LETTER FROM THE EDITOR

If errors are noted in your name or address, please bring these to my attention. If you know of someone to add or delete from our mailing list, please notify me. I can be reached at work at 325-670-4302, or by e-mail at callen@hendrickhealth.org. We are now sending our newsletter electronically to those who request it be sent that way. Please send me your e-mail address if you would like a link to the newsletter.

If you know of someone who would be a good speaker at one of our meetings, please contact us.

– Charlotte Allen, MSN, RN-BC, CWOCN

LAST MEETING
For the February 13 meeting, Marka Riddle, registered dietician, talked to the group about dietary issues. She shared some good websites for tracking and learning about healthy food choices.

NEXT MEETING
Since March is Colon Cancer Awareness Month, Dr. Brad Kendrick, colorectal surgeon, will speak to the group at the March 13 meeting. Hope you all can come out and support him.

MAY & JUNE MEETING
For the May and June meetings, we will hold visitor training. This program trains ostomates on how to visit patients with new ostomies. Mark your calendars now to attend. The WOC nurses really want volunteers to be encouragers to new ostomates!

Everyone is welcome. Bring your spouse or a friend or come alone.

We meet in the Diabetes Center at 1742 Hickory (corner of Hickory and N. 18th) at 6:30 p.m. Hope to see you there!

CONTACT US

For more information, please contact us at 670-4302.

Newsletter Editor & Professional Advisor:
Charlotte Allen, RN, CWOCN
670-4302
email: callen@hendrickhealth.org

March
Colorectal Cancer Awareness Month

Via American Society of Colon and Rectal Surgeons, 2017 retrieved from: https://www.fascrs.org/newsletter-article-sample-colon-cancer-awareness

Screening and Early Detection is Key to Effective Treatment

March is Colorectal Cancer Awareness Month, and a good time to learn more about colorectal cancer (cancer of the colon and rectum) and how it can be prevented or best treated.

Colorectal cancer is the second leading cause of cancer-related deaths in the United States for both men and women combined. This year, approximately 140,000 new cases of colorectal cancer will be diagnosed, and 56,000 people will die from the disease.

"But colorectal cancer is a disease that can be prevented through regular screenings, a healthy diet and regular exercise," explained Charlotte Allen and Vina Gilbert, ostomy nurses at Hendrick Medical Center.

How can I lower my risk?
To lower your risk of colorectal cancer, the American Society of Colon and Rectal Surgeons recommends that you:

- Get regular colorectal cancer screenings after age 50. Between 80-90% of colorectal cancer patients are restored to normal health if their cancer is detected and treated in the earliest stages.
- Eat a low-fat, high-fiber diet.
- If you use alcohol, drink only in moderation. If you use tobacco, quit. If you don't use tobacco, don't start. Alcohol and tobacco in combination are linked to colorectal cancer and other gastrointestinal cancers.
- Exercise for at least 20 minutes three to four days each week. Moderate exercise such as walking, gardening or climbing steps, may help.

Can colorectal cancer be cured?
Since there are very few symptoms associated with colorectal cancer, regular screening is essential. Screening is beneficial for two main reasons: colorectal cancer is preventable if polyps that lead to the cancer are detected and removed; and it is curable if the cancer is detected in its early stages.

"If detected, colorectal cancer requires surgery in nearly all cases for complete cure, sometimes in conjunction with radiation and chemotherapy," said Allen and Gilbert. "Between 80-90 percent of patients are restored to normal health if the cancer is detected and treated in the earliest stages. However, the cure rate drops to 50 percent or less when diagnosed in the later stages."

In addition, studies have shown that patients treated by colorectal surgeons - experts in the surgical and nonsurgical treatment of colon and rectal problems - are more likely to survive colorectal cancer and experience

fewer complications. This is attributed to colorectal surgeons' advanced training and the high volume of colon and rectal disease surgeries they perform.

Who is at risk for colorectal cancer?
The risk of developing colorectal cancer increases with age. All men and women aged 50 years and older are at risk for developing colorectal cancer, and should be screened. Some people are at a higher risk and should be screened at an age younger than 50, including those with a personal or family history of inflammatory bowel disease; colorectal cancer or polyps; or ovarian, endometrial or breast cancer.

Current screening methods include fecal occult blood testing (a simple chemical test that can detect hidden blood in the stool), flexible sigmoidoscopy (a visual examination of the rectum and lower portion of the colon, performed in a doctor's office), double contrast barium enema (barium X-ray), colonoscopy (a visual examination of the entire colon) and digital rectal exam. Colorectal cancer screening costs are covered by Medicare and many commercial health plans. You should find out from your colorectal surgeon or other healthcare provider which screening procedure is right for you and how often you should be screened.

Herbs and the Intestine

Via UOAA Update

Herbs have long been proclaimed as nature's remedy for many of our maladies. The fact is that 40 percent of all prescribed drugs are based on chemicals from plants.

The following are a few examples:

- **Bay Leaves** added to slow cooking foods are said to "tone" the digestive tract. They also relieve cramps and expel wind from the stomach and bowels.
- **Cayenne** is claimed to have such benefits as easing congestion, warming your feet and aiding indigestion.
- **Dill** is an old remedy for stomach ulcers, probably because of its calming effect. But it will also reduce flatulence when uses as a seasoning.
- **Garlic** has long been proclaimed to be an aid to the immune system and effective against colds, flu and helps in gastrointestinal disorders. It works better raw than cooked.
- **Thyme** in tea is proclaimed to be a cold remedy.

Odor Management

GAOA ATL Newsletter 2010, Edited by B. Brewer, UOAA UPDATE 10/2011

Many things, such as foods, normal bacterial action in your intestine, illness, different medicines and vitamins can cause odor. Some people with ileostomies have more trouble with odor than others. Individual experimentation is the only solution to this problem. The odor of ileal contents is not the same as that of a normal stool because the bacteria that cause food breakdown (and odor) in the colon are not present in the small intestine.

Here are some hints for odor control:

- Use an odor-resistant pouch.
- Check to see that the skin barrier is securely sealed to the skin.
- Empty the pouch frequently. (odor may permeate the pouch)
- Check out the closure of the pouch to ensure that it is closed properly.
- When showering, wash the clamp and the spout.
- Do not put holes in the pouch as gas/odor will seep out continuously. Note. Some ostomates find the pouch filters very helpful, however, some ostomates are concerned about gas/odor escaping in public and would prefer to go into the toilet and open the bottom of the pouch in private.
- Place special deodorant liquids or tablets in the pouch.
- Oral preparations are available. Check with you physician or ostomy nurse about the suitability of these products and recommended dosage. Among those that many have found effective are chlorophyll tablets and Devrom®. This helps to prevent odor when empting.
- Urostomates should rinse or wipe off the spout of the pouch with a toilet tissue after emptying. *Note: Most urostomy pouches on the market are odor-proof, but the connector tubing and bedside drainage unit is not.. (One part white vinegar to three parts water is good for cleaning urine pouches, tubing and bedside bag.) Or dispose of and replace these products when they take on odors.*

G: Good News and Bad News

My older sister Carolyn was having a heart cath, and my sisters Kathy and Marsha and I decided to make the trip to Columbia to be with her. We arrived after a two-hour trip from Charlotte before she got to the hospital, and the nurses generously offered to let us stay in her assigned room.

As we sat there waiting, a nurse walked in, looked straight at me and said, "I need to get you in a gown." I informed her I was not the victim—I mean patient. A few minutes later another nurse came in and tried to take blood out of me. When Carolyn finally arrived, we informed her that we had good news and bad news for her. The good news was they thought I was her, and my heart was in excellent shape. The bad news was if that was true, someone had stolen her rectum! The nurses got a good laugh, too.

Diana Boyles of North Carolina had a colostomy in 1995 and six months later this was changed to an ileostomy. She states she got through her hard times with family, church and the love of her man, Charles.

Used with Permission from Brenda Elsagher from: I'd Like to Buy a Bowel Please: Ostomy A to Z, *www.livingandlaughing.com*

Important Ostomy Questions & Answers

From the UOAA Winter 2017 Update
By Amparo Cano, MSN, CWOC and Debbie Walde, BSN, CWOC

Urostomy UTI, Crusting Procedure, Peristomal Skin Problems, Hydration, Diet, Hospitalization and More!

What are the signs and symptoms of UTI in people with a urostomy?
Fever, strong smelling urine, cloudy urine, increased mucus, retroperitoneal pain, bloody urine or new onset confusion (in elderly patients).

What is the crusting procedure which helps to cure irritated or raw peristomal skin?

1. Clean the peristomal skin with water (avoid soap) and pat the area dry.
2. Sprinkle skin barrier powder onto the denuded skin.
3. Allow the powder to adhere to the moist skin.
4. Dust excess powder from the skin using a gauze pad or soft tissue. The powder should stick only to the raw area and should be removed from dry, intact skin.
5. Using a blotting or dabbing motion, apply the polymer skin barrier over the powdered area, or lightly spray the area if you're using a polymer skin barrier spray.
6. Allow the area to dry for a few seconds; a whitish crust will appear. You can test for dryness of the crust by gently brushing your finger over it; it should feel rough but dry.
7. Repeat steps 2 through 6 two to four times to achieve a crust.
8. You may apply a pouching system over the crusted area. Stop using the crusting procedure when the skin has healed and is no longer moist to the touch.

Dealing with Social Situations

Via Dr. Craig A. White, Metro Maryland

Social anxiety usually occurs when you believe that something will go wrong in a social situation. You may worry that your ostomy will make a noise or that you will smell. You may imagine that your bag will leak all over your clothes in the middle of the supermarket or that noises might erupt from the bag during prayers at church. Accidents and unplanned incidents do happen. Instead of assuming that you couldn't cope, why not make a coping plan now before it happens? Instead of stopping your thought process after you have considered the worst possiblity, take it forward and construct a coping plan. Remember, even if your worst fears do come true, there is always something you can do to cope.

Most likely you will never have to use your coping plan, but at least you know it is there if you need it. Most people say they find it easier to put into action a plan they've already thought through, rather than having to improvise when something happens.