPLIANCES

If you have a very short, or flush stoma, or a deep contour around the stoma, you will probably need to use what is called a convex appliance. These are available in one or two-piece the same as standard appliances. The difference between a convex and a regular appliance is the flange is shaped in such a fashion around the opening so that when applied, it presses down on the skin around the stoma. This makes the stoma stick out more. Stomas that are short or flush do not always drain into the bag properly, causing leakage, so a convex flange may correct the problem. If you think your ostomy falls into this category, you should ask your ET what type of convex flange might work better for you.

POUCH LINERS

These are flushable, very thin plastic liners that fit inside a two-piece pouch. They perform best with colostomies or ileostomies with thicker output. When it comes time to empty, you simply remove the liner and flush it down the toilet, leaving your pouch empty and clean. These are popular with those who prefer using a closed-end appliance. Flushable liners can help save costs if this is a concern. This product is also available in a biodegradable material. Ask about these at your ostomy products supplier.

A top-down view of a dining table set for a meal. In the foreground, a white plate with a scalloped edge holds a portion of salmon, a serving of yellow rice with sliced radishes, and a mix of sliced yellow, orange, and green bell peppers. To the left of the plate, a clear glass bowl is filled with strawberries, some of which are dipped in chocolate. Two glasses of red wine are positioned above the plate. The table is covered with a red and white patterned placemat. Silverware with white handles is visible around the plate.

*Foods,
Diet and
Nutrition*

RESUMING A NORMAL DIET AFTER SURGERY

COLOSTOMIES AND UROSTOMIES

After the bowels have healed after surgery, colostomates and urostomates are usually able to return to their previous eating habits with little or no alteration. However, you should exercise some caution and common sense when eating for a week or two after you leave the hospital, just to be on the safe side. Chew your food well and take it easy with things like nuts, fruit skins, raw vegetables and popcorn. This applies as well to those who have undergone radiation to the pelvic area, as portions of the remaining bowel can be irritated by this treatment.

ILEOSTOMIES

It was once thought that many types of foods were strictly off-limits to ileostomates, but this need not always be the case. Ileostomy surgery removes most or all of the large bowel and may change how your body processes food. Ileostomates need to learn how their new body reacts to the foods they used to eat, and how to carefully re-introduce these items back into their diet. If you have an ileostomy, you need not fear mealtimes, just exercise moderation to start and CHEW YOUR FOOD WELL. Soft cooked items are gentle on a healing system. Raw fruits and vegetables or their skins may be hard to pass through your system. Although fibre is good for you and necessary for a balanced diet, you may need to experiment with what agrees and what does not. Fibre is not as necessary for those with ileostomies. Below are some common foods and hints on how to safely eat them for those recently returned home from ostomy surgery. (See lists on pages 15 to 16).

VEGETABLES

Vegetables like celery, asparagus, and broccoli can have long fibrous strands running through them. Such strands are hard to digest and can 'ball up' causing a painful blockage. When eating such vegetables, peel off the outer tough stalk, or eat only the tender 'hearts.'

Asparagus can cause odour in the urine. Onions can produce odour in the stool. Broccoli, cauliflower, and turnips are gas producers. Whatever give you gas before will continue to give you gas.

For some people, mushrooms, especially fresh ones, are notorious for going through the system undigested or causing blockages. Slice

them thin and yes . . . chew, chew chew. Corn on the cob, canned corn and popcorn are also often the cause of bowel obstructions or blockages. Eat these in moderation. If in doubt about trying a vegetable for the first time, peel the skin, and steam or soft-cook it. Beets can turn waste pink or red -- this is harmless.

FRUIT

Fresh fruit can, and should, be included in a well balanced diet. Bananas can be especially beneficial to ileostomates to replace lost potassium. If you are having trouble digesting oranges or grapefruit, try squeezing the juice and discard the skin and pulp. Try peeling apples, pears, plums and peaches to start off. Be cautious with fresh coconut. You may be able to eat all of the above items right away, however, post-surgery it's best to approach fruit with caution and moderation. Keep in mind that fruit is also a natural laxative that may increase bathroom visits. (for colostomies and ileostomies)

NUTS AND MEATS

Hard nuts such as peanuts, almonds and hazelnuts should be introduced in very small amounts and chewed well. Peanut butter will act as a stool thickener in some people, which can help with diarrhea. Poultry do not present major problems but steak, chops, roasts or hamburger must be carefully chewed and consumed in moderation. High fat items, heavy casings on sausage, and gristle may be more difficult to digest after ileostomy/colostomy surgery. Eat slowly, avoid the gristle and limit your intake.

SPICY FOODS

Heavily spiced foods and sauces can act as cathartics (cause loose stool) and gas producers.

FOODS THAT INCREASE ODOUR

asparagus	broccoli	brussels sprouts
cabbage	cauliflower	beans
eggs	fish	onions
some spices		

FOODS THAT INCREASE GAS

beans	beer/carbonated soda	
broccoli	brussels sprouts	cabbage
cauliflower	corn	cucumbers
mushrooms	peas	radishes
spinach	dairy products	excess sugar

FOODS THAT THICKEN STOOL (SLOW OUTPUT)

applesauce	bananas	cheese
boiled milk	marshmallows	pasta
creamy peanut butter	pretzels	rice
bread	tapioca	toast
yogurt	bagels	oatmeal

FOODS THAT LOOSEN STOOL

green beans	beer	broccoli
fresh fruits	grape juice	raw vegetables
prunes/juice	spicy foods	fried foods
chocolate	spinach	leafy green
aspartame/Nutrasweet	sugar	vegetables

HIGH-FIBER FOODS THAT MAY CAUSE BLOCKAGES

dried fruit	grapefruit	nuts
corn	raisins	celery
popcorn	coconut	seeds
coleslaw	Chinese vegetables	oranges
meats with casings	mango	

CAN YOU STILL DRINK ALCOHOL?

Yes! And you may find that gastrointestinal upsets associated with alcohol that used to occur before surgery are now gone with the removal of the diseased bowel. A word of caution however: those with ileostomies are at greater risk of dehydration and electrolyte loss when drinking alcohol. Have water on the side, or extra juice or pop along with your drink. Unless a fair amount of the large colon was removed, colostomates are in little danger of dehydration when drinking liquor. Beer and carbonated drinks can produce gas. Some medications are less effective if taken with alcohol -- be sure to follow instructions. Alcohol may give you loose output or extra output, or it may have no effect on waste at all. Everybody's different.

Urostomates need not fear dehydration but you will be making more trips to the bathroom to empty your appliance. Over-imbibing for all categories will of course result in a form of dehydration known as 'hangover'.

PRESCRIPTION DRUGS AND OVER THE COUNTER REMEDIES

Prescription and non-prescription drugs as well as vitamins are absorbed primarily through the intestines, therefore if you have had a significant portion of your bowel removed, absorption of these substances can be affected.

While the chemical nature of most drugs allows absorption along a significant length of the intestinal tract, the shorter the functional intestine, the less will be absorbed. Only a very few drugs, such as alcohol, can be absorbed to any great extent through the stomach.

Absorption of medications can vary depending on the size and type of pill (ie tablet or capsule). Chewable tablets are effective if they are chewed well; in most cases they are better absorbed than capsules or compressed tablets.

Ostomates who have a significant portion of their intestine removed may achieve better absorption by emptying the contents of a capsule into applesauce, or crushing a compressed tablet and adding the powder to food. A word of caution, though -- not all tablets can safely

be crushed, and not all capsules should be emptied. Generally speaking, time-release tablets should not be crushed, nor should time-release capsules be emptied. The result could be 12 to 24 hours worth of medication being released all at once. Time release medications should be avoided by ileostomates or discussed with their pharmacist.

Enteric-coated tablets should not be crushed. The reason those tablets are coated is to prevent irritating the lining of the stomach. If possible, avoid this type of tablet as they can pass intact through your system.

FOLLOW INSTRUCTIONS FOR TAKING ALL DRUGS. If in doubt about an over-the-counter drug, or how different drugs may interact, consult your pharmacist or doctor. Ileostomates should not take laxatives or stool softeners; such products are not needed with this type of ostomy.

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

Obviously, if you stop eating, you will have little or no output. Starving yourself or limiting liquids to avoid producing waste is foolish and dangerous. **NEVER** restrict fluid intake -- the consequences of dehydration are serious for an ostomate. Sticking to regular mealtimes can help you learn your body's behaviour patterns and anticipate the times when your output is lowest. Some people eat less at certain times of the day or evening in order to help make their stoma less active. Skipping meals entirely will not stop ileostomy output however, and can produce more gas than if you eat regular meals. Ileostomies and urostomies will always have output.

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

USE OF IMODIUM AND SIMILAR PRODUCTS

Give your body time to settle down after you leave hospital. Some colostomates can have loose stool for several weeks or longer after surgery. This should sort itself out in time without the use of anti-diarrhea agents. Even after you have healed completely, you may have periodic bouts of diarrhea the same as a person with an intact digestive tract -- it can happen to anybody. But before reaching for an antidiarrheal you should first consider what you may have recently consumed that might be the cause. In most cases, periodic looseness will sort itself out after a day or two without the need to take anything.

However, people with chronically overactive colostomies and ileostomies sometimes use agents such as Imodium to help control things. These should be used only if the situation is chronic and not improving by watching your diet. Follow directions and do not exceed the recommended dosage, or ask your ET nurse for guidance regarding the use of these products. Lomotil is another antidiarrheal available only by prescription; its use should be discussed with your doctor. Occasional diarrhea is not a cause for panic; as much as possible give your body time to adjust on its own. If you take Pepto Bismol, be aware that your stool will turn black. This is harmless.



*General
Management*

GENERAL MANAGEMENT

HOW OFTEN SHOULD YOU CHANGE YOUR APPLIANCE?

Whether you choose a two or one piece system, 7 days is the recommended maximum time a flange should be on your body. Some people can successfully stretch this considerably longer without compromising skin health or hygiene, but don't try to set records. Three to four days is perfectly acceptable wear-time.

How long you choose to wear, or can wear a flange depends on how your skin reacts to being covered with this material, your technique in applying, and upon the placement of the stoma itself. Some people get too itchy to keep one on for more than a few days. Some can keep an appliance on for long periods of time without any discomfort. Some people have the sort of skin and ostomy placement that won't hold a flange on properly without using an ostomy belt or extra products. And some people can change their entire appliance every day without irritating their skin. We're all different.

HOW DO YOU EMPTY YOUR POUCH?

Most people sit to empty their pouch. Let it fall between your legs, open the end closure and let the stool or urine drop into the toilet. Colostomates and ileostomates should wipe the inside of the pouch end with tissue before closing to avoid odour. Some people prefer to kneel, facing the toilet although this can be hard on the knees. Some prefer to stand -- if you prefer this method you should put some tissue in the toilet bowl first to control splashing.

HOW OFTEN SHOULD YOU EMPTY?

All categories -- colostomy, ileostomy and urostomy -- should empty when the appliance becomes one third full, or sooner. Waiting longer than this can make you uncomfortable, puts unnecessary strain on the flange and can contribute to leakage. How many times do most people empty per day? This varies depending on type of ostomy, what you've been eating and drinking and also on what your tolerance is for having waste present in the bag. Very generally speaking, colostomates empty 3-4 times a day, ileostomates 6 to 8 times a day and possibly during the

night as well, urostomates 8 to 10 times per day. If you want to empty more frequently than this, by all means do so. It's your body and you should do what you need to feel clean and comfortable. Many urostomates use a night drainage system. (See next topic)

NIGHT DRAINAGE SYSTEMS FOR UROSTOMATES

Urine will collect in the appliance continuously throughout the day and night. Many urostomates should use a night drainage system rather than rely on waking up during the night to empty a full appliance. Letting a urostomy appliance get overfull during the night is asking for leakage. Night drainage systems consist of a tube which is connected to the drain spout at the bottom of your appliance, and then connected to either a collection bag or bottle kept beside your bed. Most of the major suppliers make night drainage tubing and collection devices. You should discuss these products and how to use them with your ET nurse.

HOW SHOULD YOU CLEAN YOUR APPLIANCE?

Trying to clean inside an appliance while you're still wearing it is largely a waste of time (not to mention near impossible) and you really don't have to do this. What you should do is wipe inside the pouch end with toilet paper after each empty and before closing to avoid odour. If stool is 'pancaking' inside or near the top of your pouch you can use a plastic squirt bottle of water to rinse this out. (Take care that you don't flush water around the stoma as this may get under the flange.) Adding a few drops of ostomy lubricating deodorant inside the pouch before applying it helps stool slide to the bottom rather than collecting at the top.

If you wear a flange with a two-piece system, sometimes the inside of the ring can become soiled which bothers some people. Q tips can help clean this but don't make yourself crazy trying to get the flange ring 100% clean. You can break the seal if you scrub it too hard. You're going to cover it anyway once the pouch is applied.

Urostomates should rinse the night drainage system every day -- it's advisable to use a mild vinegar/water solution and flush the tubing and collection device. Some manufacturers also market cleaning products specifically for your urostomy night drainage system.

HOW SHOULD YOU DISPOSE OF USED APPLIANCES?

People can get way too complicated about this. Once you've drained the pouch into the toilet, put it (and the flange if you are changing that as well) in a plastic bag like one of those you get from the grocery store, or a doggie bag or a small zip lock bag. Some companies offer opaque odour-proof bags for disposal. Buy yourself a little plastic waste basket with a lid and keep it under the bathroom sink. Put your bagged waste in there and take it out regularly. If you're in a public washroom and must dispose of a used appliance and don't have a plastic bag, wrap it up in toilet paper and put it in the nearest wastebasket. Ladies have the added advantage of having disposal units for menstrual products inside public cubicles -- you can use these. Far too many people are anxious about this subject -- believe us, nobody is watching what you throw away and so long as you're tidy, nobody cares. Ostomy waste is not radioactive, folks.

COLOSTOMY IRRIGATION

Those with a descending or sigmoid colostomy have another option for managing their ostomy. Irrigation is a water enema administered through the stoma, either once a day or once every other day. The procedure takes about an hour in the privacy of your own bathroom, and requires a minimum of specialized equipment. Irrigation works on the principle that if all or most of the large bowel is emptied at one time, it will take 24 - 48 hours for stool to output again. ***Irrigators who achieve good control can be freed from wearing, emptying and changing standard ostomy bags, and report a dramatic improvement in quality of life.*** In between irrigations, the stoma is inactive, or produces very small amounts of stool, allowing the individual to wear only ostomy caps, patches or mini-bags to protect the stoma. To be a candidate, you must have a reasonable amount of hand/eye coordination, the capacity to learn and remember a simple sequence of steps and the motivation to control your body. If your bowel habits were regular before surgery, your chances are good that your remaining colon will respond well to irrigation. If bowel irritability was common before your surgery, or if you were prone to diarrhea, irrigation may not be much of an improvement for you. If you have a hernia, or serious heart or kidney disease, you should see your ET nurse or doctor to discuss the advisability of irrigation.

Irrigation can be safely commenced once your incisions and stoma have healed completely. If you are required to undergo chemo or radiation after surgery it may be advisable to wait until you have completed treatment before trying irrigation, although in some cases where patients tolerate treatment well, you might be able to start sooner. You will need to contact your ET nurse for an appointment to receive instruction on technique and what equipment to purchase. If you want the nurse to do the procedure with you for the first time, you should let them know so they can book an adequate amount of time for your session. It's advisable to have an ET on hand initially to monitor possible drops in blood pressure. If this isn't possible you can start at home after verbal instruction. Have someone present at home the first few times you can summon in case you feel faint.

The Vancouver Chapter has members who irrigate who will be happy to act as irrigation mentors and coaches after you have seen your ET on this matter. Your nurse can refer you to irrigation mentors. Patients with a urostomy, ileostomy, or ascending colostomy cannot irrigate. In rare cases, transverse colostomies can irrigate but results are generally too poor to justify the effort. If you have been told that you cannot stop irrigation once you start because the bowel will no longer work, or that you must adhere to a rigid timetable, this is simply not true. You can stop anytime you wish if irrigation does not suit your lifestyle and although it is recommended that you adopt a routine timetable for elimination [much as you probably did prior to surgery] this can be modified to suit your own schedule.

We strongly encourage descending or sigmoid colostomates to look into irrigation.

MISCELLANEOUS PRODUCTS

Paste

Paste comes in tubes or as packaged sticks which can be squeezed or molded by hand. Paste is often misused and, it could be argued, misnamed. (It could be said that 'putty' might be a better term). This product should not be used as an adhesive. The main purpose of paste is to fill in any uneven areas on the skin under the flange to make the skin level, and gain a good seal to the flange. The second function of paste is as a caulking material around the base of the stoma to keep discharge from leaking at the base and getting under the wafer. Apply

a small bead of paste, like putting toothpaste on a brush, around the opening in the flange or around the stoma. Do not spread the paste. If you want to remove paste from your skin, let it dry out a little first. Don't worry if a little bit is left on your skin. Recap the paste tube immediately after use to prevent it from drying out. You don't need paste if your skin is even and the appliance is staying on well.

Powder

Skin barrier powder may sometimes be recommended by your ET to dry a raw, weepy area on your skin. To apply, clean the irritated area with water and pat as dry as you can. Lightly dust the powder over the affected area and smooth it evenly. Brush off the excess and apply your pouch as usual over top. Some people dab or spray a skin sealant over the powder before applying their flange.

Skin Sealant

Skin sealant (sometimes called barrier film or skin prep) puts a plastic-like coating on the skin. It comes in the form of sprays, wipes and gels. A sealant may help if you have skin that tears easily, or are using an ostomy skin barrier powder. Some people who have dry or oily skin find that their pouching system sticks better when they use a skin sealant. Some skin sealants still contain alcohol which stings on open areas of skin, or skin that is sensitive. These should not be used routinely. No-alcohol sprays and wipes such as Cavilon may be used if regular sealants are too irritating. Nexcare No Sting Bandage is also alcohol free and does essentially the same job as Cavilon.

Ostomy Adhesive

Adhesive cements and sprays are not as widely used these days, but may be helpful for those who are having a lot of trouble keeping a flange in place. A light, even coating should be applied and given time to dry before applying the flange. It is important to follow manufacturer's instructions, as many adhesives require 3 to 5 minutes to dry properly.

Adhesive Remover

A sticky residue can sometimes build up on your skin. Ideally, you should remove this with mild soap and water, but if it's not coming off you may need to use an adhesive remover. Newer adhesive removers come in spray (to loosen the flange) and wipes (to clean the skin) and do not leave an oily residue. After using this product you should wash the skin well with water, then rinse and dry completely.

Tapes

Common brands such as Micropore can be purchased over the counter at most drug stores. These products are skin-friendly (can be removed without damaging the skin) and can help keep a hard-to-stick flange secure. People often tape the edges of their flange for extra security if engaging in sports or swimming although most appliances these days hold up well in water. Ask your ET/WOC to recommend tape for your particular needs.

Absorbent Gel

Some manufacturers make absorbant gel products designed specifically to convert liquid ileostomy waste into a more solid and easily managed consistency. Gel can be in powder form or packaged in a dissolvable film packet which is dropped into the pouch each time the pouch is emptied or cleansed. As the pouch fills, the packet dissolves and liquid waste becomes more solid, reducing pouch noise and the chances of peristomal irritation. Ask your supplier or ET about this product.

Ostomy Belts

An alternative way to keep your appliance in place during vigorous activity is to wear an ostomy belt. These are elastic belts that hook onto the small loops on your pouch or flange. Ostomy belts are also helpful in holding the flange snugly to the body, preserving the seal and helping prevent leakage.

ALL THESE PRODUCTS! DOES EVERYBODY HAVE TO USE ALL THIS STUFF?

No -- many people with ostomies use none of the above products. It depends on your skin and stoma type -- some folks have very dry or very oily skin, some are prone to irritation, some have a hard-to-fit stoma due to siting, shape, scarring or body type. Your own stoma and skin may fit none of these categories and you don't necessarily have to use skin sealants, paste and the like. It helps to know about these products if you run into problems with leakage or skin irritation, otherwise you may not need to use them at all. If you've been using a lot of products and wonder if you really need to, try an appliance change or two without them. Whenever possible, make your routine as simple as you can. "Less is Better" really applies in ostomy care.

A woman wearing a straw hat with a red ribbon, sunglasses, and a teal shirt is kneeling in a garden. She is holding a yellow watering can and watering a plant. The background shows a white wall and other green plants with purple flowers.

*Potential
Problems &
How to Avoid
Them*

POTENTIAL PROBLEMS AND HOW TO AVOID THEM

The following conditions are not necessarily common, but they can happen. Knowing how to identify, treat and avoid them will help you prevent them.

BOWEL OBSTRUCTIONS: HOW TO KNOW IF YOU HAVE ONE, AND WHAT TO DO BEFORE YOU CALL THE DOCTOR

Bowel obstructions, or blockages, can occur in colostomies but are far more common with ileostomies. An obstruction is usually caused by eating something fibrous or difficult to digest, such as popcorn, celery, or tough meats to name a few. Eating too quickly, not chewing your food well enough, or introducing solid foods too quickly to your system after surgery can result in a bowel blockage. Blockages can be mild and resolve themselves, or they may be extremely painful and require hospitalization. It's important that you know how to avoid them, how to identify them if you think you have one, and what to do should you experience a blockage.

Signs and symptoms of a possible blockage:

- Nausea and vomiting
- Distention of the abdomen
- Minimal or no stomal output
- Cramping and pain
- Swollen Stoma

Symptoms may become severe or they may last for more than 24 hours. There are several things you should do if you suspect you have a bowel obstruction and several things you absolutely should not do:

DO NOT:

- eat solid food
- take laxatives or pain killers
- insert anything in the stoma

DO:

- stop eating
- sip non-carbonated fluids, warm fluids or fluids containing electrolytes
- check to see if the stoma is badly swollen, if so you should remove the flange and replace it with one that has a larger opening
- soak in a hot bath to relax the abdominal muscles
- massage the abdomen or try a knee-to-chest position; walk
- call your doctor or ET nurse, or go straight to emergency if vomiting and other severe symptoms are not going away
- have someone drive you to hospital

Treatment for severe blockage may include an IV to replace the fluid, sodium, and potassium you have lost and the administration of pain medication. An X-ray or other diagnostic test may be conducted to determine the source of the obstruction. Depending on the patient and the suspected culprit for the obstruction, a tube may be inserted into the stomach via your nose to decompress built-up pressure.

Be alert to the early signs and symptoms of bowel obstruction. A partial blockage usually displays itself through cramping abdominal pain, watery output with a foul odour, and possible abdominal distention and stomal swelling followed by nausea and vomiting. A complete blockage with an ileostomy is evident when there is total absence of output for more than 4 hours, severe cramping pain, abdominal and stomal swelling, and nausea and vomiting.

Some common blockage-causing foods are popcorn, nuts, heavy fibre (such as that found in the stalks of celery), fruit skins, and poorly chewed meat. Strip tough fibre out of celery stalks and peel fruits such as apples. Cut meat into small pieces and chew your food properly rather than washing things down with liquid. Introduce fresh fruit and vegetables slowly to your system, in small amounts.

DEHYDRATION

The large intestine does not play a major part in absorbing nutrients; although it absorbs some minerals, notably salt, its main job is to extract water from waste coming from the small intestine. If all or much of the large intestine is removed, the patient loses this natural 'rehydrator' and can be at risk for dehydration. Therefore, dehydration affects ileostomies more than any other type of ostomy. Physical activity (especially sports) and hot weather can increase the risk of dehydration. Thirst is not always an accurate measure of your body's needs; those with ileostomies should develop the habit of drinking fluids throughout the day. (8 to 10 glasses per day is recommended.)

SYMPTOMS :

Mild Dehydration: (increase fluid -- and for babies, call a medical professional): Thirst, dry lips, dry mouth, flushed skin, fatigue, irritability, headache, urine begins to darken in color, urine output decreases

Moderate Dehydration: (call a medical professional): All of the signs of mild dehydration, plus: skin doesn't bounce back quickly when pressed, very dry mouth, sunken eyes, (in infant - sunken fontanel, the soft spot on the head), output of urine will be limited and color of urine will be dark yellow, cramps, stiff and/or painful joints, severe irritability, fatigue, severe headache and increased heartrate

Severe Dehydration: (call emergency number): All of the signs of mild and moderate dehydration, plus: blue lips, blotchy skin, confusion, lethargy, cold hands and feet, rapid breathing, rapid and weak pulse, low blood pressure, dizziness, fainting, high fever, inability to pee or cry tears, disinterest in drinking fluid

Ileostomates should make a habit of drinking more fluids per day than they did before surgery. For further concerns call the HealthLink at 811.

PERISTOMAL HERNIAS

A hernia is a portion of intestine that bulges out of a weakened area of the muscle wall of the abdomen. In those with an ostomy, some individuals may be susceptible to hernia formation around the stoma.

Contributing causes of stoma hernia:

- Coughing, being overweight or having developed an infection in the wound at the time the stoma was made
- Improper lifting, lifting too heavy an object anytime after surgery (less than 5 lb for 6 to 8 weeks post-operatively is recommended)
- Engaging in strenuous sports

Hernias develop most often in ostomates around the stoma. Because a small circle of abdominal muscle was removed during surgery to bring the intestine to the surface, a weak spot was created. Lifting too heavy a load or starting strenuous exercise too soon can cause the intestine to protrude through this gap. In some individuals even sneezing, coughing or standing up can make the bowel bulge through this weak spot. The size of a hernia may increase as time goes by. Peristomal hernias are rarely painful, but are usually uncomfortable and can become extremely inconvenient. They may make it difficult to attach a bag properly and sometimes their size is an embarrassment as they can be seen beneath clothes.

Although it's a rare complication, the intestine can sometimes become trapped or kinked within the hernia and become obstructed. The intestine may then lose its blood supply, known as strangulation. This is very painful and can require emergency surgery to untwist the intestine. Regardless of inconvenience or pain, hernias are defects in the abdominal muscle wall and should not be ignored simply because they might not hurt. Some surgeons advocate that small stoma hernias that are not causing any symptoms do not need any treatment. Furthermore, if they do need treatment it should not be by surgery in the first instance but by wearing a wide, firm hernia belt. Your ET nurse can help measure you and show you the different belts available. This is probably true with small hernias, in people who are very elderly and infirm or people for whom an anaesthetic would be dangerous (serious heart or breathing problems, for example.) Operative repair of a stoma hernia may be necessary to improve the quality of life, prevent progressive enlargement of the hernia and make it easier to manage the stoma. Give your muscles time to heal and introduce physical activities slowly and gently.

HOW YOU CAN HELP PREVENT A PERISTOMAL HERNIA

For the first two to three months after surgery, **DO NOT** do activities that put stress on your abdomen:

- Do not lift, pull, or push anything more than 5 pounds.
- Do not do any heavy exercise.
- Try not to strain your abdominal muscles (sneezing, hard coughing, or straining to have a bowel movement [constipation]).

Talk to your surgeon about any specific limits for you.

Support or hold your abdomen with a pillow or your hand(s) to help give your abdominal muscles some support if you cough or sneeze. Regular physical exercise such as walking and swimming are good for overall health and wellness.

Some specific exercises that can help strengthen your body's core are:

Two (2) months after your surgery:

Pelvic tilt

- Lie on your back on a firm surface with knees bent and feet flat on the floor or bed.
- Make sure your feet, ankles, and knees line up and are hip-width apart.
- Tighten your abdominal muscles, pulling your bellybutton down towards your spine.
- Tilt your bottom upwards slightly while pressing the middle of your back into the bed.
- Hold this position for 2 seconds.
- Slowly relax back to your start position.
- Repeat 10 times.

Knee rolling

- Lie on your back on a firm surface with knees bent and feet flat on the floor or bed.
- Tighten your abdominal muscles.
- With your knees bent, drop them slowly down to one side then to the other side.
- Repeat 10 times.

Chest Lift

- Lie on your back on a firm surface with knees bent and feet flat on the floor or bed.
- Make sure your feet, ankles, and knees line up and are hip-width apart.
- Place your hands on the front of your thighs.
- Tighten your abdominal muscles, pulling your bellybutton down towards your spine.
- Tilt your chin slightly down.
- From the top of your head, slowly lift your head and upper spine off the floor or bed (just far enough that the bottoms of your shoulder blades are still touching the floor or bed).
- Hold for 3 seconds.
- Slowly return to your start position
- Repeat 10 times.

Note: Some people are at more risk for developing a hernia. Talk to your ET/WOC nurse about what you can do to minimize the risk.

FOLLICULITIS

Folliculitis is an inflammation of the hair follicles and happens most often in men. It is usually caused by traumatic hair removal, for example, hair under the flange that is pulled out when the flange is removed, or by shaving. If your skin has become irritated with this, usually the use of a skin protective powder will permit the skin to heal.

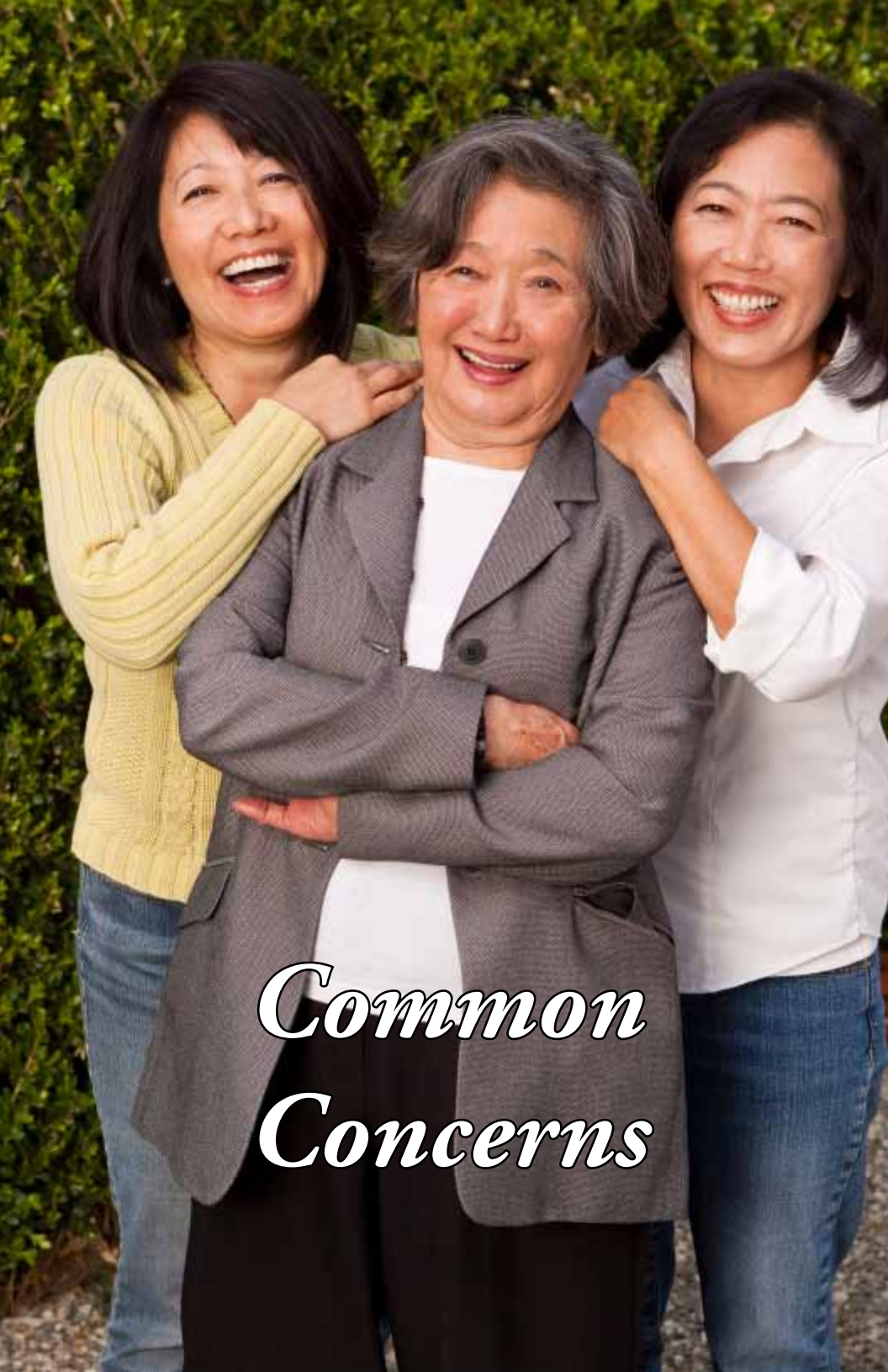
If you suspect you may have folliculitis, you should see your ET nurse to confirm and treat the problem.

Men can avoid this condition by carefully shaving or clipping the skin that will be covered by the flange. You can use either an electric or safety razor for this. Shaving in the direction of hair growth may help avoid skin irritation. Adhesive remover sprays can help prevent pulling out hair follicles Tip: if you're nervous about shaving so close to your stoma, an empty cardboard toilet roll makes a good shield around it.

PROLAPSED STOMA

A prolapsed stoma is a stoma that begins to hang noticeably farther and farther out of your body without retracting. This is not normal and should be reported to your ET nurse.

It's normal for your stoma to change in length slightly throughout the day but this should not be confused with a true prolapse. Your stoma can look contracted and almost flush with your skin, minutes later it may appear soft and look longer. This minor variation in length is normal stoma behaviour. It can react to cold or being handled by contracting and 'shortening' up. Peristalsis can also make the stoma look shorter or longer. They can look, and feel, either hard or soft depending on whether or not contraction is happening. What is not normal is if you notice your stoma is looking consistently longer and starting to hang out of your body more than usual. Measure your stoma's length after six weeks and if you notice it is getting longer, you should have your ET nurse check it. Prolapsed stomas are inconvenient and more prone to injury. There is no 'standard' stoma length -- they can be less than half an inch long, or up to an inch and a quarter.



*Common
Concerns*

COMMON CONCERNS

LEAKS AND ODOUR

Although leaks and accidents can and do happen to all of us, they are by no means the norm and you should not accept constant leakage as a part of living with an ostomy. Most of the time accidents are caused by the appliance not being put on correctly, or by being poorly fitted and it's common for beginners to make errors.

COMMON CAUSES OF LEAKAGE:

- The flange opening not cut to the right size. The flange opening should be cut approximately 1/16" larger than the stoma diameter. If it's too big waste can get under the flange onto your skin. If it's too small your stoma will be pinched, or displace itself under the flange. A new stoma will shrink in circumference for up to 8 weeks after surgery. It should be measured with each appliance change, with the new flange cut accordingly.
- Wearing the same flange for too long
- A poorly placed stoma. You may need to adjust your beltline if it's interfering with how the stoma empties.
- Dislodging or loosening the flange during physical activity. You might consider using an ostomy belt to keep the flange on firmly.
- A very flush stoma that does not exit waste into the bag properly. Consider using convex flanges to correct this problem.
- Flanges not sticking properly. Your skin needs to be completely dry and clean before applying the flange. Avoid using soaps that leave a residue. An uneven abdomen can make it difficult for the flange to stick properly; you may need to use ostomy paste or a skin barrier ring to achieve a good firm fit.
- Folds or creases. If skin folds or creases have developed and leakages are always along the crease, wafer pieces or ostomy paste can be used to build up the area in order to avoid leakage. See your ET nurse for 'how-to' information.
- Peristomal skin irritation. Pouches don't stick well to irritated skin, so perform meticulous skin care to avoid irritated or denuded skin or a rash. If any of these problems develop, see your ET nurse as soon as possible.

- Improper pouch angle. If the pouch doesn't hang vertically, the weight of its contents can exercise an uneven pull on the wafer, and cause leakage. Every ostomate must find his or her optimal angle, based on individual body configuration.
- Waiting too long to empty the pouch. Pouches should be emptied when one-third full or sooner. If allowed to overfill, the weight of the waste can break the seal and cause leakage.
- Extremely warm temperatures. Leakage in warm temperatures may be due to wafer 'melt-out'. More frequent pouch changes or a change in wafer material may be required to avoid leakage.
- Pouch wear and tear. If you are stretching your wear times to a week or more, leakage may be due to the wafer wearing out. Try more frequent pouch changes.
- Faulty appliances. Although it is not common, some batches of appliances can leave the factory with flaws. If you suspect your appliances have pinholes or faulty seams you should stop using items from that box, report the lot number and return the unused items to your supplier. Manufacturers want and need to know if their products are not performing! *(Note: please don't send used faulty appliances through the mail . . . the manufacturer will take your word for it, honest.)*

WHAT ARE SKIN BARRIER RINGS AND HOW DO YOU USE THEM?

People with chronic leakage and fitting problems, or very sensitive skin may find using skin barrier rings beneficial. The rings, or seals, as they are sometimes called, are similar to a flange, but made out of different material that is hypoallergenic and soothing to the skin. Rings come in different thicknesses depending on the company, and can be molded or stretched by hand to custom fit around the stoma. This increases the adhesion of the flange, which is applied over top. Sometimes pieces of the ring material are all that's required to address a small problem area. You should see your ET for help learning to apply a barrier ring correctly. Most of the more popular manufacturers now offer barrier rings. Each brand is worth your time to check out. Ask your supplier what they might recommend.

ODOUR CONTROL

This is one of peoples' first major concerns. You should not have odour unless you are emptying or changing your pouch. Colostomies tend to emit more odour than ileostomies because of the bacterial abundance in the colon. When sigmoid and descending colostomies are irrigated, odour is much less evident. Ileostomates experience almost continual peristaltic waves which sweep the ileum and prevent stagnation of the intestinal contents, thereby eliminating much of the bacterial growth that occurs with colostomies. Urine has a characteristic smell, but a foul odour could be a sign of infection. Certain foods will affect the odour of both feces and urine -- eggs, onions, spicy foods, cabbage, and fish to name a few -- you may want to cut down on your consumption of these if odour is bothering you. Proper appliance application is critical to avoid odour-causing leaks. Here are some other tips and products:

Pouch deodorant. All the major companies offer bottles of liquid ostomy deodorant. Try all the different products as individual body chemistry makes a difference in how well each brand works. A few drops of this in the pouch can help dispel unwanted smell. Ostomy manufacturers are coming out now with gels and liquids that function as both pouch lubricant and deodorizer at the same time. Ask your supplier for samples.

CLEAN THE TAIL OF YOUR DRAINABLE POUCH! Emptying regularly is important but just as important to odour control is wiping out the inside of the end of the pouch tail before you close the pouch.

Try to keep stool from collecting, or "pancaking" at the top of your pouch, as this can contribute to leaks and wafer undermining. Pancaking is a common annoyance, especially if you are spending a lot of time lying down or sitting. Clothing that restricts the top of the pouch can also cause pancaking. Lubricating products from ostomy manufacturers work well when put inside the top of the bag when you change to help things slide to the bottom. If no ostomy lubricant is handy, vegetable oil or spray will work too, although such oils don't mask odour.

Internal deodorant products. A popular over-the-counter tablet is Devrom (bismuth subgallate) available through your ostomy products supplier or at some pharmacies. These are chewable tablets taken right after you eat a meal, or more frequently throughout the day depending on how much effect you want. The usual dose is one or two tablets at a time. Devrom is pretty effective if you take it regularly and most people report it eliminates or reduces gas and stool odour. The drawbacks are you have to carry and remember to take the tablets. You can also purchase chlorophyll capsules at your local health food store, which produce a similar effect, that of neutralizing the bacteria which produces excess odour in fecal matter and gas. Devrom can turn your stool very dark and chlorophyll can turn your stool green. This is harmless. You'll need to experiment with internal deodorants to find which work better, and how much to take.

Powdered charcoal supplements are ineffective and can contribute to blockages in some individuals. Do not take these internally for odour control.

- Cranberry juice may help reduce odour for urostomates.
- Eat parsley! Next time you get a sandwich with parsley garnish don't throw it away! It's one of nature's best deodorizers.
- Probiotic yogurt may cut down on odour in some individuals

You can spray room deodorant in the bathroom if you dislike the smell after you have emptied your appliance. Candles and incense work too. Some manufacturers market ostomy sprays you can use for this purpose.

Some people find that their appliances develop an odour that they dislike despite their best efforts to keep everything clean. Everybody's body chemistry is different and some folks can wear one brand without annoyance while others think it smells. If your appliance is fitting you well, you're not getting leaks and nobody else can smell anything but you still don't think it smells right, you might consider trying other brands. Changing the pouch more frequently often helps. Ask a family member to tell you if they think you smell. Sometimes it's your imagination!

You'll be more self-conscious about scent for a while after you have an ostomy.

RECTAL DISCHARGE AFTER OSTOMY SURGERY

People with a loop stoma (an ileostomy or colostomy that has two openings), or a type of colostomy called a Hartmann's Procedure, may pass mucus through their anus while they have their stoma. With these surgeries, all or part of the large intestine is bypassed so stool no longer passes through it.

Even though it is being bypassed, the lining of the bowel still continues to secrete mucus, which is something the intestine does to help stool pass through more easily. Mucus can build up, and create a feeling of needing to pass stool through the anus. The frequency and amount of mucus drainage is very individual, ranging from several times per day to once a month to no mucus drainage at all. Mucus is usually clear or putty-coloured, and sometimes it can be brown.

Most people deal with the mucus drainage by sitting on the toilet when they feel the urge and gently bearing down as if to have a bowel movement.

If the amount of discharge is bothersome, please talk to your ET/WOC nurse or physician.

SEX AND INTIMACY

Resuming sexual relations after surgery can be an anxious time. What do you do with the bag? What if your partner finds it offensive? How do you tell a prospective partner about the ostomy? Can you have sex at all?

The answer to the last question is yes, of course. Women with an ostomy have no physical impediment to intercourse, although stenosis (narrowing) of the vaginal canal is a common side effect if your surgery required removal of the anal sphincter. If the anus has been removed, intercourse may be uncomfortable or painful. Generous use of lubricant is key, as is a gentle partner. Stenosis of this sort usually eases over time in sexually active women.

Men may face more challenges. Erectile dysfunction is more common after urostomy surgery than ileostomy or colostomy surgery. How long this lasts will vary depending on:

- type of surgery performed and how invasive it was; how much nerve damage may have occurred
- the man's age at time of surgery
- his general health condition

Returning to sexual relations may happen after a few weeks, or it may take months. It's alright to masturbate if you want, so long as you aren't experiencing any pain while doing so. If you have healed well and are otherwise in good recovering health after six months and are still not happy with your sexual performance, you should see your doctor. Impotence can happen to any man, not just those with an ostomy. Treatment prescribed usually consists of oral medication such as Viagra, Cialis or Levitra. In all cases, dosage, method, and possible side effects must be thoroughly discussed with your doctor.

PRACTICAL CONSIDERATIONS DURING INTIMACY

It goes without saying that you should empty your appliance before intimacy and take care that you are clean and have no odour. Folding the bag up and taping it to your abdomen can get it out of the way and stop it from distracting you. (any more than you're already distracted, that is.) If you are feeling self-conscious sometimes camisoles or 'adult' lingerie can make things more discreet for the ladies. Men may keep a T-shirt on so the appliance is less obvious. The plastic in some pouches can rustle in an annoying manner -- those with fabric covering are quieter. It's a good idea to have some tissue, or a towel nearby in case of surprises. Some ostomy manufacturers make appliances that can be used during intimacy -- stoma caps or mini-bags. These are much smaller than a standard pouch and very discreet. How long they are effective depends greatly on what sort of ostomy you have and what its output patterns are. Colostomies tend to work slowly and only during certain times of the day, so you can expect to get several hours' use out of a cap or mini. Ileostomies will get much less time, depending on when you last ate. (Ileostomates often choose their intimate moments before eating in order to have less worries during sex.) Caps are not advised for urostomates; mini-bags will not have the capacity to last very long, either. Regardless of what kind of ostomy you have, if you want to give these products a try you should wear one for a while without engaging in sex to see how effective it's going to be.

When and how you choose to resume sexual relations is a very personal decision; above all remember that communication with your spouse or partner is essential. Talk about intimacy in advance and try not to put too much pressure on each other to do everything you did before right away. Remember that your spouse or partner may be as nervous and self-conscious as you are!

Whatever your previous sexual habits were before, you should be able to return to these activities if you choose -- just bear in mind that the stoma should be unrestricted during intimacy and must NOT have anything inserted in it. You may wish to discuss any concerns about the safety of sexual practices with your doctor, ET nurse or counsellors in the field of sexuality. Other ostomates can be a good resource as well, for they may share similar concerns and be willing to have a personal discussion.

DATING

Single people often worry about how to tell a new partner about their ostomy. How and when do you tell? Get to know the person before making the decision to take the relationship to the next step. When the time is right, explain to them that you've had surgery that has left you with some alterations to your body that will have an impact on intimacy. Answer any questions honestly and simply. Never spring an ostomy on a new sexual partner without telling them well beforehand -- you'll be putting both of you in a potentially embarrassing situation. Just as it took time for you to get used to your body, others will need time, too.

Sexual rejection is hurtful for anyone, not just those who have an ostomy. If someone you are interested in is suddenly not interested in YOU after they learn you have an ostomy, consider this a clear sign that they were not the right person for you in the first place. You must move on and remember there are many others out there with a less shallow outlook. Don't let fear of rejection keep you from finding the right partner.

A man with dark hair, wearing a bright blue zip-up jacket and black athletic pants with a white stripe down the side, is captured in mid-stride while running on a grassy hill. The background is a soft, out-of-focus blue, suggesting a clear sky or a distant landscape. The overall mood is energetic and active.

*Sports &
Exercise*

SPORTS & EXERCISE

You should begin walking in moderation after your surgery and do this regularly, every day after you get home. Walking stimulates the return of bowel function and will get you back on the road to regaining the muscle you lost while in hospital. Whatever sports you may have played in the past, you can enjoy them again with few exceptions. Common sense is required -- gym rats take note! You *cannot* jump back into training or exercise at the same level you left. This means **NO** heavy lifting or stress on your core during the weeks immediately following surgery. Unless your surgery was done laparoscopically, your abdominal muscles will have been weakened by incisions and must be given adequate time to heal. Improper lifting, or lifting too heavy a weight too soon could cause a hernia. Again, **NO** lifting, not even a vacuum cleaner or laundry hamper for those first few weeks and then only introduce light loads gradually and carefully. If you want to return to the gym you can do this but you should avoid abdominal exercises for a while, and then only introduce these in gradual, gentle amounts. A personal trainer, if you can afford one, can work with you to develop a safe exercise regime.

Ostomates who regain previous fitness levels can and do return to a huge variety of sports and exercise -- running, swimming, biking, snorkelling, golf, hiking, hunting, yoga, riding, team sports, triathlon -- you name it. The list includes contact team sports as well -- professional footballers have played with an ostomy. Unless your chosen sport before was power lifting or wrestling, you will probably be able to do it again.

PROTECTING THE STOMA DURING SPORTS

Stomas are fairly hardy, but some common sense rules apply. You may want to wear a hernia belt as precaution while engaging in strenuous sports. Stomas should be protected from direct physical blows, from too tight clothing, and from rigid objects (ie: belt buckles) over them. Ostomates engaged in contact sports should consider protecting their stomas by wearing a stoma guard and if desired, and an abdominal / surgical support belt as well.

A stoma guard is similar in function to a male athletic cup and is held in place with an ostomy belt. Abdominal/surgical support belts aren't

'belts' per se, but more like corsets that close in front with velcro. They come in different sizes; you can make them as tight or loose as you want. It's like wearing armour and can boost confidence if you're anxious about being bumped in crowds or groups. They can be worn under clothes but they're bulky and rather restricting.

The main danger to a stoma during strenuous sports is being cut or lacerated. Because the stoma itself has no nerve endings, you can be injured without knowing it. Causes of stomal laceration include shifting of the wafer, too small an opening, and rigid items too close to it. You don't want to overdo things, but stomas can withstand a bit of rough and tumble.

KEEPING THE APPLIANCE ON DURING SPORTS

Ostomy belts are useful, as is taping the appliance around the edges. If you sweat a lot, you should check your flange periodically -- you might need to change if a game is ongoing and you feel the appliance slipping.

AND VERY IMPORTANT . . .

HYDRATION. Especially for ileostomates -- drink lots of fluids if you're exercising, playing sports or just out for a long walk.

TRAVELLING, CAMPING AND PLACES FAR FROM HOME

The cardinal and never-to-be-broken rule of air travel is: **CARRY ALL SUPPLIES ON BOARD IN YOUR HAND LUGGAGE.** No matter how reliable the airline, **NEVER** pack supplies in checked luggage. Lost supplies can be hard to locate and replace. At best, you'll waste valuable holiday time finding what you need. If you cut your own flanges, do so before you travel. Some lengths of ostomy scissors are now allowed onboard flights if you explain their use, but you can't be sure they won't be confiscated. Pack your scissors in checked luggage, and cut everything you'll need beforehand.

Current airline restrictions prohibit liquids over a very small amount from being taken onboard a flight. This can pose a problem on long flights for ileostomates who must maintain their fluid intake. If you

cannot purchase water or juice in restricted areas, ask the cabin attendant for water or juice at the earliest opportunity.

Customs officials may or may not ask to inspect your hand luggage -- if they do, don't worry about it. If asked what this is, tell them you have an ostomy and these are your appliances. They may or may not understand what an ileostomy or urostomy is; colostomy is generally a more familiar term. Security scans will not damage your appliances. Body scans will show that you are wearing an appliance and you may be questioned about this. You can ask for a pat down in private if you are anxious about body scanners. In all cases, just be upfront about your ostomy if questioned. The more we are open and relaxed about this, the more airport personnel will be educated. An ostomy travel card explaining that you have an ostomy may facilitate things. These cards can be obtained from the Ostomy Canada Society website. Some folks wear a medical ID bracelet. It's a good idea to keep a detailed list of products you use, and your ET's contact information in case of emergencies.

If your travels include long flights or bus rides, you may want to wear a larger appliance for this. Urostomates who know they may face unusually long delays between bathroom breaks may want to consider a leg bag. Ask for an aisle seat as close to the bathrooms on a plane as available; choose the back of a bus that has toilet facilities. For other modes of transportation, such as trains, just make note of where the toilets are. Cruise ships are an easy travel choice for ostomates plus they all have medical centres on board. A word of caution, however -- 'medical centre' does not necessarily mean they stock ostomy supplies. Most do not and although the ship's doctor will be happy to issue a medical prescription for appliance purchase at the next port of call, the next port of call could be days away. **TAKE ALL SUPPLIES WITH YOU, ALWAYS.** Never rely on being able to purchase things 'along the way'.

The other cardinal rule of travelling with an ostomy is "PACK AT LEAST TWICE -- THREE TIMES IS EVEN BETTER -- WHAT YOU THINK YOU'LL NEED". One good bout of traveller's diarrhea can go through a lot of appliances in a hurry! Change in climate can also affect appliance performance.

Seat belts in cars or airplanes can pose a problem if they cut across

your stoma. This may be uncomfortable and/or the stoma may not drain properly into the pouch. You may need to loosen the belt, or place padding between the stoma and the belt to even out the pressure.

If you like to hike and camp, take an adequate supply of plastic bags with you to deal with disposal. Don't you DARE bury used appliances in the woods!! Pack out all your non-biodegradable ostomy waste. Your water needs may be greater, so plan ahead for adequate safe water sources. An extra small pocket flashlight (something you can hold in your mouth so your hands are free) or a camping headlight can be handy if you have to take care of things in the dark. Camping supply stores are a good place to find these items.

And one last thing . . . no, your bag is not going to blow up in an airplane. This is a myth, folks. It doesn't happen.

USING PUBLIC WASHROOMS

If you need to empty your appliance in a public washroom, do it the same way you would at home. It's a good idea to carry a basic change kit with you when out and about if your ostomy is a busy one; if you need to change your appliance you can do this in a cubicle although finding a spot to set things down will require some ingenuity. You have a legitimate reason to use the handicapped stall if you need to change the appliance. If you've left quite a smell in the stall a spray or two with a little ostomy room deodorizer is a considerate thing to do for the next user but really, how many 'normal' people do that?

Don't rush or feel guilty about taking up extra time in a public stall. You do what you need to do. If you're feeling self-conscious about using a public washroom, consider this: before you had your surgery, how much attention did YOU pay to others in a public washroom? Chances are the only person who might take any notice of you will be another ostomate. People really aren't interested in what you're doing -- they just want to do their business and get on with things. So should you.



*Internal
(J-Pouch) Surgery*

WHAT IS THE ILEOANAL RESERVOIR (J-POUCH) PROCEDURE?

An ileoanal reservoir, also known as pelvic pouch, ileal pouch or J-pouch procedure is a type of surgery that involves creating an internal pouch formed of small intestine that provides a storage place for stool in the absence of the large intestine. This surgery eliminates the need for an external bag to collect waste as stool now passes through the anus rather than through an ileostomy.

It is usually a three-stage procedure, although in some cases it can be completed in two stages. The first stage is removal of the large colon except for a rectal stump and anal sphincters. An end ileostomy is then created. During the second stage the internal pelvic pouch is created from a loop of the small intestine. The third stage reverses the ileostomy and re-connects the bowel. In very rare cases, a pelvic pouch may be created in one step. The decision of when to complete the later stages of the procedure depends upon when the surgeon feels it is appropriate to re-operate. The spacing between surgeries can vary from months to years.

Once connected, the internal pouch may take up to a year to fully adapt. Stools will usually become thicker within 2 - 3 months, depending on the patient's recovery and diet. Most patients have bowel movements an average of four to seven times a day. Functioning of the pouch will continue to improve over time.

POSSIBLE CANDIDATES FOR J-POUCH SURGERY

Common candidates for J-pouch surgery include patients who have chronic ulcerative colitis, familial polyposis or colon cancer. Suitable candidates must:

- have their anal canal intact
- have undamaged anal sphincters
- be strong enough to withstand up to three surgeries in a relatively short period of time

UNSUITABLE CANDIDATES FOR J-POUCH SURGERY

Patients who would be unsuitable for this type of surgery would include those who:

- have other medical conditions that make anesthesia and surgery

excessively risky

- are incontinent or have poor sphincter muscle tone, or who have had previous sphincter injury
- have a diagnosis of Crohn's disease
- have undergone partial removal of the small bowel
- are obese
- are elderly

WILL BOWEL MOVEMENTS BE THE SAME AS BEFORE?

Close, but there will be differences. A person with a J-pouch internal reservoir will always need to have more bowel movements per day than someone with an intact set of bowels and the consistency will be looser. As the patient adapts and the pouch stretches to normal capacity, the number of stools per day should decrease. Most patients have an average of four to seven bowel movements daily but this number may be larger immediately after surgery and as the patient begins eating.

DIETARY CONSIDERATIONS FOLLOWING J-POUCH SURGERY

Once patients are discharged from hospital, they can try new foods, one at a time, to ensure a proper adjustment to a normal diet. Keep in mind that each individual is different and there may be a bit of trial and error that takes place during the months after surgery. Sometimes a food causes a problem to one person but may not cause a problem for another. J-pouchers must use common sense and caution with their diet, much as someone would with a regular ileostomy.

General guidelines:

- Drinking more water is very important because the large bowel, which re-absorbs water, is gone
- Small frequent meals should be eaten to keep some food in the stomach all the time. Gas increases in production when the bowels are empty.
- Eat a well balanced diet
- Eat slowly and chew your foods well
- If you insist on eating nuts, seeds or popcorn, do so in

MODERATION

FOODS THAT MAY CONTRIBUTE TO DIARRHEA

alcohol	excessive fruit juice	broccoli
cabbage	dairy	spicy foods
prune juice	fatty and fried foods	

FOODS THAT HELP CREATE BULK AND THICKEN STOOL

applesauce	bananas hard	boiled eggs
hot breakfast cereals,	mashed potatoes,	oatmeal,
smooth peanut butter	plain pasta	toast (no seeds)
white rice	yogurt (with live culture).	

FOODS THAT MAY INCREASE POUCH OUTPUT

raw fruits	raw vegetables	alcohol
leafy green vegetables,	spicy foods	caffeine
chocolate		

FOODS THAT MAY DECREASE POUCH OUTPUT BY THICKENING IT

applesauce	bananas	boiled rice
pasta	smooth peanut butter	cheese
tapioca pudding	potatoes without skins	

FOODS THAT ARE DIFFICULT TO PASS AND MAY CONTRIBUTE TO A BOWEL OBSTRUCTION

corn	mushrooms	peanuts
popcorn	nuts and seeds.	

Stay hydrated! Drink at least 6 to 8 glasses of fluid a day but cut down on caffeinated beverages as these can cause loose stools. If you feel you are getting dehydrated, beverages like Gatorade or Pedialyte can restore a lot electrolytes. Try to include potassium and sodium-rich foods in your diet (ie: bananas, orange juice, tomato juice, smooth peanut butter; or bouillon, soups, crackers, pretzels)

After recovery and adjustment, many “J-pouchers” can tolerate just about anything they want to eat within reason.

CAUTIONS AND POTENTIAL PROBLEMS FOLLOWING J-POUCH SURGERY

“Butt-burn”

This is a burning sensation during and after defecation. This is often due to the fact that more bile juices are moving through the body and out the rectum. Avoid foods that may cause burning stool and anal irritation such as coconut, peppers, spicy foods, nuts, raisins, salsa, certain raw fruits and vegetables (oranges, apples, coleslaw, celery and corn), popcorn, Chinese/oriental vegetables, dried fruits, and foods with seeds.

Dehydration

Removal of the large bowel removes your natural ‘re-hydrator’. Over time, the small intestine will take over more of the function of fluid absorption, but it is important to be aware of the signs of dehydration. They can include extreme thirst, dry mouth and dry skin, shortness of breath, decreased urine output or urine that is dark in color, nausea or abdominal cramping and achiness. If you are dehydrated, you need to drink extra fluid and replace lost electrolytes, sodium and potassium.

Irritated skin around the anus

Warm baths are soothing for this as well as protective ointment that can be used after each bowel movement to keep the stool off the skin. Ask your ET nurse or doctor to recommend a protective ointment.

Incontinence or leakage of stool

This usually improves with time as your stool thickens, your pouch stretches and your sphincters become stronger. It may help to sleep on a small towel that can absorb leakage and avoid foods that contribute to increased pouch output and diarrhea.

Sexual intercourse

This should be avoided in women for six weeks after J-pouch surgery to let the reservoir heal since the vagina and rectum are very close together. There are some women who have occasional pain with intercourse; however this affects younger women more often than older women. Anal sex is strongly discouraged as it may cause damage

or lead to abscesses and fistula formation.

Women who wish to become pregnant should discuss this with their surgeon prior to J-pouch surgery. Some surgeons recommend that women consider delaying pelvic pouch procedures due to concerns about fertility and risk of damage to the pouch and/or anal sphincters during pregnancy and childbirth. Although infertility is quoted as a complication after this type of surgery there are reports indicating that some women are able to carry their babies to term. Most J-pouch women have caesarean sections but there are also some who have had vaginal births after this surgery. Each person is different and if this is a concern for you, you should talk to your gastroenterologist and/or surgeon to determine your risks.

Pouchitis

Pouchitis is inflammation of the ileo anal pouch occurring particularly in cases where the pouch was created to manage ulcerative colitis. One of the factors that may contribute to this is that the pouch may not be emptying adequately with each bowel movement leading to stool lying in the pouch for prolonged periods of time. This lends itself to overgrowth of certain bacteria. Pouchitis can happen at any time, even months or years following surgery. Symptoms are similar but much less acute and painful than that of ulcerative colitis. These include diarrhea (sometimes bloody), urgency, difficulty passing stools, and pain. You will need to see your surgeon to discuss treatment which usually consists of a course of antibiotics. Some surgeons may recommend taking probiotics as well.

Blockage

Signs of a blockage are similar to that of an ileostomy blockage and may include nausea and vomiting (for more than 24 hours), abdominal cramping, pain, bloating, and decrease in bowel activity. In the event of a blockage, you should go to your nearest emergency room. Most often, blockages resolve themselves within 72 hours.

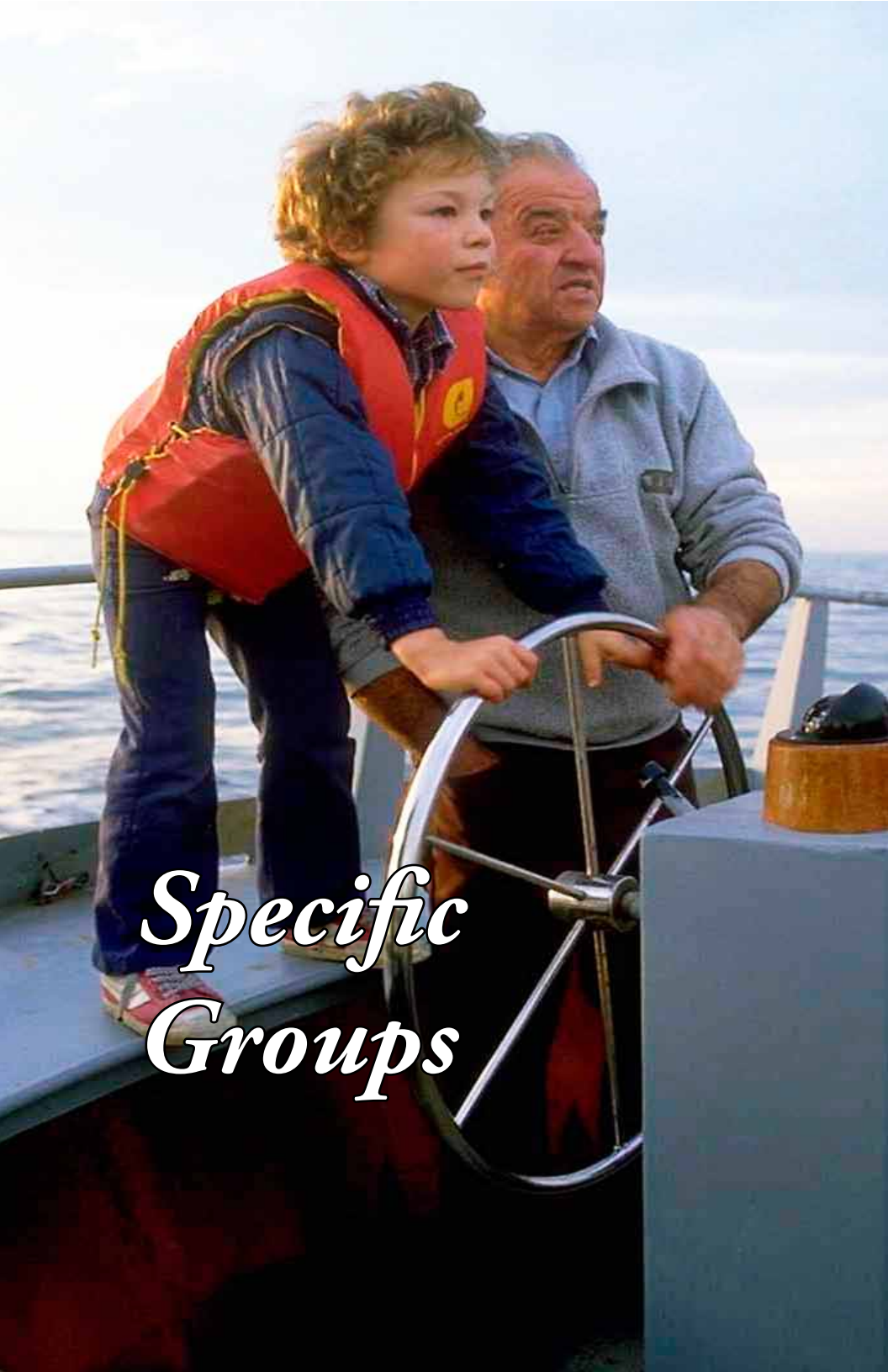
Anal strictures and fistulas

Sometimes occur but these are not common complications.

Steroid dose taper

Patients who were on steroids before going into J-pouch surgery should gradually decrease or taper their steroid dosage under their doctor's supervision until the steroids are no longer needed. Under no circumstances should you abruptly stop taking your medication because this may cause serious problems. If the steroid taper is too quick, you may feel like you have the flu or have no energy. If during your taper you feel as though you can't get out of bed, call your doctor to discuss a slower taper. In all cases of steroid taper, it is advised to check in with your physician at regular intervals.

Improved surgical technique and treatment has made J-pouch surgery an increasingly viable option for younger patients in recent years. The Vancouver United Ostomy Association (we are a member of Ostomy Canada Society) has a number of "J-pouchers" who would be happy to share information and personal experiences with you.



*Specific
Groups*

THE ELDERLY

Senior patients can face extra challenges not the least of which is fear of loss of independence with an ostomy. It's especially important that elderly patients (and their families, if possible) receive adequate instruction and coaching on appliance management before they leave hospital. The senior ostomate may receive home care for a period of time to help them and their family adjust. The elderly person's ET and doctor will assess how much assistance the person may need. Older people are as capable of managing an ostomy as those much younger, but they may need more time to learn and remember new routines.

As we grow older, our skin loses elasticity and becomes thinner and drier, thus becoming prone to wrinkles and irritation. These changes can become problems for those who must wear an appliance all the time. To prevent leakage as the skin becomes more wrinkled, one should stand up straight when changing the appliance (using a mirror may help you see what you are doing).

The skin over the entire body tends to bruise more easily and heal more slowly as we age. Seniors need to be more careful when removing an appliance. Use two hands to remove the barrier -- one to hold the skin down so it isn't being stretched unnecessarily, and the other to pull the flange off. Adhesive removers may help.

Arthritis and lessening dexterity can make it more difficult to snap a two-piece appliance together. You might consider a one-piece appliance to make this easier. Ask your ET if a different kind of coupling might help. Using scissors to cut the flange hole can get harder if your hands are stiff; order appliances with a pre-cut opening if cutting is becoming a chore.

INFANTS AND CHILDREN

The same general rules apply for ostomy management with infants and children, although the appliances will of course be smaller. Unless specifically recommended by your ET nurse, do not use skin preps, paste and the like -- your baby's skin is tender and probably doesn't need these products, anyway. You should check your baby's appliance

with each diaper change to ensure it isn't leaking or slipping. You can bath your little one without an appliance on, although in the case of a urostomy, you should check with your doctor about immersing your baby in water with an uncovered stoma. Lotions, creams and powders should be kept off the skin around the stoma. You can diaper your infant with the pouch in or outside of the diaper, depending on the location of the stoma. Try different ways to see what works best.

One of the biggest challenges can be trying to change the appliance on an active infant! If you can, plan a pouch change when your baby is quieter, perhaps in the morning or after a bath. Choose a time when you know the stoma will be less active. If your baby is upset and crying, wait for a bit. Cuddle him or her and give them time to calm down. When they're in a happier mood, the whole process will go more smoothly for both of you!

Having your spouse nearby, or an older sibling can be an advantage -- the extra hands may be needed plus another person can entertain or distract an active baby during a pouch change.

Babies and small children are naturally curious and will pick or pull at the appliance once they discover it. One piece outfits can help discourage this exploration.

OSTOMATES RECEIVING CHEMOTHERAPY

What chemotherapy drugs your oncologist decides you should receive will vary depending on your cancer stage and type of cancer. You will be coached regarding how to deal with potential side effects. Chemo drugs may have no effect on your skin or stoma, or you may experience some changes:

ALL OSTOMIES TYPES:

Peristomal skin reactions

- Skin is more difficult to heal due to increased or decreased blood counts. Take extra care when removing the flange -- use two hands
- Chemotherapy may cause deep red or purple skin discoloration under the pouch faceplate. Small red spots may appear under the flange due to decreased platelet counts as on other areas of skin -- let your physician know if this occurs.

Stoma Reactions

- Stomatitis - small ulcers may appear on the stoma as on the rest of the gastrointestinal tract. If you irrigate, your physician may recommend that irrigation be stopped until stomatitis resolves itself.
- Due to decreased platelet count, the stoma may bleed when touched.
- Peristomal skin may be more prone to infection.

COLOSTOMIES AND ILEOSTOMIES

Diarrhea

- Possible reaction to chemotherapy; monitor amount of stool output; inform physician if increased significantly above normal.
- Drink adequate amounts of fluids. Nausea can sometimes make drinking enough fluids difficult; if you're having trouble, be sure you're taking your anti-nausea medication properly.
- Eat foods to help thicken stool, ie. applesauce, cheese, white rice, bananas, peanut butter, plain tea and boiled milk.
- Stay away from fatty foods, highly spiced foods and foods or beverages which cause gas or cramping.
- Potassium is lost in diarrhea and needs to be replaced. Foods high in potassium include orange juice, potatoes, bananas, soybeans, avocados, apricots, pomegranates, parsnips and turnips. Gatorade and similar sports drinks do not have high amounts of potassium, but can be helpful if that's all you can get down. Hydralyte and Pedialyte are two fluids useful for electrolyte replacement.

Constipation

- An occasional reaction to chemotherapy (may also be a reaction to some pain medications such as codeine)
- Drink adequate amounts of fluid, as above. Prune juice daily may be helpful.
- Eat foods with a laxative effect, ie: raw fruits and vegetables, chocolate, coffee, cereals, bran, whole wheat bread, dried fruit and nuts. (Remember to be cautious if eating dried fruit, nuts or raw foods. Start with small amounts and chew THOROUGHLY.)
- Do not take strong laxatives

UROSTOMIES

Check carefully for skin infections, especially yeast, which can feel very itchy and look like a rash, red spots, or weeping, irritated areas. Your ET nurse should check your skin if you suspect a yeast infection. Some chemotherapy may turn urine colours -- don't be alarmed. Adriamycin turns urine red, methotrexate turns urine yellow(er). If any blood is noted in the urine, report this to your physician immediately. Some chemotherapy drugs need extra fluids to be adequately flushed from the kidneys -- cytosan, cisplatinum. Drink LOTS of water.

PREGNANCY WITH AN OSTOMY

Having a stoma is not a contraindication to pregnancy and delivery. There are, however, several things the expectant mother will need to consider during the course of her pregnancy and after delivery.

The most significant changes that will occur during pregnancy are to the stoma (usually its height, degree of protrusion, and diameter) and to the peristomal skin contours (dips, creases, and curves). As the fetus grows and you begin to gain weight, the stoma may begin to protrude less, the diameter may increase, and the skin around the stoma may start to flatten out. The stoma may, in fact, become flush or retracted during the latter part of gestation, though its function will not likely alter. Changes in stomal height and diameter and in the peristomal contours may require a change in the type of appliance you will need to use. Switching to an alternate product is usually not required in the first trimester and the early parts of the second trimester; however, in the latter part of the second trimester and throughout the third trimester, alternate products may be required. It is best not to buy large quantities of product in the latter stages of pregnancy because of these changes in the stoma and adjacent skin. If you find that your appliance is not staying on as well as before, make an appointment with your ET nurse who can recommend adjustments.

Nausea and vomiting associated with morning sickness can be problematic if you have an ileostomy. Fluid and electrolyte imbalances can occur rapidly under these conditions, causing dehydration, so make sure you are drinking enough fluids throughout the day.

If you have a colostomy and irrigate, you may find that you are having difficulties getting enough water into the bowel, or inserting the cone. It might be necessary to suspend irrigation in this case until after delivery.

The stoma may become hard to see as you gain weight; you might need to use a mirror to see what you're doing. You might also consider temporarily switching to a longer pouch to make emptying easier.

After delivery, the stoma and peristomal skin will go through changes again: the birth of the baby may make the skin less taut, with more wrinkles/creases than previously, and the stoma may begin to protrude again. As you lose the weight associated with the pregnancy, you can make adjustments to the products you are wearing.

LGBTQ OSTOMATES

Gay, lesbian, bi, trans and queer identified ostomates have all the same issues as the straight population, with the added concern that some may be uncomfortable seeking support outside of the gay community. Please -- be upfront with your nurse or doctor about your orientation. It will help them avoid assumptions regarding your sexual activities and social situation. If you wish to speak with another gay ostomate, ask your ET nurse. They've had gay patients before and can sometimes put you in touch with them. In addition, your local UOA chapter can often connect you with a gay or lesbian member or associate.

If your surgery has or is going to involve the anus/rectum, it's imperative that sexually active gay men discuss this with their surgeon as this activity may no longer be an option.

MUSLIM OSTOMATES

The Islamic faith has very definitive rules that must be followed in preparation and during the time of prayers. The question has arisen about the wearing of a pouch during the time of prayer. Mr. Mohamed Hanafy Ahmed, when he was the General Manager of ConvaTec, Middle East, petitioned Fatwa Commission of the AL-AZHAR University for a ruling. The Fatwa Commission is the official Islamic body governing such matters worldwide and is located in Cairo, Egypt. The following submission

is an English translation of the official response as a service to ostomates of the Islamic faith.

Question -

“There is a large group of patients afflicted by colon and bladder cancer where the malignant tumor has to be removed together with the vital organ of the body so as to prevent the spread of disease. In such cases the natural opening of the body is by-passed and replaced by a stoma in the abdomen to work as an outlet through which urine or stool is emitted in an involuntary manner. Pouches used for collecting such matter are replaced when necessary.

At the time of prayers, the stoma patient is unable to change the pouch. Is it possible for such a patient to pray while the pouch is carrying such excrements and what is the rule in such a case ?”

Answer -

Praised be Allah, Lord of all creatures and peace and prayers be upon the master of messengers Mohamed, his Kin and his followers.

“In answer to this question, we reply that whoever is in such a situation is considered to have a religiously legitimate excuse. Since a stoma patient cannot replace the pouch for each prayer, he may perform absolution at the onset of each prayer interval. He may then pray as many times as he may wish during this prayer interval. At the onset of a new prayer interval, the absolution performed in the last interval is no longer valid and the stoma patient should perform a new absolution for the new prayer interval and so on (for each of the five prayer intervals.)

Chairman of Fatwa Commission of AL-AZHAR

Abd Allah Abd-Alkalik Al Mishad

8 Jumada I, 1407

8 January 1987

A young boy with blonde hair is sitting on a swing, wearing a dark blue patterned sweater and blue jeans. An elderly woman with short white hair, wearing a red long-sleeved shirt, is sitting behind him, holding the chains of the swing. They are both smiling and looking at each other. The background is a blurred outdoor setting, likely a park.

*Most
Commonly
Asked
Questions*

MOST COMMONLY ASKED QUESTIONS

CAN YOU BATHE AND SHOWER? DO YOU HAVE TO WEAR THE APPLIANCE WHILE DOING THIS? CAN YOU GO IN A HOT TUB?

YES OF COURSE you can bathe and shower. You can take the entire appliance off too, if you want. (Remember, though that you can't re-use the flange; a fresh one must be applied.) Showering is good for your skin circulation and makes you feel wonderfully clean. Plus it's nice to take that appliance right off on occasion. A shower head that is set to a hard spray may feel uncomfortable on the peristomal skin (the skin right next to the stoma) so you may need to adjust the spray to a more gentle setting. But unless you've got a real blaster of a shower you won't hurt your stoma if the spray hits it. If it feels comfortable, spray away. If not, cover your stoma with your hand or stand in such a manner that it's out of the line of fire. What if your ostomy starts working while you're in the shower? Don't worry about it. Rinse yourself and the tub/stall extra well and throw a little cleaner down the drain. You can take long baths too but ileostomies and urostomies should keep the appliance on for this. If there's a filter on your pouch, tape it closed. Your flange will begin to melt off the longer you're in there and may need to be replaced when you get out. If you wear a two piece, bathe or shower with it all on, or all off -- leaving just the flange on during bathing or showering can compromise the seal. All ostomates can go in a hot tub as well, but you may want to tape the edges of the flange so it'll hold. You may need to change the flange when you get out if it's melted down too much. You may have heard of some folks wrapping their torso in plastic wrap like Saran Wrap or Cling Wrap. Wrapping yourself in this stuff is mostly a waste of plastic.

CAN YOU SWIM? SNORKEL? DIVE?

Definitely. If you have a filter on your appliance this should be taped so water doesn't damage the filter. Filters work poorly or not at all once they're wet or even damp. Some people tape the flange edges, some don't. If you've changed your flange before swimming it's a good idea to wait an hour before going in to make sure it has adhered properly. If you wear any sort of wet suit for water sports you should of course empty the appliance before suiting up and you may need to come

back up to re-empty sooner than your diving companions. You don't necessarily have to buy special swim suits to go swimming. One piece or two-piece swimsuits that are high enough to cover the appliance work well for women. Consider buying something with a pattern or a skirt to make the outline of the appliance less visible. Board shorts are a popular choice for men who may opt to also wear biking shorts underneath for extra security. Remember that the great majority of 'normal' people have lumps, bumps and imperfections on their bodies -- very few of us are model-perfect in the first place -- and nobody is going to be staring at you. There are ostomy swimwear companies that make custom clothing if regular suits aren't working for you.

WHAT IF IT MAKES A NOISE IN PUBLIC?

There is no way to stop your ostomy from expelling gas. Ileostomies and colostomies will emit gas, which may or may not be audible to others. Snug clothing can help muffle a noisy stoma, as can a hand or forearm pressed over it. Stoma noises often sound the same as a rumbling stomach and since the sound is coming from the front of your body people often assume it's just your stomach if they notice any sound at all. Ambient noise or clothing makes most stoma noises inaudible, but if this is embarrassing you, consider cutting down on or eliminating gas-producing food or drink. Bear in mind that you're going to be hyper-sensitive to your own stoma sounds for a while. What sounds loud to you may not even be noticed by others. A polite 'Excuse me' works as well!

SOMETIMES THE STOMA BLEEDS -- WHAT DO I DO?

Stomas will bleed if cleaned too roughly, if the appliance is improperly applied, or if you accidentally scratch them with fingernails or cloth. This is normal and looks like spotting; it should stop soon if you dab the spots with tissue. Some stomas will bleed more easily than others, and certain medications (such as aspirin or blood thinners) can increase the likelihood of bleeding. Prolonged bleeding, increased amount of bleeding or very easy bleeding may indicate other problems and should be reported. If bleeding is coming from the peristomal skin area, you should see your ET at once.

NOTHING HAS COME OUT ALL DAY -- IS SOMETHING WRONG?

Just as people with an intact set of bowels can get constipated, so

can you if you have a colostomy. So long as you feel well otherwise, periodic inactivity doesn't mean anything is wrong. Drink grape or prune juice if things haven't moved in a 24 hour period. Give your body a chance to sort itself out before resorting to laxatives, and if you do, take such products sparingly. Prolonged lack of output from an ileostomy or urostomy is NOT normal and should be reported to your doctor or ET.

CAN I WEAR THE SAME CLOTHES AS BEFORE?

In most cases, yes! Make sure, if possible, to have your stoma site properly located by an ET nurse before surgery. It should be placed in a spot that won't be irritated by the type of clothing you like to wear. While you are healing you may want to wear garments with a loose waistband, such as track pants. Swelling in your abdomen after surgery will subside and in most cases, patients can return to the wardrobe they liked before surgery and this can include form-fitting outfits. If you liked wearing extremely tight or low-cut jeans or pants before, unfortunately it might be best to give those away. Pants that are really tight over the stoma won't allow waste to drop properly into the bag.

Depending on body type, some stomas may have to be located higher than usual. If this is the case with you, you can opt to wear pants or skirts higher in the waist. Or, you can take the opposite approach and wear your clothing lower on the hips with a shirt worn out over top. Men sometimes find suspenders to be a good addition to their wardrobe.

WHEN CAN I RETURN TO WORK?

Your doctor will be the best judge of when you are fit enough to resume work. If your job involved heavy physical activity, you need to let your doctor know this so he or she can recommend any changes in duties that may be necessary. In most cases patients can resume their former employment without problems. It can take months to regain former strength and stamina however, so you should discuss the possibility of shorter hours or part-time shifts with your employer for the first few weeks. It's also best to explain that you may need to take more bathroom breaks than before. (It could also be possible that you won't need to use the bathroom as often as you did before!)



*Tips &
Tricks*

TIPS AND TRICKS

- The best tip for changing an ileostomy is to be prepared and organized *before* you start, and do your change as efficiently as possible. The more you wipe and fool around with the stoma, the more opportunity it will have to produce output when you least want it to.
- To help stop ileostomy discharge during a change, delay eating a meal and eat some plain marshmallows up to 30 minutes before changing the appliance.
- Make sure your peristomal skin (the skin around the stoma) is *completely* dry before applying the flange. Bathrooms can be warm and humid after a bath or shower -- give your skin plenty of time to dry thoroughly.
- A few drops of pouch lubricant inside the top of the appliance will help prevent 'pancaking' of stool around the stoma. Most of the manufacturers make such lubricants, ask for a sample.
- Use two hands to remove a flange -- one to hold the skin down and the other to gently peel the flange off. Try to minimize how much you are stretching or pulling on the skin.
- Write the day you change your appliance in ink on the outside of the barrier itself to help you remember when it's time to change again, or keep a calendar in the bathroom for this purpose..
- If using a hairdrier to speed up drying of the peristomal skin during a change keep it on LOW setting. High heat can burn delicate stoma tissues.
- If your paste tube has become too hard to squeeze, put it in a glass of hot water for 20 minutes.
- If you are being admitted to hospital for tests or any other reason, take your own ostomy supplies with you! The hospital may not

stock what meets your particular needs, or attending nurses may not be familiar with ostomies. Even if the hospital has what you require, it may take a bit of time to locate it.

- If shaving abdominal hair, use an empty cardboard toilet roll as a shield around the stoma. Shave in the direction of hair growth.
- Oatmeal added to your bath can relieve itchy skin. Pour some oatmeal into a cloth bag or a piece of cheesecloth, tie it shut and put it into the bathwater. You can also use the oatmeal bag like a sponge to soothe irritated skin.
- Use non-alcoholic adhesive removers to get residue off peristomal skin. Limit use of alcohol to clean your skin.
- Don't use the same flange too long. The shape and size of your stoma, body contours, and type of waste all have a bearing on the durability of the seal. It is not advisable to leave an appliance in place for more than 7 days as 'hidden' seepage or leakage can occur under the flange. You can extend wear time only if your skin is in very good condition, and there is no evidence of seepage on your skin.
- If you use skin sealant, make sure it dries completely before applying the flange.
- Pay attention to skin problems. Address signs of skin irritation immediately. If you're not sure what to do, call your ET.
- Don't wrap the drainable pouch tail around and around the clamp before closing it. This will not make the clamp work better, it will just spring it out of shape. Replace your old clamp with a new one if it shows signs of loosening.
- Don't let the pouch get full before emptying. Excess weight will separate a two-piece system and will also put too much weight on the skin barrier resulting possibly in multiple problems. Empty the pouch when it is about one-third full, or sooner.

- You don't need to wear gloves to change or empty your appliance. When you were discharged from hospital, your kit may have contained gloves. Since your nurses and doctors usually wore gloves when tending to you, you might be led to believe you should always wear gloves when changing your appliance. There is no need to wear such things while maintaining personal hygiene. (Have you had children? Did you wear gloves when changing your little ones' diapers? Of course not. You're no more unclean than they were.) Wash your hands after changing or emptying.
- If urine is collected for urinalysis be sure your doctor and nurse know a sterile specimen must be taken directly from your stoma and not from the pouch. Bacteria builds up in the pouch quickly and may give false test results. If they are not sure how to do this, do the following:
 - remove your pouch
 - clean the stoma
 - catch the urine in a sterile cup or have an ET/WOC nurse catheterise your stoma to get a sterile sample
- An ostomy belt can help keep your appliance secure if you're having trouble keeping it in place.
- Try tips from other ostomates that might apply to issues you have but remember everyone is different. What works for one person may not work for another but it's worth a try.
- Perhaps the most important bit of advice is don't get down on yourself if you make mistakes! We've all made mistakes and sometimes we still do. Learn from any errors you may make and keep moving forward.

*Emotional
Issues for the
Patient and
their Family*



COMING HOME

You will be discharged from hospital after your doctor and/or ET nurse is confident that you have recovered sufficiently from your surgery and understand the basics of stoma management. No doubt you will be glad to be in familiar surroundings again but coming home with a new ostomy can be a difficult time. The reality of what has happened may hit once you are out of the hospital, away from the everyday routine of the ward, once the visitors and flowers are gone. It may be a shock to discover that you feel worse, emotionally, when you get home. You wouldn't be the only one who has felt that way.

Give yourself time. You'll feel weak and uncomfortable during the early weeks or months and may wonder if you'll ever feel like your old self again. The task of caring for a new ostomy can seem overwhelming and you may feel dismayed at all the new things you need to do and remember. You may experience sadness, frustration, anger or depression -- all these feelings are normal and we all went through them in the beginning. Just as it takes time for the body to heal, it also takes time to heal emotionally from this kind of surgery. It's common to have negative feelings and far better to release them through tears or talking than to bottle them up. Negative feelings or withdrawal cannot be allowed to become a way of life, however. Fundamental management techniques must be learned, and new experiences or problems that may develop can be met and managed as they occur. As you learn and master the skills needed, you will gain in confidence.

You don't have to like your ostomy. You DO have to learn how to live with it.

Ostomy patients can fear being shunned or pitied by others. We have all felt the dread of losing our independence, our self-confidence and our dignity. Such reactions are universal and valid. It's important, however, for the new ostomate to realize that how they see themselves will be how others see *them*. If you are embarrassed and ashamed, those around you will reflect that. If you think you can't do something and refuse to try, others will gradually assume you are incapable. You have a responsibility to live your life fully and to provide an example of triumph over adversity, courage over despair and pride over pity.

There is no answer for “Why Me?” No illness or injury is fair. Rather than question why this has happened to you, give some thought to how you will live your life from this point on, for you have indeed been given a second chance. Not all patients get to come home from hospital. You did.

SPOUSES, FAMILY AND CAREGIVERS

This is a change in your life, too. Your loved one may cope well with the ostomy and resume former activities at a surprising rate. Some individuals need more time to regain their confidence. There is no set timetable, we all adjust at our own speed. It is important however, for a new patient to resume their normal routine as before, and to learn to manage their ostomy by themselves. Unless your family member is physically unable to change their own appliance, they should not be relying on you to do this for them. Independence is vital to regaining self-esteem. Dealing with a new ostomy can be frustrating so encouragement and patience may be needed. Family members and loved ones should be aware that coming to terms with an ostomy is a process that can involve grieving for what has been lost.

Just as a new ostomy patient can feel overwhelmed with it all, you may feel overwhelmed yourself. If this is the case, seek out other spouses or caregivers with whom you can share your feelings. SASO (Spouses and Significant Others) is a volunteer group formed by spouses and partners of ostomates for the purpose of providing support and encouragement to the spouses of new patients. Contact your local Ostomy Canada Society chapter or Peer Support Group for SASO contacts in your area.

A woman with short, layered blonde hair is looking intently at a laptop screen. She is wearing a bright pink top and has her left hand resting on her chin in a thoughtful pose. The background is a bright, out-of-focus window.

*Additional
Resources &
Information*

OSTOMY MANUFACTURERS

The most prevalent brands of ostomy products in Canada are Convatec, Coloplast and Hollister, Marlen, SALTS, B Braun, Nu-Hope and CyMed. We strongly encourage all those with an ostomy to try new products and experiment to find the best possible match for your needs. **Ostomy companies want you to try their products!** Don't be shy about contacting them. All will supply free samples upon request. This is an ideal way to 'test-drive' different products without cost. The following companies have toll-free numbers you can call to request samples. When calling, you should specify the type of ostomy you have, what your stoma size is, and any particular concerns you may have.

Not sure what size your stoma is? You should have been given a measuring template by your ostomy nurse, or you will find one in your current ostomy supplies. If you have misplaced or lost these, your nurse or any supplier will gladly give you one free of charge.

It can take time and some trial and error to find the right products for you. Free samples can take up to several weeks to arrive, so be patient.

ARGYLE MEDICAL DISTRIBUTORS Inc.
(distributors of SALTS Healthcare ostomy products)
1-877-927-4953

COLOPLAST

Toll-free phone: 1-888-880-8605
1-866-293-6349
Toll-free fax: 1-877-820-8206
Monday to Friday, 8:00 am to 6:00 pm (Eastern Standard Time)

CONVATEC

Toll-free phone: 1-800-465-6302
Toll-free fax: 1-877-437-1777
Monday to Friday, 8:00 am to 7:00 pm (Eastern Standard Time)

CYMED (pronounced "sigh-med")

Toll-free phone: 1-800-582-0707
Monday to Friday (8:00 am to 5:00 pm) (Pacific Standard Time)

HOLLISTER

Toll-free phone: 1-800-263-7400

Monday to Friday, 7:00 am to 5:45 pm (Central Standard Time)

MARLEN

Phone: 604.638.2761 Toll Free: 1.844.379.9101

Monday to Friday, 8:00 am to 4:00 pm (Pacific Standard Time)

NU-HOPE

Toll-free phone: 1-800-899-5017

Monday to Friday, 8:00 am to 4:30 (Pacific Standard Time)

B BRAUN

Toll-free office: 1-855-822-7286

Toll-free Canadian customer support: 1-800-624-2920

Monday to Friday, 8:00 am to 4:00 pm (Eastern Standard Time)

Ask at your local supplier for availability.

OSTOMY SUPPLIERS

It is not possible for us to list all ostomy suppliers in the Vancouver area -- these are some of the ones with a product selection on site if you want to take a look in person. If you reside in an outlying area, you can consult your ostomy nurse for dealers who live closer to you. You can also inquire about free delivery service offered in your area. Many suppliers offer full-time or part-time ET nurse clinics. Call to inquire regarding ET consultation services. Some suppliers will also supply samples of products upon request -- call to inquire. Some suppliers now offer online ordering as well, while others are exclusively online.

DAVIES PRESCRIPTIONS AND PHARMACY

www.daviespharmacy.com

1401 St. Georges (across from Lion's Gate Hospital)

North Vancouver, BC V7L 3J3

604-985-8771

LANCASTER MEDICAL

www.lancastermed.com

601 West Broadway

Vancouver, BC V5Z 4C2

604.873.8585 (Vancouver)

604.526.3331 (Burnaby) 604.582.9181 (Surrey)

LIFECARE MEDICAL

www.lifecarel.ca

130 - 3030 Lincoln Ave

Coquitlam BC

604.941.5433 Fax: 604-941-2383

1 - 22722 Lougheed Highway

Maple Ridge, BC

604-481-5433 Fax: 604-481-5436

MACDONALD'S PRESCRIPTION #3 KITSILANO

www.macdonaldsprescriptions.ca

2188 West Broadway

Vancouver BC

604.738.0733

(note: there are several Macdonald's Prescription outlets throughout the lower mainland; consult your phone book to find those that stock ostomy supplies in your area)

NIGHTINGALE MEDICAL SUPPLIES LTD. (7 locations)

www.nightingalemedical.ca

Nightingale Vancouver - Broadway

104 - 950 W Broadway

Vancouver, BC V5Z 1K7

Phone: 604.563.0422

Toll Free: 1.800.663.5111 Fax: 604.336.3179

Nightingale Vancouver - South

125 - 408 East Kent Avenue South

Vancouver, BC V5X 2X7

Phone: 604.879.9101

Toll Free: 1.800.663.5111 Fax: 604.879.3342

Nightingale Langley

103 - 19909 64th Avenue

Langley, BC V2Y 1G9

Phone: 604.427.1988

Toll Free: 1.855.427.1988 Fax: 604.427.1989

Nightingale White Rock

1477 Johnston Road

White Rock, BC V4B 4A1

Phone: 604.536.4061

Toll Free: 1.877.386.8773 Fax: 604.536.4018

Nightingale Victoria
815 Bay St
Victoria, BC V8T 1R3
Phone: 250.475.0007
Toll Free: 1.855.475.0007 Fax: 250.475.0004

Nightingale Vernon
111 - 3400 Coldstream Avenue
Vernon, BC V1T 8B5
Phone: 250.545.7033
Toll Free: 1.800.545.8977 Fax: 250.558.0034

Nightingale Kamloops
632 Victoria Street
Kamloops, BC V2C 2B4
Phone: 250.377.8844
Toll Free: 1.877.377.8845 Fax: 250.377.8889

OSTOMY CARE & SUPPLY CENTRE

www.myostomycare.com
2004-8th Avenue
New Westminster, BC V3M 2T5
604.522.4265 or toll-free 1.888.290.6313

REGENCY PRESCRIPTIONS & MEDICAL SUPPLIES

www.regencyrx.com
1144 Burrard Street (across from ST. Paul's Hospital)
Vancouver, BC V6Z 2A5
604.688.4688 Fax: 604.648.8028
(note: there are several Regency outlets throughout the lower mainland; consult your phone book to find those that stock ostomy supplies in your area)

SHOPPERS HOME HEALTH

shoppershomehealthcare.ca
2790 Oak Street (near Vancouver General Hospital)
Vancouver, BC V6H 0A5
604.876.4186
(note: there are several Shoppers Home Health outlets throughout the lower mainland and BC; consult your phone book to find those that stock ostomy supplies in your area)

DOES MEDICAL COVERAGE INCLUDE OSTOMY SUPPLIES??

BC's Fair Pharmacare plan which was implemented in May of 2003 subsidizes eligible ostomy products. The deductible you will pay for your supplies will vary depending on your annual income, based on the tax year two years prior (ie: your 2017 coverage would be based on your 2015 reported income) If you have experienced a drop in annual income, you should contact Pharmacare to ensure your deductible reflects this change in finances. Extended medical plans such as Blue Cross will provide considerable coverage after a minor yearly deductible.

What's covered?

Basically anything for use specifically with ostomy management is eligible, such as:

- all types of pouches, flanges, stoma caps, stoma patches
- irrigation and night drainage kits
- paste, skin prep, ostomy adhesive remover
- Micropore tape
- Devrom
- ostomy belts

Examples of products NOT covered are:

- any brand of tape other than Micropore
- liquid ostomy deodorant (figure that one out!)
- hernia belts
- general skin care or first aid supplies
- Imodium, Metamucil and similar products

If you are unsure about coverage for any products you use, contact Pharmacare directly or inquire at your ostomy supplier. For questions about how to receive your maximum financial assistance under PharmaCare or how to register, call toll-free in BC:

1-800-387-4977

8:00 AM to 8:00 PM weekdays

8:00 AM to 4:00 PM weekends

ET CLINICS AND OUT-PATIENT RESOURCES

The following is a list of pre-surgical counselling and post-surgical follow-up clinics. Few hospitals offer out-patient ostomy appointments now and not all hospitals have full time ET nurses. Call your hospital or supplier to inquire about the nearest out-patient options for your area. Out-patient services are often available at local ostomy suppliers. Call for availability and appointment times. Most out-patient clinics outside of the hospital offer initial appointments with an ET nurse free of charge, some may charge a fee for this service. Hours vary at retail clinics, call to inquire. *Note: suppliers in your area may offer ET clinics not listed here -- call to inquire.*

HOSPITALS

Vancouver General Hospital 604-875-5788

(Vancouver)

St. Paul's Hospital. 604-682-2344

(Vancouver)

ext. 62917

Children's Hospital 604-875-2345

(Vancouver)

local 7658

Lion's Gate Hospital 604-984-5871

(North Vancouver)

Royal Columbian Hospital 604-520-4292

(New Westminister)

Surrey Memorial Hospital 604-588-3328

(Surrey)

Langley Memorial Hospital. 604-514-6000

(Langley)

ext. 5216

M.S.A. General Hospital. 604-853-2201

(Abbotsford)

ext. 7453

Chilliwack General Hospital. 604-795-4141

(Chilliwack)

ext. 447

Peach Arch Hospital. 604-531-5512

(White Rock)

local 7687

Richmond General Hospital 604-278-9711

(Richmond)

ext. 5235

CLINICS

Lancaster Sales & Rentals 604-873-8585

(Vancouver)

LifeCare Medical 604-941-5433

(Coquitlam and Maple Ridge)

Macdonald's Prescriptions 604-738-0733

(Kitsilano)

Nightingale Medical Supplies Ltd. 604-879-9101

(7 locations)

Ostomy Care & Supply Centre 604-522-4265/

(New Westminster)

1-888-290-6313

Regency #6 604-688-4644

(Vancouver)

CONNECT WITH OTHERS ON THE INTERNET

The internet has radically changed how we gather information and network with other ostomates. From product information, advances in treatment and surgical technique, to fellowship and support, there is a wealth of information online. Just as we encourage new ostomates to try different products and to join and participate in local ostomy support groups or chapters, we encourage those with access to a computer to look into some of the following sites. They will inform, entertain, reassure, and above all, let you know you are not alone.

OSTOMY DISCUSSION BOARDS

Discussion boards, forums and blogs come and go too often to keep a comprehensive up to date listing so we are listing only a handful. Many more exist and can be found with a general search. These boards deal with every conceivable ostomy type, issue and concern. All are free, as anonymous as you wish, and moderated for taste and privacy. These are not chat rooms, although some have chat areas.

VeganOstomy (Canadian)

<https://www.veganostomy.ca/community/ostomy-forum/>

Inspire Ostomy (United States)

<https://www.inspire.com/groups/ostomy/>

Ostomyland (UK)

<http://www.ostomyland.com/ostomyland/>

UOAA (United States)

<https://www.uoaa.org/forum/index.php>

OSTOMY CANADA SOCIETY WEBSITES

Ostomy Canada Society

<http://www.ostomycanada.ca/>

Ostomy Canada Society List of Chapters

<http://www.ostomycanada.ca/support/canadian-chapters/>

Vancouver United Ostomy Association

<http://uoacvancouver.weebly.com/>

Peace District Ostomy Association

<http://www.peaceostomy.com/>

Calgary Ostomy Society

<http://www.calgaryostomysociety.com/>

Edmonton Ostomy Association

<http://www.ostomyedmonton.com/>

Saskatoon Ostomy Association

<http://www.saskatoonostomy.ca/>

Winnipeg Ostomy Association

<http://www.ostomy-winnipeg.ca/>

Ostomy Toronto

<http://www.ostomytoronto.com/>

Ostomy Ottawa

<http://www.ottawaostomy.ca/>

Hamilton Ontario Ostomy Association

<http://www.inform.hamilton.ca/record/HAM0235>

Fredericton and District

<http://ostomyfredericton.weebly.com/>

Ostomy Halifax

<http://www.ostomyhalifax.ca/>

Niagara Ostomy Association

<http://www.niagaraostomy.com/>

Ileostomy/Colostomy Association of Montreal

<http://www.aicm-montreal.org/>

International Ostomy Association

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

MISC

United Ostomy Associations of America

<http://www.ostomy.org/Home.html>

Colorectal Cancer Society of Canada

<http://www.colorectal-cancer.ca/>

Bladder Cancer Canada

<https://www.bladdercancer canada.org/en/>

Badgut Gastrointestinal Society

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

Canadian Cancer Society

<http://www.cancer.ca/>

Crohn's and Colitis Foundation of Canada

<http://crohnsandcolitis.ca/>

Friends of Ostomates Worldwide (FOW)

<http://www.fowc.ca/>

HealthLink BC

<http://www.healthlinkbc.ca/>

The J-Pouch Group

<http://jpouch.org/>

Canadian Association of Enterostomal Nurses

<https://caet.ca/>

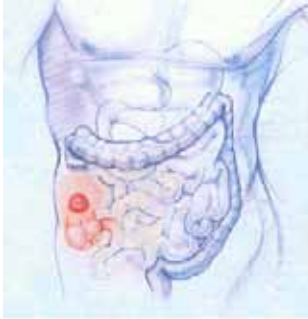
Find An ET Nurse in Your Area (CAET website)

<https://members.caet.ca/etfinder>

COMMON TYPES OF OSTOMY SURGERIES

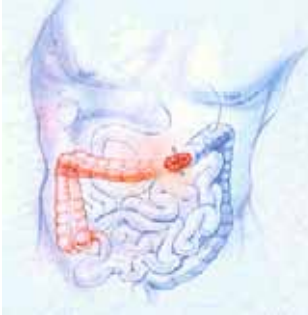
COLOSTOMY

A colostomy is a surgically created opening in the abdomen through which a small portion of the colon is brought up to the surface of the skin. This new opening, called a stoma, allows stool to pass directly out of the body, bypassing a diseased or damaged section of the colon. In some patients, this section may be removed. There are four main types of colostomies, named after the portion of the bowel where the colostomy is located:



ASCENDING COLOSTOMY

Output will be liquid, rich in digestive enzymes and irritating to the skin around the stoma. Output will be frequent.



TRANSVERSE LOOP COLOSTOMY

Waste will be liquid to semi-solid, and less irritating to the skin. Output will be less frequent.



DESCENDING COLOSTOMY

Waste will be semi-solid to solid as water has been removed during passage through the preceding large bowel. Output is non-irritating to skin and less frequent.



SIGMOID COLOSTOMY

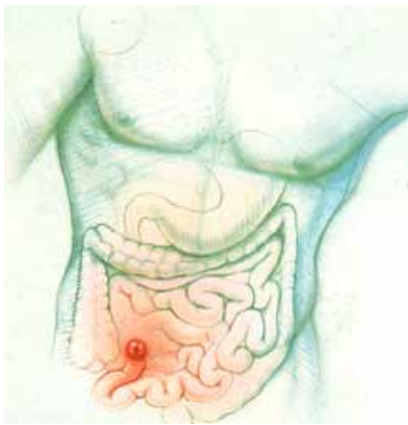
Waste will be formed and similar to that of an intact bowel. Output is non-irritating to skin and occurs at certain times of day or night, depending on diet and when one eats.



LOOP OSTOMY

(Ileostomy or colostomy) An incision is made into the bowel itself without completely cutting the bowel in half. Sometimes a rod is placed under the bowel on top of the level of the skin to prevent the bowel from slipping back beneath the skin surface. This rod is typically removed before leaving the hospital. Once this is done, the bowel is then turned inside out and the surgeon

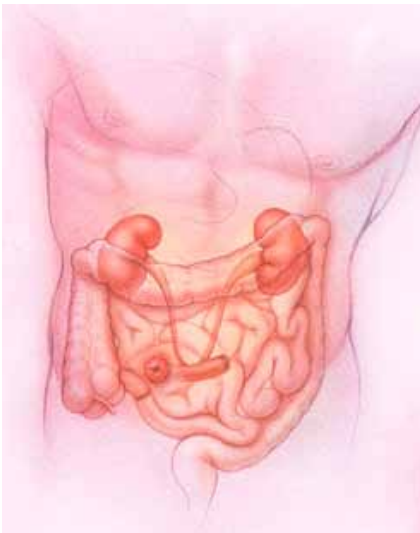
sutures the bowel to the surface of the skin. There will be 2 openings to the stoma. The one opening will pass stool and the other opening will pass mucus. With a loop stoma, there may be a feeling or urge to have a bowel movement. If you sit on the toilet you may pass some mucus. This is normal. [See the section on rectal drainage.]



ILEOSTOMY

Severe cases of ulcerative colitis or Crohn's disease may be treated by the surgical creation of an ileostomy, where the end of the ileum is brought to the surface of the skin. The colon may be left intact in order to heal and allow the patient to be reconnected, or, in many cases it will be removed entirely. Its function, reabsorbing salt, electrolytes and water will

be carried out to some degree by the small intestine. Ileostomies are active at frequent intervals throughout the day, usually after a meal.



UROSTOMY

A urostomy, or urinary diversion is a surgically created opening in the abdomen that allows urine to pass directly out of the body. Most commonly performed to remove bladder cancer, a urostomy may also be necessary where interstitial cystitis or some types of kidney disease are present, or if there is severe injury to the urinary tract. Urostomies are always on the right side of the body, and generally have very little or no odor.

Waste will collect throughout the day and night. Some patients employ a night drainage system to collect urine while they are sleeping.

- illustrations courtesy ConvaTec

ABOUT THE UOA VANCOUVER

The Vancouver Chapter of the United Ostomy Association began over 45 years ago as the dream of Miss May Fawcett, a forthright, outspoken, Fort Macleod, Alberta, school teacher who moved to Vancouver in the 1950's and worked as a salesperson for a major Vancouver printer, until her passing in St. Paul's Hospital in 1987.

May had her ileostomy surgery in 1967 at St. Paul's and soon discovered there was no organized help or support for ostomates in British Columbia. Once they left the hospital, new ostomates pretty much had to experiment and figure things out on their own with the help of eager, but inexperienced salespersons in the ostomy appliance retail shops. Miss Fawcett, mercifully, set out to change all that.

In 1968, with the help of her surgeon, Dr. E. N. McHammond and his brilliant and dedicated associate, the now retired, Dr. Kenneth Atkinson, May set about organizing a local support group for new and existing ostomates in the Vancouver area and in the summer of 1968 the Ileostomy Association of British Columbia (IABC) was registered as a non-profit Society with the Provincial Government in Victoria, with May as President and Bea Brail as Treasurer. There were 30 members, annual membership fees were \$3.00 and monthly meetings were held at G. F. Strong Rehabilitation Centre at 900 West 27th.

From the beginning the IABC affiliated with the United Ostomy Association in the USA, headquartered in Los Angeles. Miss Fawcett also volunteered as a Provincial Representative and was instrumental in organizing Ostomy Chapters throughout British Columbia and Alberta. In November of 1970 the IABC became the United Ostomy Association of British Columbia and later the Vancouver Chapter of the UOA.

On June 12, 2000, the Vancouver Chapter, along with almost all other Canadian Chapters, bid a fond thank you to the wonderfully helpful UOA in the USA and joined the new Canadian group, the United Ostomy Association of Canada. The UOAC was formed in 1991, after lengthy and tireless efforts of the late Alan Porter of the Hamilton, Ontario chapter.

The Vancouver Chapter serves all municipalities in the lower mainland. The Vancouver chapter publishes a newsletter 'HighLife' six times yearly, and holds 4 meetings per year in Vancouver. Attendance at meetings is free, and all are welcome regardless of whether or not you have an ostomy. For more information on meeting times and dates, please see our website:

<http://uoacvancouver.weebly.com/>

Interested in joining our chapter? Please fill out the application below.
We'd love to meet you.

MEMBERSHIP APPLICATION
Vancouver United Ostomy Association Chapter

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

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

I am enclosing my annual membership dues of \$30.00. I wish to make an additional contribution of \$_____, to support the programs and activities of the Vancouver United Ostomy Association. Vancouver Chapter members receive our HighLife Newsletter six times yearly, become members of the Ostomy Canada Society, and receive Ostomy Canada magazine twice yearly.

Name: _____

Address: _____

City: _____ Postal Code _____

Phone: _____ Year of Birth _____

email: _____

Type of ostomy: colostomy ileostomy urostomy
 continent ostomy internal pouch

other (specify) _____

email newsletter? yes no

Contributions of \$20 or more will be issued a tax receipt.

Please make cheque payable to:

UOA Vancouver Chapter

and mail to:

Vancouver United Ostomy Association

PO Box 74570, 2768 West Broadway, Vancouver, BC V6K 2G4

The Vancouver United Ostomy Association Chapter wishes to thank the following publications, associations, websites and manufacturers for reference material:

Ostomy Canada Society
UOAA
Evansville Re-route
Ostomy International Magazine
Metro Halifax Ostomy News
Regina Ostomy Newsletter
The British Hernia Centre
Ottawa Ostomy News
Coquitlam UOAC
Ostomy Toronto
Prince George Ostomy Hotline
Argyle
Coloplast
Convatec
Cymed
Hollister
Marlen
Nu Hope
Ostomy International
Winnipeg Ostomy Association
New Directions, Ft. Worth, TX
Stratford & District, ON
Mayo Clinic On-line
Wound, Ostomy and Continence Nurses' Society

A Handbook for New Ostomy Patients was conceived and produced by Vancouver UOAC member Debra Rooney in 2006. Thank you to Fred Green for writing the history of the Vancouver chapter and Shabita Teja for writing the J-Pouch section. Thank you as well for major contributions of proofing and input from ET nurses Andy Manson and Arden Townshend of Ostomy Care and Supply Centre and Lauren Wolfe of Nightingale Medical Supplies.

