The Outlet

New Zealand Stomal Therapy Nurses

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MARCH 2019

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The Outlet

New Zealand Stomal Therapy Nurses

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Chairperson's Report

LEEANN THOM

Welcome to the first edition of "The Outlet" for 2019.

As I write this I am feeling refreshed after taking a long break to go camping with family and friends over the Christmas period. After listening to Nic Marcon speak at conference on the topic of "Caring for the Carer" I decided to heed his advice. However I returned to the sad news that our fellow stoma nurse, Ginnie Kevey-Melville had passed away early in January. While I did not know Ginnie personally, I have learned much about the esteem in which she was held, and the passion and compassion with which Ginnie approached her work and life. My thoughts, as with many of you, are with Ginnie's family and friends.

I have now been working in the field of Stomal Therapy for fifteen years and the longer I remain in the role, the more I realize what a privilege it is to work in this very special field, however as Stomal Therapists we are facing some challenges. Many of these relate to succession planning. As our more experienced senior nurses in the field reach retirement age we need to ensure that the nurses following in their footsteps are well supported and well trained. This is becoming increasingly difficult due to the lack of a New Zealand based qualification, the increasing cost of the Australian qualifications on offer, and it becoming increasingly difficult to obtain financial support from DHB's to undertake study. With this in mind, as a committee, we will continue to work on the projects identified as important by the previous committee. Some of these include working with ARA polytechnic to develop a Stomal Therapy qualification in NZ and the development of a Stomal Therapy Knowledge and Skills Framework.

I have also become aware that as our senior nurses retire, with them will go the history of how Stoma Nursing began in New Zealand. Some of our senior Stomal Therapists have had the privilege of working with the pioneering nurses that first developed Stomal Therapy services in New Zealand. With this in mind it is timely that we now write up the History of Stoma Nursing in New Zealand before this information is forever lost. This is a project am excited about, and I know that I will learn a lot about the nurses that have gone before me and the profession as it was in it's early days.

The projects I have outlined will be a lot of work, and on top of these projects there is the Tripartite conference in Auckland on the 10th-12th of November 2020 to be organized. It is going to be a busy two years for our current committee. By the time you are reading this your NZNOCSTN committee will have met on the 20th of February in Wellington. We look forward to working on your behalf. Please contact us if you have any queries or questions, or have the desire to work with us, or offer your expertise on any of the projects I have outlined.

All the best for 2019,

Leeann Thom

Ginnie Kevey-Melville

7 DEC 1954 -11TH JAN 2019

It was with great sadness that we said our last good-bye and celebrated the life of Ginnie at a lovely garden funeral on the 15th January this year.

Ginnie was a very private person and most people didn't know that she had been battling breast cancer since 2006, however 10 of these years she was in remission and had, we had hoped, been cured, which unfortunately turned out not to be the case.

Ginnie became a Stomal Therapy Nurse in 2001 after completing her qualifications at the last NZ course at Waiariki Polytechnic, she worked alongside Marie Oldridge at Northland District Health Board. At this time, I was working on a Surgical ward and this is how I first met Ginnie as she came to visit the patients on the ward.

However, I didn't really get to know Ginnie until I started working as a Stomal Therapy Nurse in 2006, lucky for me, but unfortunate circumstances as the reason I got employed was because Ginnie was off having treatment. However, she returned stronger than ever.

She held 3 positions at this time as she worked as a Stomal therapy Nurse 2 days, Continence nurse 1 day and as a district nurse the other day. That was hard work as her roles often crossed over, despite this you knew the paperwork would be all done and the patients would have everything they needed. She always had the patient's best interests at the heart of her work day.

Ginnie had great nursing initiative she was able to perceive problems that others may have missed and she was willing to share her knowledge. She always worked extremely hard and believed that quality patient care was paramount. She was an excellent team player.

Ginnie had a unique personality she told you how it was and you were never left in any doubt what her opinion was, but there was always room to hear others views.

Ginnie served as a member of the Executive committee for the NZNO Stomal Therapy section at this time it was graduated into the College of Stomal Therapy Nurses. In 2016 she was made a life member of the College of Stomal Therapy Nurses for her contribution to Stomal Therapy Nursing in New Zealand.

She was also very proud to serve as an NZNO representative for our department, as well, keeping us up to date with the latest news and developments with the union negotiations.

On reflection we were extremely lucky to have someone of Ginnie's calibre, not only an excellent nurse but someone we could rely on.

We had a great friendship and were a great team, she had our back and we had hers. She had the knowledge and skills to tackle all the issues we come up against in our job as mentioned earlier she was thorough and reliable.

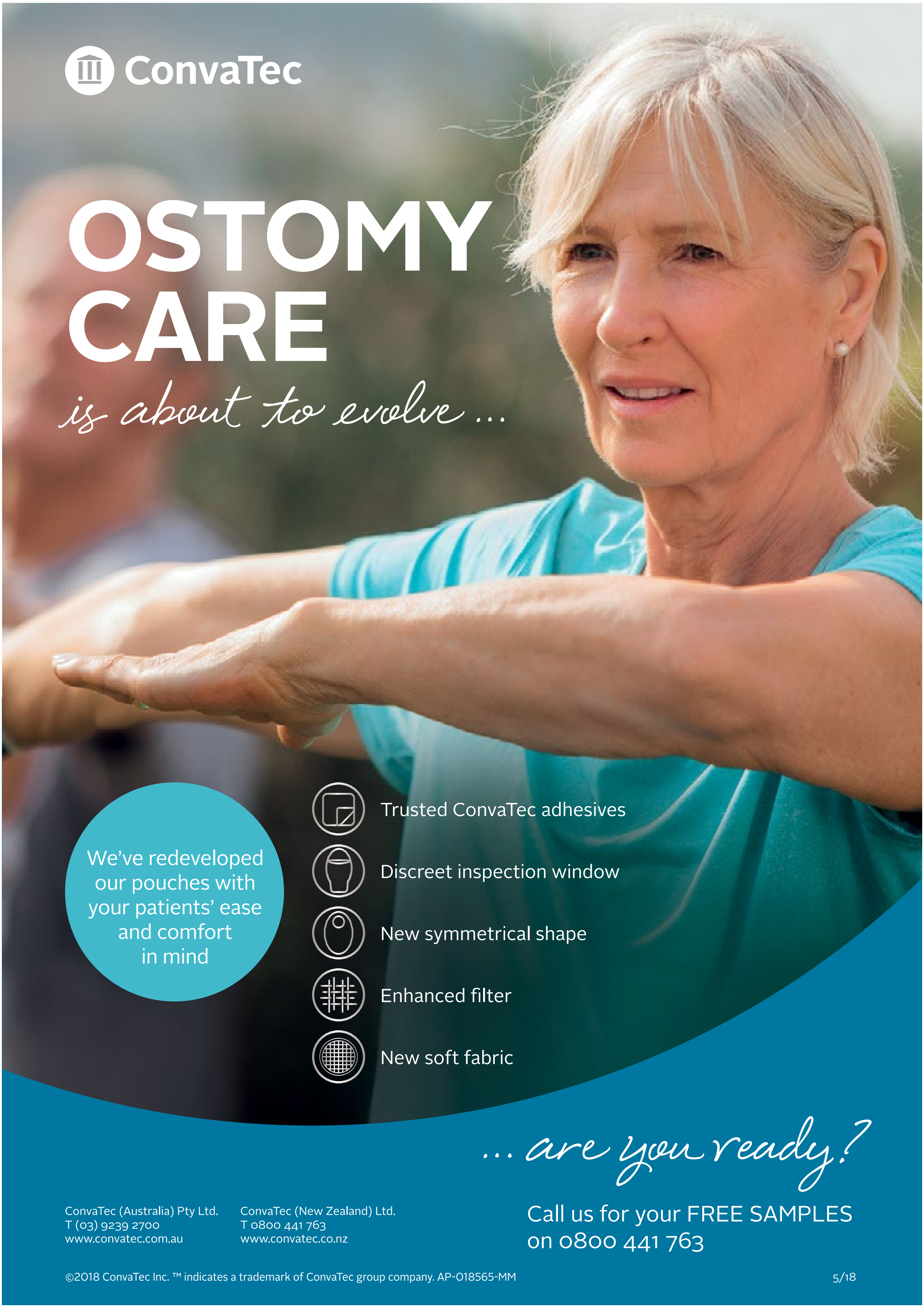
She did not want to be a 'carried' or 'not pull her weight' and when it became difficult for her to do some of the practical aspects of our job she decided to reluctantly leave, her decision was made despite my protests.

Ginnie has left behind her husband Ian, step daughter Jane and two step grandchildren also five siblings including a twin brother and many nieces and nephews.

She will be sadly missed by her family, friends, colleagues and patients.

Haere rā my friend until we meet again

Rachel



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Editor's Report

ANGELA AND DAWN

This is the first Outlet that we have edited so we hope that you enjoy it as much as we have enjoyed putting it together.

It has been a steep learning curve for the both of us. We bring lots of enthusiasm and new ideas that we will be unveiling over the coming editions (see our new profile page). All of this is done with a sense of humour and the belief that The Outlet is a fantastic opportunity to showcase what we do. As always the it is only as good as the submissions we receive, so please see our rallying call below.

We were saddened to hear of the passing of Ginnie and we thank Rachel for writing about her wonderful colleague and great friend.

WE HAVE SEVERAL BIG THANK-YOU'S

Jackie Hutchings for passing on the reigns in great shape and setting us on the right track.

Blacksheepdesign, especially Regan for all his help.

Trade Companies for continuing to advertise and also for their continued support and help in assisting us and ultimately our patients.

The new committee is up and running and we have a few busy years ahead of us, after reading Leann's Chairperson report.

The usual housekeeping continues, please update your contact details so you actually receive The Outlet. We have had several recently returned. Any changes at your workplace, please contact any of the committee members. It is so helpful have accurate details when contacting colleagues thought out the country.

The Liberty award closes end of March. This is a fantastic opportunity for funding when we all know how hard this has become.

So read and enjoy.

Angela and Dawn

CALLING FOR SUBMISSIONS

We know there are A LOT of patients that have benefitted from the expertise and persistence of Stomal Therapists or those nurses with an interest in caring for people with a stoma or fistula. WE WANT YOUR STORIES for this journal. Spread your good work for the benefit of others.

Please send your submissions to either:

angela.makwana@waitematadhb.org.nz or

Dawn.birchall@middlemore.co.nz

WE would LOVE to hear from you.

Award Bronney Laurie

STOMAL THERAPIST NURSE SOUTH CANTERBURY DHB

Congratulations to our colleague Bronnie Laurie for being acknowledged by the Ostomy Federation for her outstanding work and contribution to the care and support of ostomates.

Well done Bronnie, we are very proud of you.

The Ruth Wedlake award for services to ostomates.

The Ruth Wedlake Award has been established to recognize outstanding service and performance by Non-Ostomates, particularly Medical Professionals such as Surgeons and Nursing Staff in advancing the quality of life of Ostomates.

This Award was presented for the first time at the Training Day & AGM held in Wellington in early August with the winner being Bronney Laurie, a passionate and vibrant stomal therapy nurse at Timaru Hospital who has not only supported ostomates in her local community in an empathetic and professional way but also holds the position of Chairperson of the New Zealand Nurses Association Stomaltherapy section. Well done Bronney – a very worthy winner.

Profile Page - Emma Ludlow

COMMUNITY STOMAL THERAPIST/ DISTRICT NURSE, COUNTIES MANUKAU DHB

I always knew I would work in health care. I just didn't know where.

I got a job working in a rest home hospital at high school and stayed there for 6 years to get through university. I had visions of being a Doctor but then I heard about the study and work involved… and hurriedly changed my mind to Radiography. I completed my first year of training at Middlemore Hospital but found I was wanting more patient contact. The exposure that Radiography (what a pun!) and training at Middlemore gave me the confidence to switch and complete my nursing degree at AUT University.

By this time, I was nearing the end of my 21st year and needing to get out and see more of the world. I applied and was accepted into the new graduate programme at Lyell McEwin Hospital in South Australia. It was an incredible year; I moved out of home for the first time and overseas with my friend, started nursing and entered the real world without the shelter and guidance of my parents. I was disappointed at discovering that I couldn't afford to go out for dinner 3 nights a week like I did at home and be able to pay rent, bills and petrol on a new graduate rate. However, through the frustration, tears and absolute joy, I nailed it and wanted more. I completed my graduate year having rotated through CCU, Colorectal and Stroke rehab.

I made a knee jerk decision, purely based on a lunchtime conversation that I had had with a new nurse that had started on my ward, and moved to Darwin. I signed a 3-month contract to work on the surgical ward at the Royal Darwin Hospital and stayed for 2 years. I can't describe it any other way other than I fell into Stomal Therapy. I learnt under Donna Fisher's tutelage, while on the surgical ward, and had great aspirations of completing the post graduate certificate. I just needed to back pack through South America for 3 months and complete a 3 month contract in Riyadh, Saudi Arabia first. I arrived in Alice Springs 6 months later and completed the certificate a year after that in June 2014. I took a lot of opportunity when it presented in Alice Springs, I covered a maternity Surgical CNS position, a 3 month Wound CNS position and a 4 month Hospital coordinator position which really opened up my understanding of health care and "how a hospital works". Through this time, I made it known what I was studying and with a combination of my winning personality, the various networks I worked within the hospital and the support of the only community based Stomal Therapist in the central desert, Jenny, I became the go to person for anyone that entered with an Ostomy. Stoma formation surgery was not performed at Alice Springs hospital except in dire emergency situations but there was still plenty of people that came in from out bush, in town and the grey nomads that kept my skill up.

After 2 years in Alice, I decided to take some time out and got an unskilled visa for Canada and spent a winter season at a ski field and a summer on Vancouver Island, working part time in a couple of little cafes learning the art of coffee making and skiing, amongst other things! In the shoulder seasons and to round out the year, I travelled around meeting different friends in different places to see Canada and the US, the UK, across Europe, via train and finishing in Turkey just as Syria made the infamous move to bomb it. I had felt like coming home for about 6 months and arrived just in time for Christmas 2015. Mum was delighted.

I came back to Counties Manukau and decided to make the move out to the community and have been district nursing for 2 and half fantastic years now. I took the opportunity to become a Stomal Therapist part time, a year and half ago and love it (with the added bonus of getting paid for it this time!). I completed my Post Graduate Diploma last year and am starting my Master's this year. I'm looking forward to what my 30's brings!

PEG IN - PEG OUT (Part 1)

THERESA NEEDHAM - DISTRICT NURSE, TARANAKI DHB

ABSTRACT

Percutaneous endoscopic gastrostomies represent the intentional creation of a fistula connecting the stomach and the skin. PEG's consist of an internal gastric outlet, an external orifice and the tract between these which is cannulated with the feeding device. (1)

PEG's for enteral feeding were first introduced in the 1980's. Initially, use was mainly in children. They have become the preferred method of providing feeding and nutritional support to those with a functional gastrointestinal system who require long term enteral nutrition.

This poster will follow the care of Vanessa (PEG in) and Charles (PEG out). Vanessa has lived with a PEG for enteral feeding for the last 5 ½ years and continues with her PEG. She has written her own health biography for this poster.

After 25 months use and now post removal Charles has lived with a persistent gastrocutaneous fistula.

In the hope that their experiences will help others, Vanessa, Charles and Charles' wife Dorothy have consented to the use of their information for this poster. This is the first presentation of their care.

The definition of the word stoma is literally a hole, yet the fistula's that result post PEG removal and the skin erosion that can occur with the tube insitu are most likely to be managed by gastroenterology clinics. They seldom present to the stomal therapy service. This poster will present the case for PEG complications to be managed by the Stomal and District Nursing services.

VANESSA, PEG IN

Hi, I am Vanessa. I am a 45-year-old mother of three young adults aged 20, 17 and 15 years of age. My husband and I farm a dairy herd in Taranaki.

In August 2012, the children and I all had a stomach infection. Two weeks later, with the children recovered, I presented to our GP with ongoing symptoms. I was struggling to keep food down or even to swallow. Multiple tests and procedures plus a stay in Auckland's gastrointestinal failure unit and I had no real definitive diagnosis or reason for my condition. The most likely cause of my condition is a non-specific gastric dis-motility disorder with gastroparesis. Other suggestions for possible causes included Scleroderma, Churg Straus or Ehler Danlos syndrome.

Pre-illness I weighed 71kgs. Between August and December that year I lost 20kgs. In December a PEG tube was inserted…nearly 6 years later it remains my lifeline. This is my life.

Fig 1, Vanessa 3/4/18

Life has changed. It is hard and unfair but I just get on with it and do the best I can. I do not eat or drink at all. The PEG feeding occurs during the night and during the day if needed. I am consistently dehydrated and have a porta-cath for top-up fluids. My life includes vomiting, constipation, PEG tube site erosion and tube blockages.

My PEG site has been painful for the past 2 years with gastric fluid leaking out around the tube and eroding my skin. For 2 years I have been articulating this and how painful it is. I am very conscious of the odour and the staining on my cloths which is sometimes obvious to others. It is not unusual to change the dressing four times a day. My concerns have been negated with statements like "that is just the way it is."

Eight weeks ago, one nurse listened, that was all it took, a turning point. Since then she has been committed to sourcing and trialling products to heal the erosion around the PEG, making my life a little better. It seemed to be working.

PEG IN - PEG OUT (Part 1)

THERESA NEEDHAM

Fig 2, Vanessa 10/05/18

Fig 3, Vanessa 8/06/18

THE ISSUES

Prior to my meeting Vanessa she had used a wide range of products and dressings around the PEG site. The choices seemed very random, ranging from Mi crème to Vaseline. Many were messy and most had achieved little in the way of skin improvement.

Vanessa's PEG site was red, raw, deeply eroded, painful and bleeding on contact. Her goal was to heal the skin and reduce the pain. (see Fig1).

FIRST TREATMENT PLAN

After a joint review of Vanessa with the Territory Manager from Omnigon we commenced the following trial treatment plan:

- A Welland Aurum Hyperseal 2.5mm thickness with manuka honey as a primary interface. A replicare dressing as a top dressing with a 48 hr change time.

Rational:

- The hyperseal supports the PEG tube and formed a mini plug around the tube's orifice to reduce the gastric fluid output. The antibacterial action of the manuka would potentially contribute to skin healing. Another effect of the manuka was the ability to neutralise the acidic pH of the gastric fluid, reducing the fluids destructive impact on Vanessa's skin. The hydrocolloid absorbed the gastric fluid, trapping it in the seal itself therefore removing it from contact with Vanessa's skin.

Outcome:

While there was some improvement in the skin Vanessa continued to have red, painful skin, with odour and leakage onto her clothing.

PEG IN - PEG OUT (Part 1)

THERESA NEEDHAM

Fig 4, Vanessa 8/06/18
Welland Manuka Hyperseal with Eakin surround and Welland ultraframe

SECOND TREATMENT PLAN

Vanessa was reviewed 6 weeks after the first plan was initiated (see Fig 2). The deeply eroded areas were now intact. The skin was still red but not weeping. Vanessa reported that the pain had improved. At this stage we discovered that due to some mis-communication the dressing was being applied on top of the PEG's bumper disk and therefore was not in direct contact with the skin. This most likely reduced the effectiveness.

The plan was modified as follows:

- A 4 mm Welland Aurum Hyperseal
- A Eakin surround as the outer dressing
- Welland Ultraframes
- Twice daily dressing changes

Tweaks to the dressing application method with the dressing placed under the PEG bumper disk saw Vanessa very quickly demonstrate a high level of competency. Vanessa reported that the outer hydrocolloid edges of the dressing were quickly breaking down into a sticky mess which marked her clothing however the inner surface around the PEG remained intact. It appeared that when Vanessa was showering or bathing the water was being absorbed by the hydrocolloid at the outer edges of the dressing. Welland Ultraframes were introduced around the outer edges of the dressing. (see Fig3 & 4)

Outcome:

After 2 years of suffering skin damage and pain Vanessa's skin is healed. She continues with daily dressing.

WHAT MADE THE DIFFERENCE?

While Vanessa's PEG site skin has vastly improved of equal importance is that she felt she had been listened to and heard. Vanessa's willingness to put her past experiences behind her and become an important part of the solution was a major factor in achieving an outcome that she was happy with.

For me, working in a rural setting the importance of the company Territory Mangers who support my professional practice with their encouragement, and product knowledge is pivotal to this and other positive outcomes.

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PEG IN - PEG OUT (Part 2)

THERESA NEEDHAM

CHARLES PEG OUT

Persistent Gastrocutaneous Fistula's

Persistent gastrocutaneous fistulas (GCF) are defined as continuous drainage of gastric content through the gastrostomy site one-month post removal of the cannulating device. Generally, after removal of the device the gastrostomy site will spontaneously close in a matter of hours or days. (2)

The occurrence rate of problematic, persistent GCF after device removal is estimated to be between 16-45% (2,3,4). As gastroscopy feeding devices are more frequently used in children there is a sparsity of research on device removal complications in adults.

The two crucial elements predictive of GCF formation post device removal are the presence or absence of fistula tract epithelialization and the duration of time that the device has been insitu.

Epithelialization of the GCF tract inhibits spontaneous closure.

The strongest evidence-based statement on GCF closure relates to the duration of device use. Those who have had a gastrostomy device for more than six months are the least likely to experience spontaneous tract closure on removal. (5,6) Davies et al., (7) recommends elective surgical closure of all gastrostomies that have been in place for more than six months. El Rifai (3) suggests optional closure one month after gastrostomy device removal.

Patients with persistent GCF's generally present with eroded, painful skin and a fistula discharging caustic gastric fluid.

CHARLES PEG OUT

Charles is an 80-year-old retired farmer living with his wife Dorothy. They have two adult sons living locally with their families. The family are very supportive of Charles and Dorothy.

Prior to the events described here Charles was a robust, fit and active man.

Jan 2015 feeling tried Charles was reviewed by his GP. A blood test revealed a haemoglobin of 72.

Feb 2015 Charles underwent a staging laparoscopy and placement of trans-gastric jejunostomy feeding tube before neoadjuvant chemotherapy for a gastric cancer. His weight was 72 kgs. Histology results were T3N2MO.

June 2015 Charles underwent an open distal gastrectomy with post procedure adjuvant chemotherapy.

March 2016 A surveillance CT showed disease recurrence. A 3-month clinical trial with ramucirmab did not inhibit tumour growth.

June 2015 Charles and Dorothy self-funded further treatment with a new trial drug prembrolizumab. Six infusions at 3 weekly intervals and Charles CT scan was clear of the tumour. Charles and Dorothy are clear that this is uncharted territory and that Charles has already exceeded all expected survival timeframes.

PEG IN, THEN OUT

In his first year of treatment Charles lost over 20kgs. With PEG feeding he was able to re-gain 16kgs however over that time he had 5 difference PEG tubes and four attempts at achieving a seal around the tube to prevent leakage of gastric fluid. His skin was severely eroded when in April 2018 the PEG failed completely and was removed. He now eats as much of a normal diet with supplements as he can tolerate. Twenty-five months post insertion of the PEG and on removal Charles had a persistent GCF. (see Fig 1)

THE ISSUES

1. The GCF's surrounding skin is eroded and described by Charles as "excruciatingly painful, constantly itchy, like being continuously rubbed with sandpaper."
2. The surrounding abdominal plane is deeply creased. The creases are exacerbated in the sitting or standing positions.
3. Output is at least one litre of gastric fluid per 24/24.
4. A wide range of products had been trialled including some with alcohol content which Charles truly didn't appreciate. The longest wear time achieved was 24/24 with the shortest being one hour. Four leaks a day were not uncommon.

Both Dorothy and Charles were increasingly house bound dealing with random leaks, short wear times, pain and frustration.

Fortunately, Dorothy rapidly became a very competent problem solver with astute assessment skills.

With the help of the District nursing team Dorothy rationalised the products and found the simplest solution was actually the best. Her objective was to achieve a 24/24 wear time.

Using an Eakin wound pouch, a ring of Eakin paste was placed ½ cm away from the pouch's cut edge. Dorothy found this more successful than use of a seal.

With Charles lying flat and applying upward traction to reduce the abdominal creases Eakin paste was placed in the creases. No moulding of the paste was undertaken. Placement of the pouch moved the paste to the points of most need. The warmed Eakin pouch was then placed and the edges sealed with Welland Ultraframe. The Ultraframe sealed the edges of the Eakin

PEG IN - PEG OUT (Part 2)

THERESA NEEDHAM

Fig 1 Ex PEG site with eroded skin and Gastrocutaneous Fistula

Fig 2 The Eakin wound pouch moulded into the abdominal creases with Ultraframes surrounding the pouch.

Fig 3 Two days after commenced use of Eakin wound pouch evidence of healing.

Fig 4 Skin healed

hydrocolloid and helped with any abdominal drag if the pouch became over filled. (see fig 2).

Dorothy exceeded her expectations and regularly achieved a leak free 48 hrs wear time.

Dorothy: "Once we achieved a seal, skin healing was amazingly quick with the Eakin pouch. Even 24/24 made a difference." (see figure 3 & 4)

Dorothy and Charles are extremely appreciative of the care, support, encouragement they received from their District Nursing team.

Once his skin was healed Charles and Dorothy were able to reclaim their lives. Their goal now is to enjoy whatever time they can share, for as long as they can share it.

CONCLUSION

The care of Vanessa, Charles and to some extent Dorothy has made me more aware of the disempowerment that can occur when health professionals lack the time to listen or fail to hear the message. Vanessa, Charles and Dorothy were able to clearly articulate the issues and their needs, yet they shared the frustration of being unheard.

None of the solutions demonstrated in this poster were miracles. Vanessa and Charles found a listener, the right product, the skill and the knowledge base to make a difference within the District Nursing and Stomal Therapy nursing services. In Vanessa's case this was after years of articulating her concerns in other health departments. The difference this has made to both their quality of life is beyond measure. For Charles, this is end of life quality time, for Vanessa it is the quality that enables her to enjoy life!

No single practitioner can ever have all the answers. What we should share is the ability to listen, the professional maturity to acknowledge our limitations and the willingness to seek the knowledge and skills needed to deliver a quality service to our patients.

UPDATE

Charles has had a surgical closure of his gastrocutaneous fistula.

Vanessa has been diagnosed with Ehler Danlos syndrome (EDS).

The final words are Vanessa's "I went to Auckland for the weekend. A lot of time driving and sitting around. This normally would make for a sticky, smelly, sore stomach area. WOW! I'm a new woman. Those Ultraframes are absolutely amazing and worth gold. They change the surround product 100% and after a whole day both the seal and the surround look brand new. The little honey seal has definitely healed my skin. I am sooo happy.

I went to a meeting in Auckland and met two other women with EDS. Neither has a tube but they definitely have gastric problems. It was very interesting and helped me with accepting this is it. Now I know this is life, and it will only continue to affect more organs. I'm even more determined to make life as beautiful as possible… I have to, I'm a MUM."

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Save the Date

42nd National Australian Association of Stomal Therapy Nurses Conference

Power of connections – Coming Together

19 – 22 MAY 2019 | SMC | SYDNEY

stomaltherapyconference.com

On behalf of the NSW Stomal Therapy nurses and the committee, Australian, New Zealand and Asia Pacific colleagues & interested health care professionals are warmly invited to the 42nd National Stomal Therapy conference in Sydney.

More information available on the AASTN website.

Early bird registrations close
27 March 2019

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TRIPARTITE COLORECTAL MEETING 2020

9-12 NOVEMBER, AUCKLAND, NEW ZEALAND

Looking Forward, Looking After | Mā Muri Ki Mua

Save the Date - Tripartite 2020 Meeting

We are excited to announce that the 2020 Tripartite Colorectal Meeting will take place from **9-12 November 2020** at the New Zealand International Convention Centre in beautiful Auckland, New Zealand. **Mark these dates in your calendar now.**

This Meeting is the pre-eminent event for global leaders in Colorectal surgery and will offer outstanding opportunities for professional development and personal connection.

Come to Tripartite 2020 and:

- Be inspired by top international experts;
- Keep up with the latest research and developments in the field;
- Engage with the most pressing issues facing the field today;
- Meet colleagues from around the world – connect, learn and share with others who are passionate about your field;
- Share your research by presenting a paper or poster – make your own contribution to the field and raise your professional profile. We'll be calling for abstracts in late 2019.

NZ Nurses Organisation College of Stomal Therapy Nursing

Australian Association of Stomal Therapy Nurses Inc

CSSANZ Colorectal Surgical Society of Australia and New Zealand

Royal Australasian College of Surgeons

The Royal Society of Medicine

The Association of Coloproctology of Great Britain and Ireland

ESCP European Society of Coloproctology

ASCRS American Society of Colon and Rectal Surgeons

Pay It Forward

JULIE SKINNER - OSTOMY / CONTINENCE CLINICAL NURSE SPECIALIST, WAITEMATA DHB

INTRODUCTION

Ensuring that a client can end life with some dignity and in accordance with their personal values system is the final act of caring that a nurse can offer a family. To be facing the issues involved in end of life health care while also learning the skills needed to manage a new stoma would seem to be double jeopardy with the potential to destroy any quality of remaining life.

Stomal therapy practice is unique in its involvement with patient's long term and across the life span. While each day presents many, varied new challenges the opportunity to make a difference is always a privilege.

This poster will present the end of life stoma care of Harry and Rose. Both Harry and Rose developed abdominal wall metastasis around their stomas. This tumour growth and the challenges of adhering a pouch for effective containment on an abdomen with topography, which changed almost daily, definitely had an impact on the quality of life they had in their final weeks of life.

ABDOMINAL WALL RECURRENCE

Colon cancer recurrence in the abdominal wall post primary tumour resection is a poorly studied phenomenon which has come under renewed scrutiny due to the occurrence of laparoscopic port site metastasises. (1)

Scars from open surgery, drain or port sites, and the stoma are all potential sites for local tumour recurrence. (1 & 2) The potential implantation of tumour cells to these sites seems to occur after the shedding of malignant cells once a tumour has broken through the peritoneum.

After concern that laparoscopic surgery was contributing to an increase in the presentation of abdominal wall metastatic disease the indication today is that abdominal wall recurrence rates between open and laparoscopic surgery are comparable at 0.6% and 0.85% respectively. (3) The average timeframe for the recurrence of disease of this nature is 24 months from primary resection.

Survival once peritoneal/abdominal wall recurrence has occurred is limited to a median of 5 months. The patient who presents with symptoms of obstruction has a particularly poor survival of between 3-4 months.

HARRY

Harry was a 68-year-old gentleman who lived with his wife Margaret. At the time of these events there were several social stresses within the family. Margaret was recovering from a recent myocardial infarction. After years of dashed hopes one of Harry's two daughters had recently had confirmation that she was expecting a child. This happy event was over shadowed by the knowledge that Harry was unlikely to survive long enough to meet his grandchild. Harry's other daughter aged 41 years and the mother of two children also had colorectal cancer. At this stage she was also living with a stoma while having chemotherapy. This second diagnosis of a colorectal cancer introduced concerns that the family may be dealing with a familial cancer syndrome.

Harry and his family were being supported by the Palliative Care and Hospice services throughout the time that he was in my care.

HARRY'S SURGICAL HISTORY

- Right hemicolectomy and anterior resection for synchronous tumours of the right colon and rectum
- Nine days post- surgery Harry developed a bowel obstruction with abdominal distension, vomiting and diarrhoea.
- A return to surgery resulted in a completion colectomy with an end ileostomy due to anastomosis break down.
- Surgical findings: widespread peritoneal metastasis with invasion into the small bowel
- Post- surgery radiotherapy was discontinued when Harry became too unwell to continue.

Harry successfully managed his ileostomy care until he developed fungating tumour invasion through the abdominal wall around his stoma. (see fig 1). The tumours were hard, painful lumps which seemed to grow at an alarming rate. The increasing tumour load stretched the abdominal skin and flattened the ileostomy contributing to pouch leaks.

Fig 1 End ileostomy with tumour growth

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Fig 2 Scan showing abdominal wall tumour

THE CHALLENGES

- Containment: Harry had been using a flat pouch however he was experiencing obstructions, periods of no output were followed by explosive, high volume liquid output leading to leaks.
- Pouch adhesion was becoming increasingly problematic as the hard tumours were painful to pressure and with continued growth lifted the pouch off.
- Pain was increased by the pouch rubbing on the tumours and on removal of the pouch

Initially, Harry used a shallow firm convex pouch with a seal and a belt.

Outcome: multiple appliance leaks, short wear times and increased pain as the convexity ring dug into the tumours. Harry was increasingly a prisoner in his home with no quality of life and no ability to achieve the things he wished to do with his remaining time.

PLAN 1

A flat Eakin pouch

Outcome: Although this did achieve containment Harry felt insecure with what he considered to be a small adhesive footprint. He questioned the pouch's ability to contain the sudden explosive output without a belt.

PLAN 2

A Welland Curvex pouch was cut out beyond the tumours. This prevented the cut edge rubbing on the tumours. The Curvex moulded to the changing abdominal contours. Curvex's feature of mirror imaging the surface it is adhered to was perfect for the rapidly changing contours of Harry's abdominal plane. The hydrocolloid offered gentle adhesion and removal.

With belt tabs Harry now felt secure. With the Curvex Harry achieved a 2-3-day wear time.

Harry died in the care of the hospice. I believe that having a product that managed his challenges made a positive difference to the quality of life that he was able to achieve in the last weeks of his life.

ROSE

Rose is a 57-year-old woman with a high-grade serous carcinoma of Mullerian ovarian origin. She lives with her husband David and their 19-year-old daughter who attends university. Rose is a nurse by profession.

SURGICAL HISTORY

Initially, Rose presented with a long-standing history of abdominal pain, bloating and diarrhoea.

- Ultrasound confirmation of ascites and extensive omental soft tissue disease
- CT scan confirmed nodular soft tissue disease from the upper abdomen to the pelvic brim. A complex 40mm ovarian mass was identified as well as deposits in the liver.
- An operative attempt at debaulking was abandoned. Findings: extensive intra-abdominal carcinomatosis tumour deposits over most of the peritoneal and bowel surface including the mesentery.
- Over the next year, in spite of multiple chemotherapy cycles the disease continued to progress.
- Nine months after the attempted debaulking, Rose underwent a laparotomy with formation of an end ileostomy. Findings included: peritoneal deposits throughout the abdominal cavity with a large clump of tumour in the transverse colon. The small bowel was studded with metastasises.

After review by another clinician and trialling several pouches Rose successfully managed her ileostomy with a convex Eakin Pelican. She developed a large parastomal hernia which did not require active intervention at this time.

Three months after that review Rose contacted me requesting a review as her stoma "looked different".

ASSESSMENT

Due to the hernia the ileostomy which had been spouted was now flat and retracted. My experience with Harry enabled me to identify the fungating tumour at the upper mucocutaneous junction (see Fig 1 & 2).

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Fig 1

Fig 2 side view of Rose's hernia

This was confirmed by the surgeon. No further surgical intervention was appropriate.

Due to the success of the Welland Curvex with Harry the same principles were trialled with Rose. Again, the aperture was cut according to the charging shape of the ileostomy and the tumour load. This prevented the cut edge rubbing on the tumour and causing pain. The foot print of the Welland Curvex moulded easily over Rose's hernia. Rose felt secure using a belt with the pouch.

Both Harry and Rose were able to use the Welland Curvex as a pouch of choice when a flat pouch had been unsuccessful and a convex was likely to increase pain through pressure.

Rose passed away in the care of the hospice three weeks after this review.

CONCLUSION

While always needing to understand the theory and the rationale behind practice decisions Stomal therapy remains very much a hands-on skill. Expert practice is demonstrated only after the accumulation of knowledge and skills over years of practice. As with Harry and Rose the skills and knowledge gained in one patient encounter are carried forward to influence others. In this way STN's make a difference to patient outcomes while in turn having their own future practice influenced.

REFERENCES

1. Koeas,J. & Lanouette,N. & Paty,P. & Guillem,J. &Cohen,A. ***Abdominal wall recurrence after colorectal resection for cancer.*** Diseases of the Colon and Rectum May 2000, 43(5)628-32
2. Stocchi,L. & Nelson,H. ***Wound recurrence following laparoscopic assisted colectomy for cancer.*** JAMA Surgery Aug 2000, 135(8)948-958
3. Guend,H. & Patel,S. & Nash,G. ***Abdominal metastasis from colorectal cancer.*** Journal of Gastrointestinal Oncology Dec 2015, 6(6)692-698

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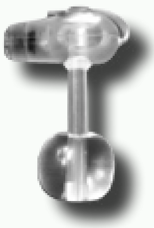

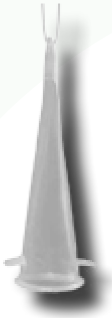

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the truth about peristomal skin itching.

patients with peristomal itching reported they have healthy looking skin.[1]

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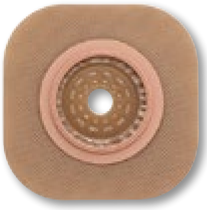

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1. Based on a survey of 140 patients. Consumer Survey of Pruritus, 2016 Hollister data on file.
2. Colwell J, Pittman J, Raizman R, Salvadalena G. A Randomized Controlled Trial Determining Variances in Ostomy Skin Conditions and the Economic Impact (ADVOCATE Trial). J Wound Ostomy Continence Nurse. 2018;45(1):37-42

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Liberty Medical New Zealand

Stomal Therapy Nurse Education Scholarship Fund

In support of advancing clinical practice and delivering improved patient outcomes, Liberty Medical New Zealand is pleased to provide educational grants to two (2) New Zealand registered nurses to the value of $4,000 NZD each, to provide financial assistance towards enrolment to the Australian College of Nursing Post-Graduate Course in Stomal Therapy Nursing.

What you need to do:

- Applicants must complete the attached application form and submit by March 31st 2019.
- Applicants must be registered nurses in New Zealand either already working in, or have a strong interest in working with stoma patients.
- Applicants must have written authority from their employer that demonstrates their ability to participate in this further education.
- Applicants will be assessed by committee members of the NZNOCSTN
- Applicants must be full members of the New Zealand Nurses Organisation (NZNO). It is preferred that applicants also be members of the New Zealand Nurses Organisation College of Stomal Therapy Nursing (NZNOCSTN).
- Recipients are expected to present on stoma care at local and international conferences.
- Recipients must be prepared to clearly demonstrate that the funds are used solely for their intended purpose.

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Application Form

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(Please attach current membership details)

Please give a detailed description as to why you would like to participate in this course (200 Words):

Signature: Date: / /

Email forms and submissions to event@libmed.com.au

Terms & Conditions:

1. Applicants must be members of the NZNO (proof required).
2. Funds must be used for enrolment to the Australian College of Nursing Post-Graduate Course in Stomal Therapy Nursing and cannot be exchanged for any other offer.
3. Recipients must be enrolled during 2019. If the recipient fails to enroll during 2019, they will forfeit the educational grant.
4. Liberty Medical NZ will supply the grant directly to the Australian College of Nursing or the NZNOCSTN on the recipient's behalf for disbursement.
5. Recipients must sign an Educational Grant Acknowledgement and Agreement Form acknowledging the specific usage of funds as being for an educational grant, and that provision of this support will not take into account the volume or value of past, present or anticipated purchases or use of Liberty Medical products or services.
6. Liberty Medical NZ reserves the right to audit to ensure that the funds supplied are used for specifically for the intended purpose.

AUH153

Writing in The Outlet

PURPOSE

The Outlet is the journal representing the New Zealand Nurses Organisation College of Stomal Therapy Nursing (NZNOCSTN), and has a strong focus on the specialty nursing area of Stomal Therapy. Local input is encouraged and supported. The editors of The Outlet are appreciative of the opportunity to assist and mentor first time publishers or to receive articles from more experienced writers. The guidelines below are to assist you in producing a clear, easy to read, interesting article which is relevant.

The main goal of writing for the Outlet is to share research findings and clinical experiences that will add value and knowledge to clinical practice of others. The essence of writing for The Outlet is a story or research study, told well and presented in a logical, straight forward way.

Readers of The Outlet are both generalist nurses and specialist Stomal Therapists. Articles should be focused on what a nurse/patient does; how a nurse/patient behaves or feels; events that have led to the situation or on presenting your research methodology and findings. Linking findings to practice examples often increases comprehension and readability. Addressing questions related to the who, what, why, when, where, and/or how of a situation will help pull the article together.

GUIDELINES

Writing Style

Excessive use of complicated technical jargon, acronyms and abbreviations does not add to the readability of an article and should therefore be avoided if possible. Short sentences rather than long running ones are more readable and generally promote better understanding. The Outlet has a proofing service to assist with spelling, grammar etc.

Construction of the Article

It may help in planning your article if you bullet point the key concepts or points, format a logical paragraph order and then write the article from that plan.

Article Length

There are no word limits for publishing in The Outlet. First time writers may like to limit themselves to 2500-3000 words which is approximately three published pages.

Photographs, Illustrations, Diagrams, Cartoons

These are all welcome additions to any article.
Please email these with your article providing a number sequence to indicate the order in which you wish them to appear and a caption for each.

Copyright

The NZNOCSTN retains copyright for material published in The Outlet. Authors wanting to republish material elsewhere are free to do so provided prior permission is sought, the material is used in context and The Outlet is acknowledged as the first publisher. Manuscripts must not be submitted simultaneously to any other journals.

Referencing

The preferred referencing method for material is to be numbered in the body of the work and then to appear in the reference list as follows:

1) North, N.& Clendon, M. (2012) A multi-center study in Adaption to Life with a Stoma. Nursing Research 3:1, p4-10

Most submitted articles will have some editorial suggestions made to the author before publishing.

Example Article Format Title

As catchy and attention grabbing as possible. Be creative.

Author

A photo and a short 2-3 sentence biography are required to identify the author/s of the article.

Abstract

Usually a few sentences outlining the aim of the article, the method or style used (e.g. narrative, interview, report, grounded theory etc.) and the key message of the article.

Introduction

Attract the reader's attention with the opening sentence. Explain what you are going to tell them and how a literature review must be included.

Literature Review

If publishing a research paper.

Tell Your Story

Ask yourself all these questions when telling your story.
Who was involved, history of situation, what happened, your assessment and findings, why you took the actions you did and the rationale for these? Your goals/plan. The outcome. Your reflection and conclusions. What did you learn? What would you do differently next time?

Remember there is valuable learning in sharing plans that didn't achieve the goal you hoped for.

Patient stories are a good place to start your publishing career and nurses tell great stories. As editors we encourage you to experience the satisfaction of seeing your work in print and we undertake to assist in every way that we can to make the publishing experience a good one.

NB: Written in conjunction with NZNO Kai Tiaki Publishing Guidelines

Updating National Contact Information

The National Contacts list on the NZNO College of Stomal Therapy Nursing website is very outdated.

There have been many changes around the country since it was written. Can you please assist us with updating this by completing the form below and ensuring each person at your DHB covering stomal patients also completes a copy.

This is a very valuable resource when you have a patient transferring or holidaying in another area or if you just want to contact another stomal therapist for assistance with a query or to discuss an issue especially for those working in isolation.

Name: ______________________________

Title/Role: ______________________________

DHB: ______________________________

Postal Address: ______________________________

____

Telephone (and extn): ______________________________

Cellphone (optional): ______________________________

Pager: ______________________________

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Please indicate: Hospital Community Both

Please complete, scan and email to nicky.bates@wdhb.org.nz

Our Logo

The band of three colours at the top of the logo are symbolic of the components of Stomal Therapy Nursing – Stomal Therapy, Wound Care and Continence, and depict also, the networking and relationships between disciplines, each who have their own identity.

The dolphin is well renowned for its healing properties and is characterised by the abstract dorsal fin in which the NZ map lies, nestled between the wave crest and rolling hill. A cultural aspect is incorporated where the wave subtly takes its beginning from the basic Koru element.

The colours of the logo itself promote healing and tranquillity and are chosen to portray calmness and serenity.

NZ NURSES ORGANISATION
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The Outlet

New Zealand Stomal Therapy Nurses