# The Outlet

*New Zealand Stomal Therapy Nurses*

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- The Challenges of Managing an Omphalocele and a stoma in an infant
- Stoma Bags: An Historical Perspective
- Tu Meke Te Peke - The Bag is Great to Me


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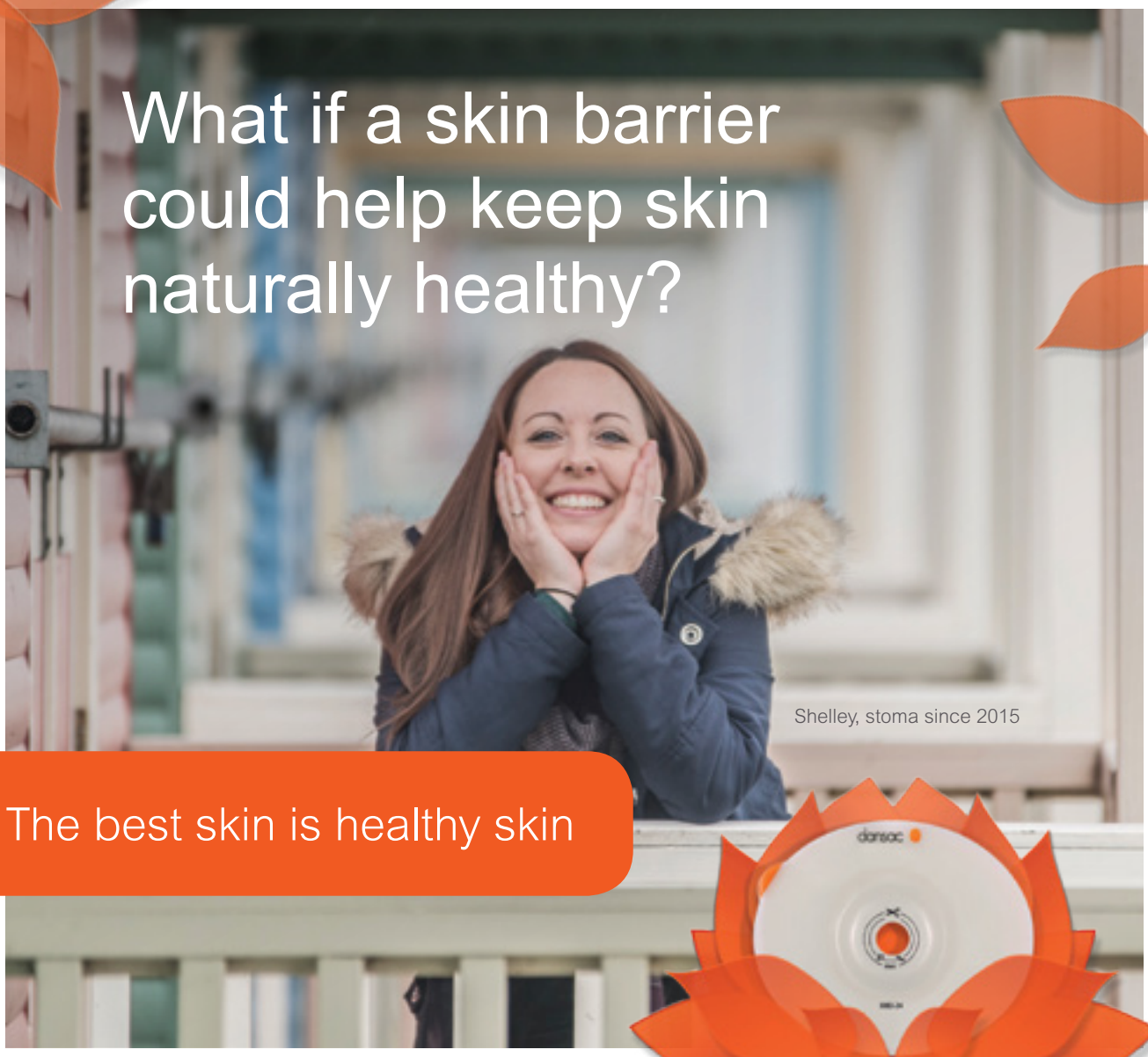

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# The Outlet

*New Zealand Stomal Therapy Nurses*

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**Nicky Bates**

**Email:** nicky.bates@wdhb.org.nz

# Your Executive Committee Members

## COMMITTEE CONTACTS

### CHAIRPERSON

**Leeann Thom**
Stomal Therapist
Southern DHB
**Phone** 03 476 9724 or 027 273 1505
**Email** leeann.thom@southerndhb.govt.nz

### SECRETARY

**Nicky Bates**
CNS Stomal Therapy
Whanganui DHB
**Phone** 06 348 1031 or 027 334 4272
**Email** nicky.bates@wdhb.org.nz

### TREASURER

**Katrina Neiman**
District Nurse/Stoma Resource Nurse
West Coast DHB
**Phone** 03 769 7721
**Email** katrina.neiman@westcoastdhb.health.nz

### CO-EDITOR

**Dawn Birchall**
Clinical Nurse Specialist
Community Stomal Therapy
Counties Manukau DHB
**Phone** 09 276 0044 ext. 53321 or 021 516 903
**Email** dawn.birchall@middlemore.co.nz

### CO-EDITOR

**Angela Makwana**
Stomal Clinical Nurse Specialist
Waitemata DHB
**Phone** 021 533 685
**Email** angela.makwana@waitematadhb.govt.nz

### COMMITTEE MEMBER

**Rochelle Pryce**
Stoma Nurse
Capital and Coast DHB
**Phone** 04 918 6375
**Email** rochelle.pryce@ccdhb.org.nz

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# Chairperson's Report

LEEANN THOM

## The year is flying by and it is hard to believe that the shortest day is already behind us.

Otago has been waking to some crisp, frosty mornings with lovely days to follow. I hope you are all keeping well and taking care on the winter roads.

I would like to welcome Julia Anderson to the committee. Julia will be working as our NZNO Professional Nursing Advisor. Julia has previously worked with the student body, but joined us earlier this year as our PNA. As a committee we appreciate all her knowledge and guidance and look forward to working with her.

Since I wrote my last report for the The Outlet, the committee has met in Wellington and developed a working plan setting priorities for the next two years. High on the agenda is the Tripartite conference, a combined Colorectal Surgeons and Stomaltherapy Australasian conference to be held in Auckland from the 10th -12th November 2020. It will be a wonderful learning opportunity with a wide range of National and International speakers. It will also offer a chance to network with our fellow Australian and International Stomal Therapists. It is important that we build and maintain partnerships with our international colleagues, and this will present a wonderful opportunity to build strong relationships. I hope as many of you as possible will be able to attend. The committee is currently working on a programme for conference and would love to hear from you with any ideas for suggested topics for conference.

The committee is about to commence work on a Knowledge and Skills framework for Stomaltherapy. It is a large body of work and will take some time to complete. We would love to hear from any of you that have an interest or desire to also participate in this project. It is a body of work that, once completed, will be a good resource for nurses newly entering the profession.

The NZNO College of Stomaltherapy Nurses now has a new generic email address. The committee can be contacted at stomaltherapynz@gmail.com. Please contact us on this email. We as nurses must ensure that we take an interest in what is happening within our profession and that our voices are heard, so please contact us and get involved. The committees are working as your representatives and encourage your input and comments.

The Bernadette Hart Award is available to all members to apply for. The application form can be found in this journal or on our website. The current committee will consider all applications for the award on their own merit. I encourage any of you considering further education to consider applying as it can make the difference in enabling someone to attend an educational forum or further their study. Unfortunately at the last close of applications there were no eligible applications and hence the Bernadette Hart award was unable to be presented.

The NZNO AGM and Conference will be held on the 17th and 18th of September 2019 in Wellington. Rochelle Pryce and myself will attend on behalf of NZNOCSTN and will report back after the two days with updates and issues that may affect the membership.

And finally an issue that has come to my attention from personal experience is the impact of the bowel-screening programme on STN's across the country. It has been wonderful to see the success of the screening with many new bowel cancers detected as a result, however it has seen a significant increase in the number of new referrals to stoma services. The remaining areas of New Zealand yet to have bowel screening introduced will see the screening programme rolled out between now and end of the 2020/21 financial year. For those of you yet to have the bowel screening programme commence in your area, it may be timely to start discussions with management in advance about the increasing workload you are likely to see and how you will best manage this.

Keep well and safe,
Kindest regards,

Leeann Thom

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# Editor's Report

ANGELA AND DAWN

## Welcome to the second edition of The Outlet for 2019.

Once again we have had a great time putting this edition together. Our job is a lot easier when we have a steady supply of excellent submissions, many of which could be published in international journals. We know that many of you are currently undertaking post graduate study or have recently finished. With a few minor changes to essays, assignments or your thesis, you too could soon be a published author. Believe us it is a great thrill to see your name in "black and white".

We have some excellent and varied case studies in this edition. As well as profiles from Julia – professional Nurse Adviser, who gives the committee professional guidance and Alison's (we will not say anymore than we love the photo!). Congratulations to our award winner which brings us on to our next point.

There will be many scholarships are advertised throughout the year in The Outlet. We thank the companies for giving us the opportunity to receive funding for further education or to attend national and international conferences. The opportunities are there for us, so please consider grabbing these opportunities.

The committee recently had a great meeting. We look forward to sharing our plans in further editions. Keep November 2020 in the back of your mind. The tripartite conference will soon be here before you know it.

Lastly, a big thank you to everyone who has given us feedback on our first edition. It has been great to receive such positive words and confirms that we are taking our journal down the right path. Please continue to let us know what works or doesn't. We want The Outlet to meet your needs.

Enjoy reading.

Angela and Dawn

---

Kia ora. I am the Professional Nurse Adviser (PNA), supporting the kaupapa and objectives of the NZNO College of Stomal Therapy Nurses.

The PNA role enables me to work alongside nurses and NZNO members, supporting them as they work to achieve their professional aspirations and seek to ensure quality practice for safe patient care.

I have worked as a Registered Nurse since 1980, completing my nursing training at Christchurch Public Hospital. I have worked in a variety of clinical roles with the majority of my career working in community, schools and homes. It has been a privilege to work with children and their families, supporting community well being, ensuring people keep well, promoting health. My roles have enabled me to work across sectors, closely with health, education, social welfare and importantly non-government organisations, undertake post graduate education to advance my nursing knowledge and better understand the crucial importance of the determinants of health and how these factors directly affect the health of individuals, whānau and communities. That health and wellness are determined by circumstance and environment.

During my career I have been an active member of both the PSA and NZNO, taking on the role as workplace delegate with the PSA and later with NZNO. My interest in professional nursing practice grew through the overlap between my clinical work, my desire to support professional nursing practice through supportive practices e.g clinical supervision, my union involvement and watching nursing struggle to have a voice with policy makers and within workplaces. I sat as the chair on the Public Health Nurse section for 9 years, advocating the role nursing can and should take in keeping individuals and communities well. The nursing voice continues to struggle to be heard today, I remain optimistic through work such as that of the NZNO Colleges and Sections we will progress.

I began work with the NZNO in 2007, working as an Organiser before moving back into a nursing role as Professional Nurse Adviser in 2011. I am passionate that nurses have their voice heard and that nursing is best placed to make the difference for the health and wellbeing of those living in Aotearoa.

# Toward The Twilight Years

ALISON MEERMAN, CONTINENCE/ STOMAL THERAPY NURSE SPECIALIST,
TARANAKI DISTRICT HEALTH BOARD

I recently bought our adorable 16 month old granddaughter a T shirt with the logo' "Oh the Adventures We will Have My Darling". It occurs to me; what a wonderful adventure my nursing career has been.

Flipping through the many photos that chronicle my personal and professional transformation from a fresh-faced raven-haired 17 year old embarking excitedly on her General & Obstetric Nursing training at Wellington Hospital, to the now silver haired, but not yet pensionable sexagenarian navigating the twilight years of her career, I am flooded with a myriad of mixed memories! Memories of the diverse nursing roles I have held, the amazing colleagues I have worked with and most importantly, the countless patients I have nursed and journeyed with through their life changing health challenges.

After graduating as an RN in 1976, I worked for a short time as a Practice Nurse in Wellington before marrying my handsome Dutchman and moving to milk cows in Taranaki. There was a drought that year so at the end of the season we headed to the Netherlands with our 17 week old son. Returning to Taranaki a year later and now fluent in Dutch, we settled in Eltham. Another precious son was born in 1980, and with time on my hands, I got my driver's licence, (in a navy blue A30 with red upholstery!) and started 2 afternoon shifts a week in the Paediatric ward at Hawera Hospital. We were blessed with a third son in 1983, and later that year I worked 3 shifts a week in the surgical ward. From 1987 to 1989 we lived in The Netherlands before returning to our beloved Taranaki. I accepted a position in the operating theatre at Hawera Hospital where I participated in creating stomas and always wondered about the aftercare. That curiosity was satisfied in 1991 when the on-call hours for theatre and balancing family life nudged me toward District Nursing. Gwen Holl was the New Plymouth based Stomal Therapist and with her workload ever increasing, I responded enthusiastically to an expression of interest for a part time Stomal Therapist in Central & South Taranaki. I joined the class of 1992 at Waiariki Polytechnic and completed my Post graduate Certificate in Stomal Therapy.

Soon after I attended The NZNO Stomal Therapy Nurses Conference and returned home puzzled at how I became the section secretary! I typed the newsletters on an electric typewriter

*Nursing student at silverstream geriatric hospital 1973*

as it was faster than waiting for "dial up" on our computer to actually dial up! How times have changed. Our newsletters were modest compared to "The Outlet" but we did the best we could with the resources available! Those committee catch ups in Taupo were so much fun as well as getting the job done!

When the Continence SCN role was advertised at the turn of last century! It seemed like a natural progression to combine this with my Stomal Therapist role and relinquish my part time Nurse Manager position. In 2001 I completed a Post Graduate Certificate in Health Sciences, endorsed in Continence Management at Christchurch School of Medicine. Often the brunt of "toilet humour" I respond, "It's funny, until it happens to you. But if it does, I may be able to help!"

However, the sun has not yet set on my nursing career! Or my passionate and professional resolve to facilitate optimal holistic outcomes for ostomates in my care. It is important to embrace the steady stream of advances in research, technology, product and service delivery which assist these patients to adapt to all aspects of living with a stoma. This can be complex, challenging, exhausting, frustrating and yet extremely rewarding. When I do retire I shall spend more time with my beloved family and friends, pottering in my large garden, re purposing furniture, finishing craft projects and curling up with a good book.

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# Liberty Medical New Zealand Educational Scholarship Recipient

In support of advancing clinical practice and helping deliver improved patient outcomes, Liberty Medical New Zealand introduced the Stomal Therapy Nurse Education Scholarship Fund to provide educational grants to New Zealand registered nurses to the value of $4,000 NZD, for financial assistance towards enrolment to the Australian College of Nursing Post-Graduate Course in Stomal Therapy Nursing.

This funding is in strong alignment with the mission of the company to make life more rewarding and dignified for those who use our products and services. After submitting well-written applications that outlined their desire for intent, as well as approval from her District Health Board, we are pleased to announce one recipient from Palmerstone North, Myung Choi. She has already enrolled in the course commencing in July 2019.

## MYUNG SUK CHOI

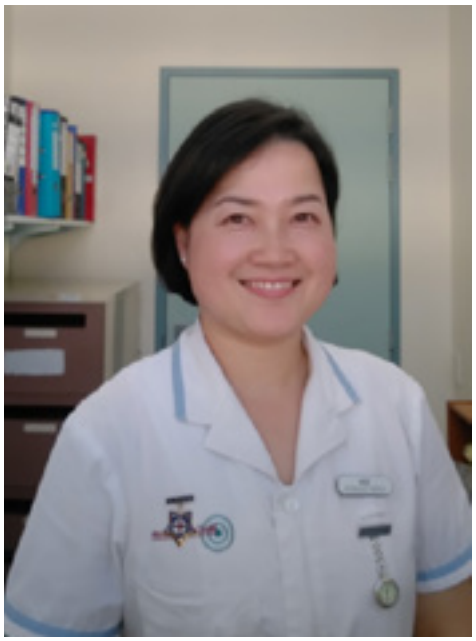
Myung Suk Choi is originally from South Korea where she worked as a registered nurse since 2000. After moving to New Zealand in 2011 she underwent a Competency Assessment program for her NZ RN registration. She finds stoma care fascinating, and has a huge passion for stoma patients and the role of the Stoma Care Nurse. She has researched the best way to keep herself up to date in relation to stoma management practices. As such, she had already enrolled the Stoma Therapy Nursing at Australian College of Nursing commencing in July 2019 but felt the financial burden might be a challenge for completing it.

However, a colleague of hers (Lawrence Mutale STN CNS for the MidCentral DHB) introduced her to the scholarship fund. The support she feels would be critical in enabling her to complete the course successfully and contribute to the promotion of better outcomes for her stoma patients with the qualifications and knowledge gained through this course. Ultimately, she feels it will compliment her role and responsibility as a nurse educator and her passion for stoma patients enhance and consolidate her knowledge related to that management.

We would like to congratulate Myung Suk Choi on her dedication to professional development and wish her well in her studies.

Paris Purnell

Senior Manager, Clinical Education



*Myung Suk Choi*

# The Challenges of Managing an Omphalocele and a Stoma in an Infant

EMMA LUDLOW, STN, COUNTIES DHB, AUCKLAND

## INTRODUCTION

Even if the birth of a baby with a congenital abnormality is a predicted and an expected event the reality of confronting the challenges required to meet their care needs can still be overwhelming.

This case study follows a small part of the care needed to support baby Malichi and his family after he was born with an omphalocele and Beckwith Wiedmann syndrome. Prior to being part of Malichi's care team I had little knowledge of these conditions. I believed that paediatric pouches were somewhat limited in number and type.

## OMPHLOCELE

An omphalocele is a birth defect occurring in 1 in 5000 live births. (1) An omphalocele presents as the abdominal organs outside the abdominal wall having generally passed through the wall at the base of the umbilical cord. Normally between weeks 6-10 of inter-uterine development the abdominal organs are projected outside the abdominal wall. By week 11 they should have migrated back in to the abdominal cavity. For no known reason the failure of this normal developmental progression results in an omphalocele.

Thirty percent of infants with an omphalocele have other genetic abnormalities noticeably Trisomy 13, 18,and 21, cardiac, spinal, urinary, gut defects/ or Beckwith Wiedmann syndrome. Some families are known to carry a sex linked autosomally dominant trait which makes the risk of a recurrence of the condition in subsequent pregnancies higher than that of the general populations. [1]

## BECKWITH WIEDMANN SYNDROME

Malichi also has Beckwith Wiemann syndrome (BWS).

BWS is a rare genetic disorder affecting 1 in 15,000 live births. BWS is classified as an overgrowth syndrome manifestation of which can present in many parts of the body.

- Macroglossia (large, often adult sized protruding tongue)
- Unexplained hypoglycaemia
- Ear creases and pits
- Abdominal wall defects with omphlocele or abdominal hernias
- Birth weight and length above average
- Increased risk of developing several types of tumours i.e hepatoblastoma, Wilms

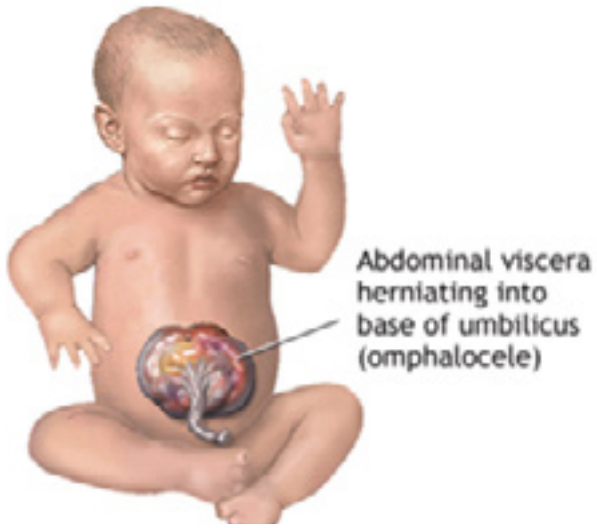



*Fig 1 Omphalocele*

## MALICHI

Malichi was born at full term and is the third child of Pete and Deb. He has two older siblings aged 6 and 7 years. The presence of his omphalocele was detected at a pre-delivery 20 week scan and was an expected finding at delivery.

## SURGICAL

**Surgery:** Repair of abdominal wall and re-siting of colon back into abdominal cavity.

Day 10 post initial repair procedure a transverse colon perforation was detected, this resulted in a return to surgery for a right hemicolectomy with formation of a divided colostomy exteriorised through the initial surgery suture line.

## MEDICAL

Pulmonary Stenosis severely compromises Malichi's breathing. When crying he is likely to run out of breath quickly and stop breathing completely. Malichi's parents have learnt to respond very quickly to any crying episodes. If he stops breathing Malichi can be revived with physical stimulation such as hugs. This makes Malichi's crying during colostomy pouch changes very frightening and problematic.

Malichi as has a cardiac malformation for which he is shortly to undergo corrective surgery.

# The Challenges of Managing an Omphalocele and a Stoma in an Infant (Part 2)

EMMA LUDLOW, STN, COUNTIES DHB, AUCKLAND

Parastomal Hernia: with crying increasing his intra-abdominal pressure, a weakened abdominal wall and his surgical incision Malichi has developed a parastomal hernia. The intermittent nature of the hernia which becomes more pronounced with crying presents a pouching challenge as his stoma template can change size by as much as 20mm.

## ASSESSMENT

**Stoma:** exteriorised through the original suture line the proximal loop is healthy and protruding. The distal loop is lateral to the proximal one and retracted below skin level. This has been the site of appliance leaks.

**Parastomal Plane:** evidence of faecal irritation around lateral suture line and a parastomal hernia.

**Output:** normal.

Pouch changing technique: faced with Malichi's tendency to stop breathing during pouch changes both Pete and Deb had developed the fastest pouch changing techniques I have ever seen. Each pouch change is planned in detail with Pete and Deb being an exceptionally efficient tag team to compete the cares in record time.

**Issues:**

- Crying during pouch changes leading to episodes of non-breathing
- Eroded and clearly painful suture line
- Short pouch wear time, often as little as 4 hours, with leaks lateral to stoma
- Intermittent changes in stoma size caused by his crying enlarging the hernia.
- Safety, by limiting the number of products used to those with the least ingredients we can avoid doing harm to Malichi's skin

**Intervention:**

- Introduced Well and Adhesive remover wipes. The siloxane based product is suitable for use in babies, contains no alcohol and therefore would not sting Malichi's raw skin. The Welland adhesive wipe does not need to be washed off so helped with the need for rapid pouch changing and prevented traumatic response crying with pouch removal.

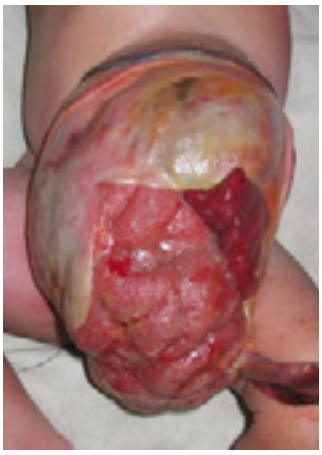


*Fig 2 Omphalocele with tear in the omentum*

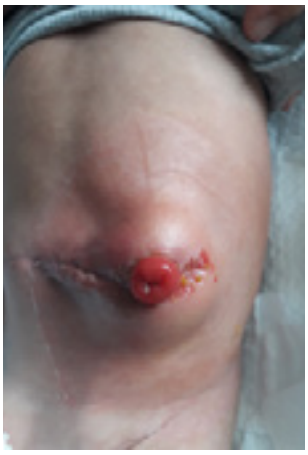


*Fig 3 Malichi showing hernia & eroded suture line post-surgical repair*


*Fig 4 Well and Adhesive remover, Eakin slim seal and Pelican Paediatric pouch.*

- Introduced Eakin slim seal to cover the eroded suture line increasing moisture absorption and promoting longer wear times. Fewer ingredients in Eakin seals reduces likelihood of reactions to products.
- Used Eakin seal around both stoma loops to fill uneven contours and provide close soft fit. This accommodated the intermittent size changes of Malichi's stoma when his crying increased the hernias size and stretched the stoma.
- Used Eakin Pelican Paediatric drainable pouch 839701 cut to 45mm. This pouch moulded well around Malichi's hernia.

# The Challenges of Managing an Omphalocele and a Stoma in an Infant (Part 3)

EMMA LUDLOW, STN, COUNTIES DHB, AUCKLAND

## OUTCOME

Malichi continues to use and follow the interventions we planned with the Welland adhesive remover wipes, the Eakin slim seal and the Eakin Pelican paediatric pouch. His skin has healed and he is achieving a two day wear time.

In spite of the challenges that his start if life have presented Malichi is achieving normal developmental milestones.

## CONCLUSION

Being part of Malichi's care team has increased my knowledge of both omphocele and Beckwith Wiedmann syndrome. I believe that Malichi's ostomy care was a genuine collaboration between his parents and myself. While I contributed the product knowledge and skill sharing which led to us conquering the challenges of his care nothing can detract from the amazing team work and care that his parents provided.

Good product knowledge and the use of products with as few ingredients as possible facilitates safe paediatric practice.

## REFERENCES

1. Chan,C. (2008) Syndromes and Disorders Associated with Omphlocele. *Taiwaneses Journal of Obstetrics and Gynecology 46(2), 96-102.*

# Stoma Bags: An Historical Perspective

FRANCESCA MARTIN, RN; B.A.; POST GRAD DIP.; CERT STOMAL THERAPY
STN SPECIALIST, AUCKLAND DHB

## ABSTRACT

The history of stoma bags is also the history of stomas, surgical techniques, stomal therapy and the ostomates who have by trial and error assisted in the development of stoma bags.

Ostomy appliances, pouches, pouching systems, drainable bags and closed bags, these are a few names for what most people with a stoma call a 'stoma bag'. From the crude containers used by early sufferers of a bowel fistula or colostomy to the sophisticated appliances of today, pouching systems have undergone a huge transformation. The development of ostomy pouching systems is closely entwined with the improvement in bowel surgery and surgical techniques for forming stomas. Along with this is the evolution of the nursing specialty of stomal therapy and establishment of medical supply companies to manufacture ostomy appliances. Networks of people with ostomies now provide support and information for other ostomates as well as providing a consumer voice in the political and manufacturing arenas.

In the distant past there were some recorded instances of bowel fistulas caused by battle wounds and abdominal trauma. There was no mention of how these were managed and what was used to catch the bowel waste. One of these records dates from 1706 where a battlefield wound caused a prolapsed colostomy. In 1710 a colostomy was formed on a baby with a birth defect. The stoma was placed on the side of the body rather than the front and a tin box was held in place over the stoma with straps. In 1776 the first successful formation of a colostomy for bowel obstruction was recorded by Dr M. Pilore in France. A sponge was attached to the opening to absorb leakage with an elastic bandage. Unfortunately the patient died of mercury poisoning due to treatments for the blockage prior to the surgery. In future procedures leather pouches and glass bottles were also used for capturing the waste output (1).

Colon surgery and colostomy formation had less morbidity than surgery on the small bowel. Throughout the 19th century there were about twenty seven recorded instances of colostomy operations but only six patients survived because of the high rate of complications and sepsis. The improvements in surgery and antiseptic techniques in the late 19th and early 20th centuries along with anaesthesia allowed more colostomies to be performed with a lower rate of morbidity.

From the 1920s to the 1950s latex pouches were developed and often held in place with wire holders and belts. Rubber cement on the peristomal skin helped contain the contents of the pouches. In the USA there were about 25 small ostomy companies prior to 1960. Many were started by people who either had a stoma themselves or had a family member with one (3).


*Fig 2 Omphalocele with tear in the omentum*

The Davol Rubber Company was one of these entrepreneurial ostomy companies that produced rubber colostomy pouches (2).

The first reported ileostomy to be formed was in 1879 on a patient with a malignant obstruction. Up to the mid-1950s ileostomies were associated with high output, severe abdominal pain, severe skin breakdown and high mortality rates. This was due to serosal inflamation of the stoma following surgery (3).

The 1950s saw a breakthrough in stoma formation. Dr Bryan Brooke, an English surgeon, introduced the 'budded' stoma in 1952. At the Cleveland Clinic, Dr Rupert Turnbull and Dr George Crile were also working on surgical techniques to reduce complications and mortality associated with ileostomy construction. Up until the 'budded' stoma, ileostomies were formed by bringing out a length of small bowel and it would eventually spontaneously mature. The exposed serosa would become inflamed and the bowel would obstruct due to the intense inflammation and oedema. The budded stoma is bowel that is folded onto itself to form a spout (4).

# Stoma Bags: An Historical Perspective (Part 2)

FRANCESCA MARTIN, RN; B.A.; POST GRAD DIP.; CERT STOMAL THERAPY
STN SPECIALIST, AUCKLAND DHB

*Fig 2 Omphalocele with tear in the omentum*

Up until the 1950s and 1960s ostomy patients were isolated and left to manage their stomas themselves with little education and very basic equipment. They had had lifesaving surgery and often were in hospital for months following their operations but when they came out of hospital their quality of life was often extremely poor. They dealt with leaking stoma devices, odour, badly eroded skin and dehydration. Little wonder that many became social recluses.

Norma Gill was a patient of Dr Turnbull's who, being at death's door, had an ileostomy for severe ulcerative colitis. After months of recovery, and with a young family, she wanted to help others with stomas and in 1958 Dr Turnbull appointed her as the first Enterostomal Therapist. She was not a nurse but because of her own experiences and desire to teach and help other ostomates she was an inspiration to many others. Her daughter describes how she had constant phone calls from other ostomates needing advice and ostomy manufacturers would ask her for suggestions in designing ostomy appliances (5). In 1962 she and Archie Vinitsky founded the United Ostomy Association the first organisation of ostomates (6). Norma worked tirelessly for ostomates. She was instrumental in setting up training for Enterostomal Therapists, and was a founding member and first president of the World Council of Enterostomal Therapists.

The developments in abdominal surgery and stoma formation throughout the 1950s and 60s called for better ostomy pouching systems. Urostomy formation required pouches with tighter seals. Various rubber systems were used but were cumbersome and uncomfortable.

Meanwhile in 1954 in Denmark, an ostomy company called Coloplast was established after Elise Sorensen, a nurse, sought help for her sister who had had a colectomy and an ileostomy. Elise approached an industrialist Aage Louis-Hansen who had a plastics factory, with an idea for a stoma bag. At the urging of his wife, Johanne, he agreed to help and an adhesive ostomy bag was created (7).

In the 1960s companies in the USA started to develop vinyl semi disposable pouches which could last up to 12 weeks. They were lighter and stronger than rubber pouches but had odour problems. There were two piece systems with a face plate that attached to the skin with adhesive. Tincture of Benzoin was used to protect the skin although over time some people developed allergies to it (8).

Hydrocolloid medical adhesive was developed in the 1960s by Dr James Chen of E.R. Squibb and Sons for use in dentistry. Hydrocolloid contains Pectin, Gelatine, Natrium Carboxy Methylcellulose and Polyisobutaleen. It can be mixed with other ingredients for elasticity and flexibility. Hydrocolloid's ability to stick to warm moist surfaces was noted by Sir E.S.R. Hughes, Colorectal Surgeon and Elinor Kyte, Stomal Therapist of Melbourne. They realised the advantage of hydrocolloid for use with stoma appliances and Squibb introduced the first hydrocolloid skin barrier, Stomahesive, in 1972. This was a major development in the ostomy industry as Stomahesive wafers increased the wear time of ostomy appliances from one or two days to between five and seven days (9).

Karaya skin barriers and washers were also developed in the 1960s. Hollister and Coloplast introduced PVDC odour proof films for their ostomy pouches. Filtrodor filters were brought in by Coloplast. Accessories such as pouch deodorants, skin barrier wipes and Karaya paste were added to the ostomy ranges in the 1970s (10).

Other ostomy companies were starting to play a larger role in the ostomy market. Hollister started as a printing company that was founded by John Dickinson Schneider in 1921. It evolved to the manufacture of medical products. In the 1960s an employee approached John Schneider with an idea for developing ostomy products. By the 1970s Hollister was dominant in the production of ostomy appliances in the USA (11).

In Europe, Salts Healthcare Ltd had been founded in 1700 in the UK. Dansac was founded in Fredensborg, Denmark in 1971. Biotrol started ostomy production in 1973 and joined with Braun to become B. Braun in 1992.

# Stoma Bags: An Historical Perspective (Part 3)

FRANCESCA MARTIN, RN; B.A.; POST GRAD DIP.; CERT STOMAL THERAPY
STN SPECIALIST, AUCKLAND DHB

T.G. Eakin Ltd was formed in Northern Ireland in 1974 and Welland Medical Ltd was founded in 1988 in the UK.

The 1970s saw more sophisticated marketing. A research study by Squibb showed that comfort, security, odour management and convenience were the main concerns of patients and ostomy nurses.

In 1978, Squibb introduced a two piece ostomy product called Sur Fit Plus. Squibb then created a company called ConvaTec which took over the ostomy and wound care production, marketing and sales (12).

Developments of two piece ostomy appliances by most of the companies continued in the 1980s. Second generation hydrocolloid skin barriers were formulated. ConvaTec produced Durahesive for urostomies. Pastes and paediatric ostomy systems were also produced.

The 1990s saw the development of pre-cut stoma pouches, improved locking systems for two piece appliances, convex inserts and convex pouches and increased comfort of pouches.

Increased sophistication of the pouching systems has continued throughout the 2000s to the present. Some of the improvements are: better air filters; integrated closures; fabric covered pouches; greater ranges of convexity; and more accessories such as seals, odour eliminators, skin barriers and adhesive removers. Many of the companies are now designing lifestyle pouches. There are pouches that can fold up to be smaller, that have colours that are less noticeable under clothing, that are more rounded and less obtrusive under clothing, and with fashionable colours such as black and white.

Ostomy companies have evolved to meet the needs of their customers. They have asked ostomates and nurses what they want from pouching systems. The companies have done extensive research and development using innovative thinking to solve issues. There is now a huge range of products that is skin friendly, trustworthy and meet patients' needs. Ostomy companies have also supported ostomy nurses through education, funding of conferences, webinars and product training. They support ostomates through Ostomy Associations and enable ostomates to compare and evaluate different products as well as providing education packages for ostomates and their families. Undeniably, there is a symbiotic relationship between the ostomy companies, ostomy nurses and ostomates.

Stoma bags are now not just a receptacle for containing bodily waste. With the help of specialist nurses, ostomates are able to live with dignity knowing that the stoma bag they use will give security, comfort and freedom to live their lives as normally as they can. Ostomy associations and other networking groups provide support and information. Ostomy manufacturing companies work hard to provide their customers with ostomy products that provide them with a good quality of life.

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# Pyoderma Grangrenosum and the Effects of Manuka Honey

KATY MARTIN-SKURR, SPECIALTY CLINICAL NURSE STOMAL THERAPY, TARANAKI DISTRICT HEALTH BOARD

## INTRODUCTION

The use of medicinal honey in would healing is well documented in ancient times by both Greek and Egyptian healers. With the discovery of antibiotic in the 1930's use of these traditional wound healing products waned. In recent times the appearance of antibiotic resistance bacteria has seen a resurgents of interest in more traditional non pharmaceutical wound healing treatments.

This poster will present the care of Hilary who was admitted with an acute exacerbation of Crohn's disease and went on to develop pyoderma gangrenosum.

Hilary has consented to the use of her information for this presentation. All names used are pseudonyms.

## WHO IS HILARY?

Hilary is a 56 year old caucasian women who presented acutely with a known history of Crohn's disease. On presentation she was nutritionally compromised weighing 45 kgs, she was dehydrated with abdominal distention, pellagric, experiencing severe abdominal pain and had malodourous diarrhoea.

Hilary acknowledged that her health had been deteriorating for some time.

Medications on admission included prednisone, azathioprine, pentaza and allopurinol.

Hilary is a heavy smoker with an intake of 3-4 standard alcoholic drinks per day. She lives with her supportive husband Bruce. They have two adult children who live locally.

## SURGICAL TREATMENT

Hilary's condition on admission was critical and she was immediately prepared for surgery. A CT scan confirmed air in her abdomen and the likelihood of perforation.

**Surgical Treatment:**

- Subtotal colectomy with formation of an end ileostomy and mucous fistula A mucous fistula is formed to allow the expulsion of gas and mucous from the distal non-functioning end of the colon post resection. Hilary's mucous fistula was formed due to concern that her remaining rectal stump may break down causing abdominal sepsis.

Hilary spent 14 days in the high dependency unit on total parental nutrition and potassium replacements. She was discharged 24 days after admission with nutritional supplements.

While Hilary initially struggled with the psychological adjustment needed to manage life with a stoma I had no specific concerns for her on discharge.

Hilary's very thin body habitus had contributed to significant creases across the parastomal plane however these had been successfully managed with an Eakin Pelican pouch and an Eakin seal. While Hilary's initial recovery had been un-eventful this was not to continue.

## SECOND ADMISSION

On review in her home four weeks post-surgery and in her first week of discharge Hilary was found to be cachexic with further weight loss. How weighing 37 kg, she was hypotensive 88/40, severely dehydrated and at risk of renal impairment.

It was apparent that once again Hilary had not taken any affirmative action regarding her deteriorating health. She was immediately re-admitted to hospital and found to have an oesophageal ulcer. After re-hydration and the initiation of omeprazole therapy and with further dietary input she was again discharged.

During this admission it was noted that Hilary had developed an ulcerative lesion by her stoma (see Fig 1).

## THIRD ADMISSION

Review in the stomal therapy clinic at 10 weeks post-surgery revealed that Hilary was again acutely unwell. She had severe abdominal pain which she rated as 10/10, was again hypotensive and dehydrated. In spite of all advice Hilary had again neglected her deteriorating health. A CT scan revealed multiple intra-abdominal abscesses in the right iliac fossa, and the pyloric and retro splenic regions. After conservative treatment with antibiotics Hilary was again discharged.

# Pyoderma Grangrenosum and the Effects of Manuka Honey (Part 2)

KATY MARTIN-SKURR, SPECIALTY CLINICAL NURSE STOMAL THERAPY, TARANAKI DISTRICT HEALTH BOARD

## PYODERMA GANGRENOSUM

The ulcerated lesions around Hilary's ileostomy were diagnosed as Pyoderma gangrenosum.

Pyoderma gangrenosum (PG) is a rarely occurring, destructive, neutrophilic dermatosis condition with distinctive clinical characteristics. Lyon et al (1) reported an incidence of 0.6% occurrence in practice or 1 per 100,000 people. Typically PG affects young to middle aged adults with a slight predominance in females. In 50% of cases PG will be associated with a systemic disorder such as inflammatory bowel disease, rheumatoid arthritis and some haematological conditions. (1 & 2) Most commonly PG effects the legs, buttocks and abdomen however it effects a parastomal skin area far more commonly.

The majority of patients with PG will have an ileostomy as opposed to any other type of stoma.(1) It has been suggested that the unique environment around an ileostomy and the repeated trauma involved in pouch removal lays the foundation for the opportunistic development of parastomal pyoderma gangrenosum (PPG).

**While the ethology of PGG is unknown the clinical presentation follows a typical pathway:**

- A painful pustule which rapidly ulcerates
- Extremely painful ulcers which have a bluish colouring (See Fig 2)
- Undermining and ragged edges

Surgery is contraindicated in the management of PPG as it usually results, not in healing but in enlargement of the ulcerated area.

The non-healing ulceration of PPG has a significant morbidity for stoma management. Morbidity from pain, discomfort, bleeding and exudate impairs pouch adhesion causing leaks and diminished quality of life.

Once resolved PPG generally results in the formation of scar tissue which can be problematic for future pouching.

Mary's parastomal pyoderma gangrenosum was initially treated with stomahesive power, a Welland manuka seal and a Welland Aurum convex manuka pouch (see Fig3). The rationale for this product selection was to achieve healing of the PPG ulcers with the manuka honey. (See Manuka Honey)

Mary's pyoderma healed rapidly and has not recurred (See Fig 4 & 5). Prior to the use of the Welland pouches Mary was changing her pouch daily. Her sense of security has improved and she now has a leak free two day wear time.

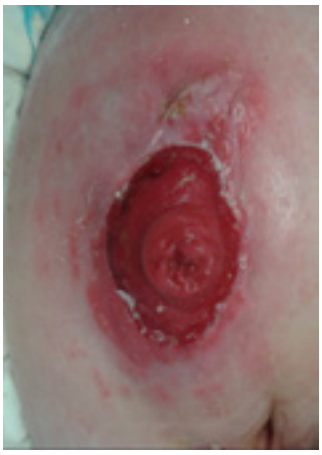

*Fig 1 Mary's pyoderma grangrenosum*

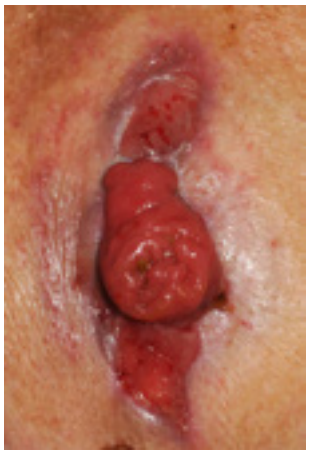

*Fig 2 Pyoderma granrenosum*

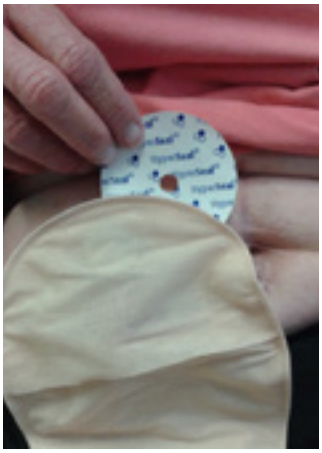

*Fig 3 Use of Welland manuka seal and Aurum Convex pouch*

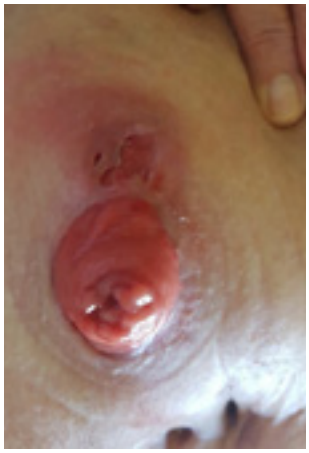

*Fig 4 Healing*

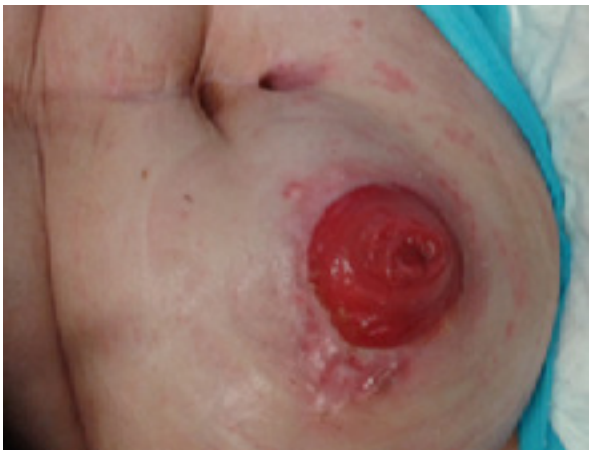

*Fig 5 Pyoderma healed*

# Pyoderma Grangrenosum and the Effects of Manuka Honey (Part 3)

KATY MARTIN-SKURR, SPECIALTY CLINICAL NURSE STOMAL THERAPY, TARANAKI DISTRICT HEALTH BOARD

When Mary developed a parastomal hernia we moved to one of the new Welland Profile pouches with manuka. The flexibility of the Welland Profile easily moulded over Mary's hernia and gave a secure fit while still giving the benefits of manuka for wound healing.

## MANUKA HONEY AND WOUND HEALING

Manuka honey has several action which contribute to wound healing.

### Antibacterial Action

Manuka honey has high concentrations of the antibacterial compound methyglyoxal (MGO). (5) This has been reported to effectively inhibit the growth of up to 60 types of bacteria including both aerobes and anaerobes either gran positive or negative.(Manda) Included in the list of 60 bacteria inhibited by manuka are MRSA, E coli, Salmonella and Stap aureus. Unlike other honeys the antibacterial properties of manuka honey are both heat and light stable.

A consequence of manuka honey's antibacterial action is the effect of deodorising offensive wound odours created by bacteria. (molan)

### Moist Wound Healing

Honey is hygroscopic drawing moisture from the environment and dehydrating bacteria to prevent growth. The high sugar content of honey osmotically draws fluid to a wound facilitating a moist wound healing environment. A moist wound healing environment facilitates easy of dressing removal preventing future trauma and pain.

### Ph Management

Wounds which are bacteria colonised, and ileostomy output share the feature of having a high skin damaging alkaline pH of 7 or above. With a low ph in the range of 3 manuka honey has an acidification effect which neutralises alkaline damage to the skin.

### Wound Pain

Most wound pain results from exposure of nerve endings to the prostaglandins which are produced as a result of the inflammatory process and from the pressure created by oedema of the wound. Manuka honeys anti-inflammatory and osmotic actions reduce the wound swelling and therefore the pain from a wound.

## CONCLUSION

My experience with Mary and the use of manuka honey in the healing of her PPG has lead me to consider the use of manuka as both a prevention and a treatment for stomal skin damage. I believe that the use of manuka in the healing of pyodermal lesion is worthy of further investigation.

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# Peristomal Pruritus – When Itch Leads to Scratch


## Abstract

Itching, also known as pruritus is the uncomfortable sensation causing the desire to scratch. When it is acute (time-limited), it may just cause a temporary annoyance. When chronic, pruritus may be difficult to treat and have more severe impact on the individual.[1] The physiology of chronic itch is a topic of interest to scientists who are investigating the neural mechanisms.[4] NIH has funded researchers at locations such as Washington University in St. Louis, and University of California, Berkeley where they have "Centers for the Study of Itch".[4]

Little is published in the literature about peristomal pruritus except in relationship to certain skin conditions such as candidiasis and dermatitis.[2] A common cause of peristomal skin complications is leakage of stool or urine onto the skin which people with ostomies sometimes ascribe as an itching sensation, this itching may not necessarily be a reflection of leakage only.

This poster presentation will examine peristomal pruritus in the absence of causation and discusses how a ceramide-infused barrier may have positive outcomes.


## Background to the Problem

People with ostomies often report peristomal skin itching with no visible signs of skin complications, leakage, or skin deterioration. Skin complications are not always visible. Skin can itch even if it looks healthy. When asked about how often they felt the need to scratch, one study found 87% of people living with a stoma experienced peristomal itching.[3] Nearly 3 in 5 people said they felt the need to scratch at least occasionally. About 16% of those said they experienced this feeling "frequently" or "very frequently". *(See Figure 1)*

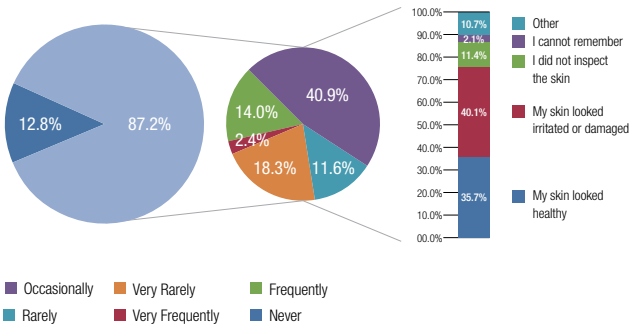


**Figure 1: Individuals with stomas needs to scratch – How did the skin look?[3]**

Now for the healthcare professional's perspective. Among stoma care nurses that were surveyed, over 95% have had patients reported pruritus.[3] Of those stoma care nurses, 27% said pruritus was the primary reason for the patient's visit. When asked how bothersome this condition was for their patients, 7 in 10 nurses reported it was at least moderately bothersome - particularly in warmer weather with higher heat and humidity.[3] *(See Figures 2 & 3)*

**What proportion report pruritus***

*As a proportion of clinicians who said 'Yes'

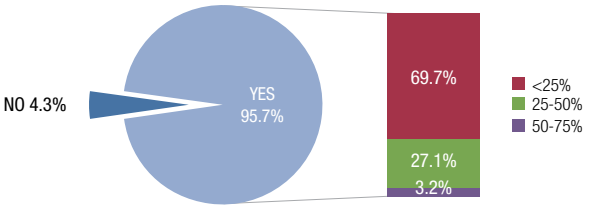


**Figure 2: Patients reporting pruritus to their stoma care nurse.[3]**

| Response | Better % | Worse % |
|---|---|---|
| Being in a dry environment | 24.0 | 7.7 |
| Anti-fungal powder | 25.5 | 2.9 |
| Heat | 3.8 | **48.1** |
| Humidity | 3.9 | **52.4** |
| Removing and replacing pouching system | **78.7** | 2.2 |
| Pressing on the pouching system | **34.3** | 7.6 |
| Scratching/rubbing the area | **44.2** | **20.2** |

**Figure 3: What made itching better or worse?[3]**

### The Role of Ceramide in the Skin

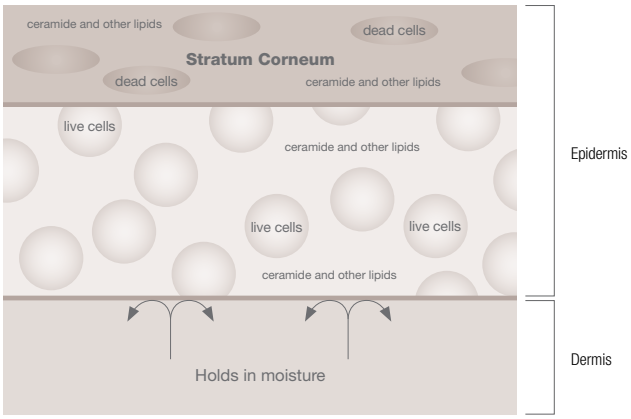


**Figure 4: Ceramides and skin**

**Paris Purnell RN STN**
Senior Manager,
Clinical Education,
Hollister Incorporated

## Reported Impacts on Itching from a Ceramide-Infused Ostomy Skin Barrier

Ceramides are a form of lipid found naturally in the outer layers of human skin. The purpose of ceramides is to link cells of the outer skin together to form a waterproof, protective barrier to help prevent water loss from the skin and keep irritants out. Ceramide levels have also been correlated to TEWL (transepidermal water loss). *(See Figure 4)*

During a recent double-blinded, randomised controlled trial (RCT) of a ceramide-infused skin barrier, it was reported by patients during this trial that they were 'very satisfied' with itching prevention.[5]

The aim of a ceramide infused barrier is to help protect the skin's own moisture barrier, which in turn may provide a positive impact on peristomal itching.

## Conclusions

Peristomal itching is a common problem experienced by ostomy patients and often reported to their stoma care nurse. However, in many cases, there is no visible causation for the itching and ostomy patients may resign themselves to tolerating the issue as an inevitable consequence of wearing an ostomy skin barrier.

New findings have demonstrated that the use of a ceramide-infused skin barrier may have positive results on patients experiencing pruritus.

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# Tu Meke Te Peke - The Bag is Great to Me

ANNA VEITCH, CLINICAL NURSE SPECIALIST OSTOMY AND CONTINENCE, TAIRAWHITI DISTRICT HEALTH BOARD

A fistula is defined as a connection between two epithelialized surfaces. Although rare in general nursing practice colovaginal fistulas are not uncommon in stomal therapy nursing. Such a presentation is often post initial review by a gynaecology service.

This distressing condition is often accompanied by a significant psychosocial morbidity. Morbidity can be demonstrated as social dis-engagement or intentional isolation, lower quality of life (QOL), and interpersonal stress in relationships.

This poster follows the care of Mary (pseudonym) who had a loop ileostomy formed following surgical excision of a colovaginal fistula.

Declaration of Interest: this poster is the first presentation of Mary's care. While pseudonyms have been used, permission to use her information has been given by Mary.

## COLOVAGINAL FISTULA'S

The incidence of colovaginal fistula's (CVF) is reported by Brown et al [1] 0.6 per 1000,000 women. The highest international incidence is found in sub-Sahara Africa where the condition is often associated with either traumatic sexual contact or maternal birth injuries such as infected episiotomy wounds, or perineal tears following an obstructed labour.

### Causes Of Colovaginal Fistula's

- In the Western world 95% of CVF's will be accompanied by a history of a hysterectomy [2.] and are often associated with:
- Diverticula disease
- Cancer of the pelvic area plus or minus radiation therapy, this includes cancer of the rectum, cervix, vagina, bladder, uterus, or anal canal.
- Ulcerative colitis
- Chronic faecal impaction

CVF formation can be delayed after any of these disease processes and may not become apparent for six months to two years or more after treatment of the initial condition.

### The anatomical sequence of events in the formation of a CVF is:

- Inflamed loops of bowel adhere to the vagina
- Abscess forms
- Abscess erodes through the vaginal wall
- Bowel content drains through the deficit in the vaginal wall

## WHO IS MARY?

Mary is a 67 year old Maori woman working full time for a social service providing emergency housing for those in crisis. While acknowledging that the work is challenging, stressful and requires long hours Mary remains passionate about making a difference in her community.

Although no longer married Mary remains in close contact with her ex-husband Doug. Mary believes that having a colovaginal fistula reduced her quality of life, heightened her awareness of body odour making her feel "dirty", led to a desire to disengage socially and limited the intimacy in her marriage.

Mary feels that these factors and the many years that she hide her condition out of embarrassment contributed to the end of their marriage.

### Mary's Medical History

- Non- insulin diabetes
- Gout
- Rheumatoid arthritis

### Mary's Surgical history

- Appendectomy
- Hysterectomy

## PRESENTATION

After years of distressing symptoms Mary conceded that she needed help and went forward for a colonscopy. Unfortunately, due to extensive scarring the scope could not be advanced beyond the rectum.

In March that year Mary underwent a laparoscopic low anterior resection with formation of a temporary loop ileostomy.

# Tu Meke Te Peke - The Bag is Great to Me (Part 2)

ANNA VEITCH, CLINICAL NURSE SPECIALIST OSTOMY AND CONTINENCE, TAIRAWHITI DISTRICT HEALTH BOARD

## ASSESSMENT

- **The Stoma:** While Mary's ileostomy protruded 1-2 cms above the peristomal plane the outlet was not at the apex of the proximal loop. It was deflected downwards towards the mucocutaneous junction.
- **The Output:** The output consistency and volume were with in normal parameters however, due to the outlets downward deflection all output was directed onto the mucocutaneous junction where the cut edge of the pouch was adhered.
- **Peristomal Contours:** Mary's stoma site had been selected and marked pre-surgery. The stoma was located with in Mary's visual field, on the top of the periumbilical roll and below a deep abdominal fold.
- **Peristomal Skin:** Repeated contact with faecal irritant enzymes due to appliance leaks and short wear times had resulted in peristomal skin which was red, eroded and painful.
- **Pouch Application:** Mary was competent with appliance changes however repeated leaks had severely compromised her sense of security and once again she was limited in her willingness to engage in social activities. Mary was discouraged, her situation seemed even less controllable than prior to surgery.
- **The Pouch:** Mary had been using a flat pouch which had been unsuccessful. With a well spouted stoma I considered that convexity may not be warranted.

### Plan A, Cervix

The rationale for the choice of Welland Curvex was the pouches ability to mirror image the surface it was adhered to. We elected to add a belt for additional security.

Outcome: The Welland Curvex was successful for 5 days without a leak however the second pouch change revealed a silent leak with contamination creeping under the adhesive area beneath the stoma.

### Plan B

Building on the progress of a longer wear time we added half an Eakin seal beneath the stoma.

**Outcome:** The half Eakin seal achieved a wear time of three days however once again on removal there was a silent leak with contamination creeping under the pouch's adhesive surface. The damage to the peristomal skin was unchanged (see Fig 1).

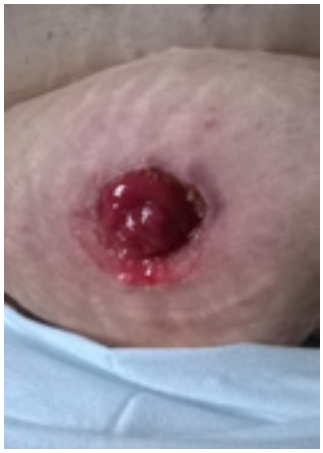

*Fig 1 clearly showing the damage and leak area*

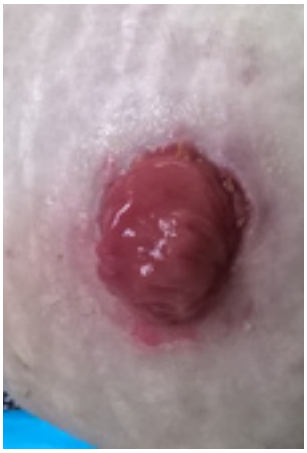

*Fig 2 Two days after introduction of the Welland Flair Active*

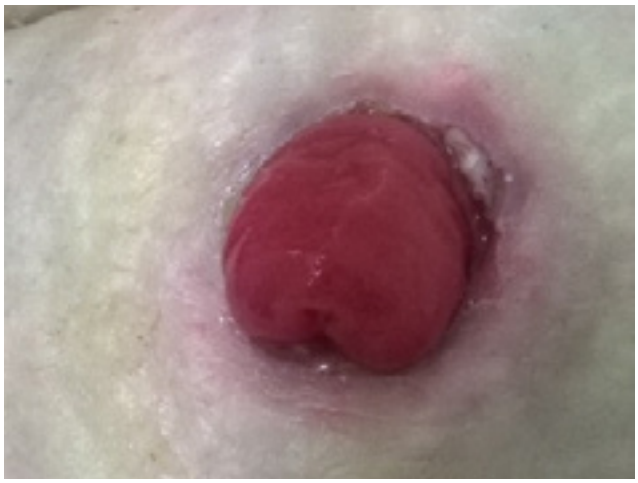

*Fig 3 Five days after introduction of the Welland Flair Active with the peristomal skin healed.*

### Plan C

In spite of being well spouted it was becoming increasingly apparent that convexity was an appropriate appliance choice. Mary needed either a full flexible or a soft convexity of medium depth. We elected to trial Flair Active convex with a 48mm convex plateau. With three convex plateaus the Welland Flair Active allows the practitioner to choose the size that will get the convexity as close as possible to the stoma where the convexity push is needed.

**Outcome:** Fig 2 & 3 show the improvement after two and then five days of using the Welland Flair Active. The skin completely healed by day five.

# Tu Meke Te Peke - The Bag is Great to Me (Part 3)

ANNA VEITCH, CLINICAL NURSE SPECIALIST OSTOMY AND CONTINENCE, TAIRAWHITI DISTRICT HEALTH BOARD

**Take Home Messages from Mary's Care**

- Stomal therapy has never been a one stop shop of consistent patient experience. No two patients, their coping skills, attitudes, social environment, abdomen, and prior experience will ever be the same. This makes every solution unique.
- Much of a stomal therapist expertise is found in the problem solving skills and product knowledge needed to build to a successful solution.

## CONCLUSION

Convexity has evolved significantly over the last decade. We no longer have only deep rigid convexity appliances available to us in practice. Mary's care has moved me towards earlier consideration of a convex appliance in any repeated leak situation. Early intervention with convexity is a justifiable practice which can save both the patient and the STN distress, time and resources.

## REFERENCES

1. Brown,H. & Wang,L. & Bunker,H. & Lowder,J. (2012) Lower reproductive tract fistula repairs in women. *Urogynecology Journal 23 (4), 403-410*
2. Berger,M. & Khandwala,N. & Fenner,D. & Burney,R. (2016) Colovaginal Fistula –.presentation, evaluation and management. *Journal of Female Pelvic Medicine 22(5),.355-358*

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# More comfort. Better outcomes.

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You know the challenges: Adhesive trauma, bodily fluids, and friction can quickly break down skin. And patients with a problem stoma and/or high output are especially vulnerable.

3M™ Cavilon™ No Sting Barrier Film is ideally suited for peristomal skin care. Its unique polymer formulation creates a breathable, waterproof coating, clinically proven to provide long-lasting protection against urine, stool, adhesive irritation and friction. Cavilon No Sting Barrier Film offers a simple, proven solution that can help improve your patients' quality of life.*

*3M data on file

For more information, and to request sample packs for your patients, please visit our website: **3M.co.nz/ostomy**


**3M New Zealand Limited**
94 Apollo Drive
Rosedale, Auckland 0632
Phone 0800 80 81 82

# *The Patricia Walls Coloplast WCET Educational Scholarship 2020*

Coloplast® Professional

## Coloplast would like to offer 3 x $2,500 Educational Scholarships to attend the WCET conference in Glasgow, Scotland, October 11-14th, 2020.

Coloplast are pleased to offer scholarships for ongoing WCET conferences. To encourage STNs to strive for the highest in the profession of Stomal Therapy Nursing, Coloplast recognises Patricia Walls' contribution within the specialty of Stomal Therapy in Australia with the inclusion of her name in this scholarship.

### Objective

Coloplast recognises the need to create innovative educational experiences for all nurses. Coloplast has three scholarships on offer to be awarded to financially assist a registered STN in Australia or New Zealand to attend the WCET conference in Glasgow, 2020.

### What must you do?

- Obtain Educational Scholarship application form and guideline pack from your Coloplast Territory Manager or by emailing aucare@coloplast.com
- Complete a case study or clinical paper illustrating health related quality of life outcomes using SenSura Mio Convex or SenSura Mio Concave and (where appropriate) Brava Supporting Products. This could include but is not limited to:
    - Reduction in leakage related challenges
    - Improvement in peristomal skin health
    - Improvement in psychological wellbeing
- Write a one-page letter of motivation (How will you benefit from participating in WCET).

### Scholarship Application guidelines

- Applications must be sent to aucare@coloplast.com by 5pm on February 1st 2020.
- All applications will then be sent to the AASTN Executive for impartial judging.
- Scholarship recipients will be announced April 1st 2020.
- All applicants must be a full member of the AASTN. New Zealand registered Stomal Therapy Nurses are also eligible to apply.

**Contact your Coloplast Territory Manager for further information or email aucare@coloplast.com**

# Policy for Bernadette Hart Award

## Process

- The Bernadette Hart Award (BHA) will be advertised in the NZNOCSTN Journal The Outlet
- The closing date for the BHA applications is 30 November each year
- The NZNOCSTN Executive Committee will consult and award the BHA within one month of the closing date
- All applicants will receive an email acknowledgement of their application
- All applicants will be notified of the outcome, in writing, within one month of the closing date
- The monetary amount of the award will be decided by the NZNOCSTN Executive Committee. The amount will be dependent on the number of successful applicants each year and the financial status of the BHA fund
- The name of the successful applicants(s) will be published in the NZNOCSTN Journal The Outlet
- The BHA Policy will be reviewed annually by the NZNOCSTN Executive Committee.

## Criteria

- The applicant(s) must be a current member of the NZNOCSTN and have been a member for a minimum of one year
- Successful applicant(s) must indicate how they will use the award. The award must be used in relation to Stomal Therapy nursing practice
- The applicant(s) previous receipt of money (within the last five years) from the NZNOCSTN and/or the BHA will be taken into consideration by the NZNOCSTN Executive Committee when making their decision. This does not exclude a member from reapplying. Previous receipt of the BHA will be taken into account if there are multiple applicants in any one year
- The funds are to be used within 12 months following the receipt of the BHA.

## Feedback

- Submit an article to The Outlet within six months of receiving the BHA. The article will demonstrate the knowledge gained through use of the BHA

and/or

- Presentation at the next NZNOCSTN Conference. The presentation will encompass the knowledge/nursing practice gained through the use of the BHA.

# Application for Bernadette Hart Award

## CRITERIA FOR APPLICANTS

- Must be a current full or life member of the NZNO College of Stomal Therapy Nursing (NZNOCSTN) for a minimum of one year
- Present appropriate written information to support application
- Demonstrate the relevance of the proposed use of the monetary award in relation to stomal therapy practice
- Provide a receipt for which the funds were used
- Use award within twelve months of receipt
- Be committed to presenting a written report on the study/ undertaken or conference attended or write an article for publication in The Outlet or to present at the next national conference

## APPLICATIONS CLOSE 30TH NOVEMBER (annually)

## SEND APPLICATION TO:

**Email:** angela.makwana@waitematadhb.govt.nz or dawn.birchall@middlemore.co.nz

## BERNADETTE HART AWARD APPLICATION FORM

**Name:** _____

**Address:** _____

_____

**Telephone** Home: _____ Work: _____ Mob: _____

**Email:** _____

## STOMAL THERAPY DETAILS

**Practice hours** Full Time: _____ Part Time: _____

**Type of Membership** ◯ FULL ◯ LIFE

## PURPOSE FOR WHICH AWARD IS TO BE USED

(If for Conference or Course, where possible, please attach outlined programme, receipts for expenses if available)

• Outline the relevance of the proposed use of the award to Stomal Therapy

_____

_____

## EXPECTED COSTS TO BE INCURRED

**Fees:** (Course/Conference registration) $ _____

**Transport:** $ _____

**Accommodation:** $ _____

**Other:** $ _____

Funding granted/Sourced from other Organisations

**Organisation:**

_____ $ _____

_____ $ _____

_____ $ _____

## PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

**Have you been a previous recipient of the Bernadette Hart award within the last 5 years?** ◯ No ◯ Yes (date) _____

**Please Indicate ONE of the below:** (please note this does not prevent the successful applicant from contributing in both formats).

◯ Yes I will be submitting an article for publication in 'The Outlet' (The New Zealand Stomal Therapy Journal).

◯ Yes I will be presenting at the next National Conference of NZNOCSTN.

Signed: _____ Date: _____

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 an educational grant to one New Zealand registered nurse to the value of $3,5000 NZD, 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 30th June 2020.
- 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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Hollister Education

Dansac Education

# Application Form

First Name: Surname:

Professional Title:

Hospital/Practice Address:

Email:

Daytime Phone No: Mobile No:

Home address:

Email:

NZNO Membership No:

(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

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58 Richard Pearse Drive,
Airport Oaks, Auckland, New Zealand
0800 678 669

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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.

# 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

# New Zealand Stomal Therapy Nurses Contact Details (Part 1)

## NORTHLAND DISTRICT HEALTH BOARD

### Rachel Pasley

*Clinical Nurse Specialist Stomal Therapy*
*Covers Hospital and Community*

**Address:** Private Bag 9742
Whangarei 0148
**Phone:** 09 430 4101 ext 7952
**Mobile:** 021 876914 & 021 363057
**Fax:** 09 486 8945 ext 47557
**Email:** Rachel.pasley@northlanddhb.org.nz
**Hours:** Mon, Tues, Thurs, Fri

## WAITEMATA DISTRICT HEALTH BOARD

### Jennifer Rowlands

*Clinical Nurse Specialist, Ostomy*
*Covers Community North Shore*

**Address:** Waitemata Community Health
Private Bag 93-503
Takapuna, Auckland
**Phone:** 09 486 8945 ext 47557
**Email:** Jennifer.Rowlands@waitematadhb.govt.nz
**Hours:** Varied

### Sandy Izard

*Clinical Nurse Specialist, Ostomy*
*District Nursing*
*Covers Community Waitakere*

**Address:** Waitakere Hospital,
Lincoln Rd,
Henderson, Auckland
**Phone:** 09 837 8828 ext 46342
**Email:** Sandy.Izard@waitematadhb.govt.nz
**Hours:** Varied

### Julie Skinner

*Clinical Nurse Specialist, Ostomy and Continence*
*District Nursing*
*Covers Community Rodney District*

**Address:** PO Box 29
Red Beach, Auckland 0945
**Phone:** 09 4270300 ext 44367
**Email:** Jennifer.Rowlands@waitematadhb.govt.nz
**Hours:** Varied

### Angela Makwana

*Ostomy Clinical Nurse Specialist*
*North Shore Hospital*
*Covers Community Rodney District*

**Address:** Private Bag 93-503
Takapuna, Auckland 0740
**Phone:** 09 4868920 ext 44125
**Fax:** 09 4884621
**Mobile:** 021 533685
**Email:** Angela.makwana@waitematadhb.govt.nz
**Hours:** Mon Tues Thurs

## AUCKLAND DISTRICT HEALTH BOARD

### Mary Vendetti

*Clinical Nurse Specialist Stomal Therapy*

**Address:** Private Bag 92189
Greenlane Clinical Centre,
Building 17,
Auckland 1142
**Phone:** 09 307 4949 ext 28532
**Mobile:** 021 348406
**Fax:** 09 623 6472
**Email:** Maryv@adhb.govt.nz
**Hours:** Full time

### Francesca Martin

*Stoma Nurse Specialist*
*Covers Hospital and Community – Auckland Central, Waiheke and Great Barrier Islands*

**Address:** Address as above
**Phone:** 09 307 4949 ext 28530
**Mobile:** 021 715224
**Fax:** 09 623 6472
**Email:** Francescam@adhb.govt.nz
**Hours:** Full time

# New Zealand Stomal Therapy Nurses Contact Details (Part 2)

## COUNTIES MANAKAU DISTRICT HEALTH BOARD

### Erica Crosby

*Nurse Specialist Stomal Therapy*
*Covers Community*

**Address:** Home Health Care,
Counties Manukau Health, Auckland
**Phone:** 09 276 0044 ext 53321
**Mobile:** 021 2279229
**Fax:** 09 270 4733
**Email:** Crosbye@middlemore.co.nz
**Hours:** Tues, Thurs, Fri

### Emma Ludlow

*Clinical Nurse Specialist Stomal Therapy*
*Covers Community*

**Address:** Home Health Care,
Counties Manukau DHB, Auckland
**Mobile:** 021 2723315
**Email:** Emma.ludlow@middlemore.co.nz
**Hours:** Wed, Thurs and alternate Fridays

### Dawn Birchall

*Nurse Specialist Stomal Therapy*
*Covers Community*

**Address:** Home Health Care,
Counties Manukau Health, Auckland
**Landline:** 09 276 0044 ext 53321
**Mobile:** 021 516903
**Email:** Dawn.birchall@middlemore.co.nz
**Hours:** Mon – Wed and alternative Thursdays
0730 – 1600

### Pravin Deo

*CNS Colorectal*
*Covers Middlemore Hospital*

**Address:** Home Health Care,
Private Bag 93311,
Otahuhu, Auckland 1640
Counties Manukau DHB,
Middlemore Hospital, Auckland
**Phone:** 09 2760044 ext 8981
**Mobile:** 021 926740
**Email:** Pravin.deo@middlemore.co.nz

## WAIKATO DISTRICT HEALTH BOARD

### Carol Lee

*Clinical Nurse Specialist Stomal Therapy*
*Covers Hospital and Community*

**Address:** Waikato Hospital, Private Bag 3200
Hamilton 3240
**Phone:** 07 8398899 ext 96801
**Mobile:** 021 2414360
**Fax:** 07 8398878
**Email:** Carol.lee@waikatodhb.health.nz
**Hours:** Fulltime

## LAKES DISTRICT HEALTH BOARD

### Gillian Bedford

*Stoma / Continence CNS*
*Covers Hospital and Community*

**Address:** Rotorua Hospital,
Private Bag 3023,
Rotorua Mail Centre, Rotorua 3046
**Phone:** 07 3497955 ext 8111
**Mobile:** 027 605 6464
**Fax:** 07 349 7939
**Email:** Gillian.bedford@lakesdhb.govt.nz
**Hours:** Fulltime

## BAY OF PLENTY DISTRICT HEALTH BOARD

### Helen Collins

*Colorectal CNS*
*Covers Hospital*

**Address:** Bay of Plenty DHB,
Private Bag 12024
Tauranga 3143
**Phone:** 07 5798652
**Mobile:** 027 7038227
**Email:** Helen.collins@bopdhb.govt.nz
**Hours:** Fulltime

### Sandra Underwood, Allison Henderson, Jules Smith, Liz Thompson

*Stomal Therapy Nurses*
*Covers Hospital*

**Address:** District Nursing Bay of Plenty DHB
Private Bag 12024, Tauranga 3143
**Phone:** 07 5798757
**Fax:** 07 5716046

# New Zealand Stomal Therapy Nurses Contact Details (Part 3)

## TAIRAWHITI DISTRICT HEALTH BOARD

### Anna Veitch

*CNS Ostomy / Continence*
*Covers Hospital and Community*

**Address:** Hauora Tairawhiti, 421 Ormond Road
Gisborne 4010
**Phone:** 06 869 0500 ext 8135
**Mobile:** 027 2263158
**Fax:** 06 869 0554
**Email:** Anna.Veitch@tdh.org.nz

### Kate Petro

*CNS Ostomy / Continence*

**Address:** Private Bag 92189
**Contact:** Contact Details as above
**Email:** Kate.Petro@tdh.org.nz

## TARANAKI DISTRICT HEALTH BOARD

### Katy Martin-Skurr

*SCN Stomal Therapy*

**Address:** District Nursing,
Taranaki District Health
Board, Private Bag 2016, New Plymouth
**Phone:** 06 753 7797 ext 8793
**Pager:** 378
**Mobile:** 027 2498716
**Fax:** 06 753 7836
**Email:** Katy.martin-skurr@tdhb.org.nz
**Hours:** Mon, Wed, Thurs

### Alison Meerman

*SCN Continence / Stomal Therapy*

**Address:** District Nursing, Taranaki District Health
Board, Private Bag 2016, New Plymouth
**Phone:** 06 753 7797 ext 8564
**Pager:** 350
**Mobile:** 027 2408184
**Email:** Alison.meerman@tdhb.org.nz

## WANGANUI DISTRICT HEALTH BOARD

### Nicky Bates

*CNS Ostomy / Oncology Nurse*
*Covers Hospital and Community*

**Address:** Community Health, Wanganui Hospital
Private Bag 3003, Wanganui
**Phone:** 06 348 1301
**Mobile:** 027 334 4272
**Fax:** 06 348 3331
**Email:** Nicky.bates@wdhb.org.nz
**Hours:** Full Time

## MID CENTRAL DISTRICT HEALTH BOARD

### Lawrence Mutale

*Clinical Nurse Specialist – GI Cancer & Stomal Therapy*
*Covers Hospital and Community*

**Address:** Palmerston North Hospital, 5TH Floor
Clinical Services Block, Private Bag 11036
Palmerston North
**Phone:** 06 350 8073
**Mobile:** 027 2727592
**Fax:** 06 350 8069
**Email:** Lawrence.mutale@midcentraldhb.govt.nz
**Hours:** Full Time

### Annet Nicholls

*Clinical Nurse Specialist GI Cancer & Stomal Therapy*
*Covers Hospital and Community*

**Address:** Address as above
**Contact:** Contact Details as above
**Phone:** 06 350 8072
**Mobile:** 027 2727592
**Email:** Annet.nicholls@midcentraldhb.govt.nz
**Hours:** Full time

# New Zealand Stomal Therapy Nurses Contact Details (Part 4)

## HAWKES BAY DISTRICT HEALTH BOARD

### Dorothy Ferguson

*CNS Stomal Therapy*
*Covers Hospital and Community*

**Address:** Hawkes Bay Fallen Soldiers' Memorial Hospital, Private Bage 9014 Hastings 4120
**Phone:** 06 878 1635
**Mobile:** 027 2406092
**Fax:** 06 878 1310
**Email:** Ostomyservice@hbdhb.govt.nz
**Hours:** Mon – Wed

### Sharon Elson

*CNS Stomal Therapy*
*Covers Community*

**Contact:** Contact Details as above
**Mobile:** 027 2406092
**Email:** Ostomyservice@hbdhb.govt.nz
**Hours:** Wed – Fri

### Maree Warne

*Ostomy Nurse RN*

**Contact:** Contact Details as above
**Generic email for Hawkes Bay:** Ostomyservice@hbdhb.govt.nz

## WAIRARAPA DISTRICT HEALTH BOARD

### Christina Cameron

*Stomal / Continence Clinical Nurse Specialist*
*Covers Hospital and Community*

**Address:** Wairarapa Hospital, PO Box 96 Masterton
**Phone:** 06 946 9800 ext 5701
**Mobile:** 027 6875235
**Fax:** 06 946 9837
**Email:** Christina.cameron@wairarapa.dhb.org.nz
**Hours:** Mon – Thurs 0730 -1600

## HUTT VALLEY DISTRICT HEALTH BOARD

### Vicky Beban

*Clinical Nurse Specialist – Stomaltherapy*
*Community Health*

**Address:** Hutt Hospital, High Street Lower Hutt
**Phone:** 04 570 9148
**Mobile:** 027 2214247
**Fax:** 04 570 9210
**Email:** Vicky.beban@huttvalleydhb.org.nz
**Hours:** Mon – Thurs 0800 – 1630
Alt Fri 0800 – 1630

## CAPITAL & COAST DISTRICT HEALTH BOARD

### Sue Wolyncewicz

*CNS Stomal Therapy*
*Covers Hospital and Community*

**Address:** Ewart Building, Community Health, 2 Coromandel Street, Newtown Wellington
**Phone:** 04 9186375 or 04 3855999 ext 6375
**Mobile:** 027 2810942
**Fax:** 04 3855868
**Email:** Sue.wolyncewicz@ccdhb.org.nz
**Hours:** Fulltime

### Rochelle Pryce

*Stoma Nurse*
*Covers Hospital and Community*

**Contact:** Contact Details as above
**Mobile:** 027 2263259
**Email:** Rochelle.pryce@ccdhb.org.nz
**Hours:** Fulltime

## NELSON MARLBOROUGH DISTRICT HEALTH BOARD

### Sue Rossiter

*Specialty Clinical Nurse: Stomal Therapy/Wound Care*
*Covers Hospital and Community*

**Address:** District Nursing, 281 Queen Street, Richmond Nelson
**Phone:** 03 5437982
**Fax:** 03 5446832
**Email:** Sue.rossiter@nmhs.govt.nz
**Hours:** Fulltime

# New Zealand Stomal Therapy Nurses Contact Details (Part 5)

## BLENHEIM

### Dianne Devlin

*Specialty Clinical Nurse Stomal Therapist*

**Address:** PO Box 46
Blenheim
**Phone:** 03 520 9927
**Mobile:** 027 4516888
**Fax:** 03 520 9906
**Email:** Dianne.devlin@nmdhb.govt.nz
**Hours:** Wed, Thurs 0800 – 1630
Can also be accessed on DN days

## WEST COAST DISTRICT HEALTH BOARD

### WESTPORT

### Di Longstaff

*District Nursing Service*

**Address:** Buller Hospital,
Cobden Street,
Westport
**Phone:** 03 788 9030 Extn 8716
**Fax:** 03 789 7678
**Email:** Bullerdn@westcoastdhb.health.nz

### Cody Frewin

**Phone:** 03 788 9216
**Contact:** Contact Details as above

### REEFTON

### Margaret Prince

**Address:** District Nursing Service,
Reefton Hospital,
Broadway,
Reefton
**Phone:** 03 769 7432
**Mobile:** 027 2448147
**Fax:** 03 732 8785
**Email:** Reeftondn@westcoastdhb.health.nz

### GREYMOUTH

### Kat Neiman

**Address:** District Nursing Service,
Grey Base Hospital,
High Street,
Greymouth
**Phone:** 03 769 7721
**Fax:** 03 769 7793
**Email:** Greydn@westcoastdhb.health.nz
or Katrina.neiman@westcoastdhb.health.nz

### HOKITIKA

### Annie Hughes

**Address:** District Nursing Service,
Hokitika Health Centre,
59 Sewell Street,
Hokitika
**Phone:** 03 756 9906
**Fax:** 03 755 5058
**Email:** Hokidn@westcoastdhb.health.nz

## CANTERBURY DISTRICT HEALTH BOARD

### Beth Dunstan

*Stomal Therapist*
*Covers Hospital and Community*

**Address:** Nurse Maude
35 Mansfield Avenue
Merivale
Christchurch
**Phone:** 03 375 4289
**Fax:** 03 375 4270
**Mobile:** 027 2851294
**Email:** Bethd@nursemaude.org.nz
**Hours:** Mon, Tues and Wed

### Jackie Hutchings

*Stomal Therapist*
*Covers Hospital and Community*

**Contact:** Contact Details as above
**Mobile:** 027 2364554
**Email:** Jacquelynh@nursemaude.org.nz
**Hours:** Fulltime

### Jenny Roberts

*Stomal Therapist*
*Covers Hospital and Community*

**Contact:** Contact Details as above
**Mobile:** 027 2230703
**Email:** Jennyr@nursemaude.org.nz
**Hours:** Fulltime

### Annie Cooper

*Stomal Therapy Nurse*
*Contact details as above*

**Mobile:** 021 990300
**Email:** Annie.Cooper@nursemaude.org.nz
**Hours:** Thurs and Fri

# New Zealand Stomal Therapy Nurses Contact Details (Part 6)

## ASHBURTON

### Jessica Goodman

*Wound and Stomal Therapy CNS*

**Address:** Ashburton Community Services,
Private Bag 801,
Ashburton 7700
**Phone:** 03 3078465 ext 28879
**Mobile:** 027 5759323
**Fax:** 03 307 8460
**Email:** Jessica.Goodman@cdhb.health.nz
**Hours:** Mon, Tues and Wed

## SOUTH CANTERBURY DISTRICT HEALTH BOARD

### Bronney Laurie

*Stomal Therapist*

*Covers community*

**Address:** District Nursing,
Private Bag 911
Timaru
**Phone:** 03 687 2310
**Mobile:** 027 2734809
**Fax:** 03 687 2309
**Email:** Dnstomal@scdhb.health.nz
**Hours:** Varied

### Coralie Bellingham

*Stomal Therapy Nurse*

**Address:** Surgical Ward,
Timaru Hospital,
Queen Street,
Timaru
**Phone:** 03 6872100 ext 8286 Hospital
03 6872310 District - Thurs

## SOUTHERN DISTRICT HEALTH BOARD

## OTAGO

### Leeann Thom

*Clinical Nurse Specialist Stomal Therapy*

*Covers Hospital and Community*

**Address:** ISIS Centre,
Private Bag 1921,
Dunedin 9054
**Phone:** 03 4769724
**Mobile:** 027 2731505
**Fax:** 03 4769727
**Email:** Leeann.thom@southerndhb.govt.nz

### Jillian Woodall

*Stomal Therapy Nurse*

*Covers Hospital and Community*

**Contact:** Contact Details as above
**Mobile:** 027 2016691
**Email:** Jillian.woodall@southerndhb.govt.nz

### Ruth Macindoe

*Stomal Therapy Nurse*

*Covers Hospital and Community*

**Contact:** Contact Details as above
**Mobile:** 027 5910650
**Email:** Ruth.macindoe@southerndhb.govt.nz
**For Otago DHB:** Stomal.Therapyotago@southerndhb.govt.nz

## SOUTHLAND

### Nicola Braven

*Stomal Therapy Nurse*

**Address:** Southland Hospital,
PO Box 828
Invercargill
**Phone:** 03 214 5783 ext 48456
**Cellphone:** 027 2947531
**Fax:** 03 2148919
**Email:** Nicola.braven@southerndhb.govt.nz
**Hours:** Mon, Tues and every second Wed
0800 - 1630

### Kim Snoep

*Stomal Therapy Nurse*

*Contact details as above*

**Email:** Kim.snoep@southerndhb.govt.nz
**Hours:** Wed 9-12, Thurs, Fri 0900 – 1500


# The Outlet

*New Zealand Stomal Therapy Nurses*