The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

IN THIS ISSUE:

JULY 2023

Aurum® Plus

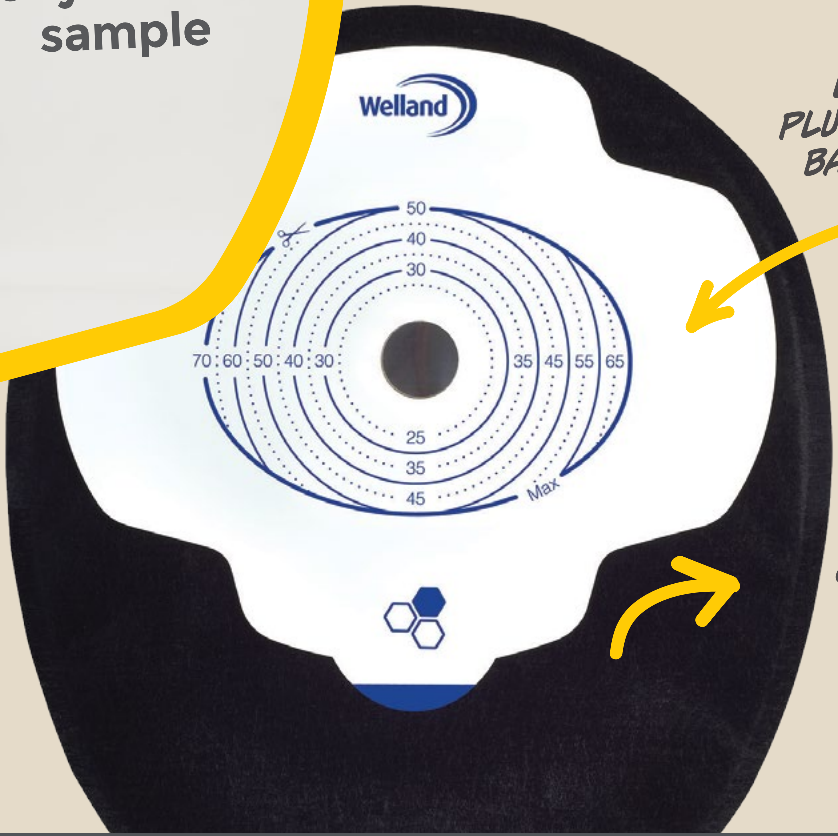
A pouch with a choice of colours plus comfort

Unique plus shaped baseplate with Comfort Curves, designed to hug your body around your stoma and reduce the risk of leak channels forming

Skin-friendly hydrocolloid contains medical grade Manuka honey, which may help to promote healthy skin around the stoma

A choice of colours Choose between Black or Sand pouches

Call 0800 440 027 for your free sample



Welland®, the Welland logo™ and Aurum® are trademarks of CliniMed (Holdings) Ltd.

OMNIGON

info@omnigon.com.au
NZ **0800 440 027** www.omnigon.com.au

The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

CONTENTS

PROFESSIONAL SECTION

EDUCATIONAL SECTION

ENCOURAGING MEMBERSHIP

EASY MEMBERSHIP SUBSCRIPTION CAN NOW BE GAINED ON THE WEBSITE
www.nzno.org.nz

IF YOUR ADDRESS HAS CHANGED PLEASE CONTACT
Emma Ludlow | Email: emma.ludlow@middlemore.co.nz

Your Executive Committee Members

COMMITTEE CONTACT

CHAIRPERSON

Emma Ludlow
CNS Stomal Therapy
Counties Manukau DHB
Email emma.ludlow@middlemore.co.nz

SECRETARY

Maree Warne MNSc
Clinical Nurse Specialist | Ostomy Service
Te Matau a Māui Hawke's Bay
Email Maree.Warne@hbdhb.govt.nz

CO-EDITOR

Marie Buchanan
Ostomy Clinical Nurse Specialist
Te Whatu Ora Waitemata
Email Marie.buchanan@waitematadhb.govt.nz

CO-EDITOR

Preeti Charan
Ostomy Clinical Nurse Specialist
Te Whatu Ora Waitemata
Email Preeti.charan@waitematadhb.govt.nz

COMMITTEE MEMBER

Holly Dorizac
District Nurse
Te Whatu Ora Counties Manukau
Email Holly.Dorizac@middlemore.co.nz

TREASURER

Christina Cameron
Stomal/Continence Clinical Nurse Specialist
Wairarapa District Health Board
Email: Christina.Cameron@wairarapa.dhb.org.nz

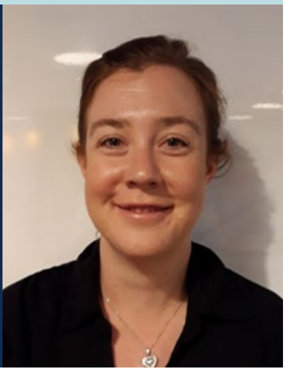
ISSN 2324-4968 (Print) ISSN 2324-4976 (Online)

www.nzno.org.nz/groups/sections/stomal_therapy

Published three times a year by Blacksheepdesign **www.bsd.nz**

Chairperson's Report

EMMA LUDLOW



Dear all,

I hope you have been all keeping well, warm, and finding exciting wet weather activities to do on your weekends!

Thank you to everyone who submitted a clinical guideline to be peer reviewed, we greatly appreciate the specialist expertise that went into each submission.

The committee has been working hard over the last few months peer reviewing the submissions, ensuring accuracy, and reconciling the guideline document into a publication that we can be all proud of. The final draft document will have been circulated to all stakeholders by the time you read this, so we hope you have taken the opportunity to forward your feedback.

The committee is fully in the throes of organising the next New Zealand Stomal Therapy Nursing conference! Please check out the flyer in this edition of The Outlet for details. The conference is being held on the 29th February and 1st March 2024 at the Ellerslie Racecourse in Auckland. We really hope you will all submit abstracts and speak on topics that you're passionate about! Please start thinking about your topics and getting pen to paper so you can share your work with your fellow colleagues. The call for abstracts will start soon and close later in the year. We will also be running workshops on topics that are applicable to new practitioners as well as experienced. Significant updates on the conference will be sent out via email otherwise, keep an eye on the College website.

A new scholarship, that is also advertised in this edition of The Outlet, is the Coloplast Patricia Blackley Scholarship. There are 3 scholarships available, each with $5000 scholarships that can be used with any post graduate education. I strongly urge you to apply if seeking funding for the graduate certificate in stomal therapy or any advanced education that pertains to stomal therapy. Submissions close July 31st

Thank you all,

Emma

Editors' Report

PREETI AND MARIE

We hope this edition of "The Outlet" finds everyone well, safe and gearing up for the winter challenges.

Again many thanks to everyone who contributed towards 'The Outlet'. We have gathered some great articles again and are always humbled by the amazing work you all do. Thank you for sharing your knowledge with us to all learn from. Look out for the feedback on the AASTN conference, We are sure we didn't hear EVERYTHING that went on over there but it sounded great. Special shout out to the ongoing support from our stoma supply companies, this never goes unnoticed or appreciated, thank you. We remain grateful to our small college of Stoma Therapy Nurses who are always giving their best to the ostomy patients in the hospital and out in the community with every increasing in the complexity of care required. Our expertise is getting wider and wider as the patients we see are not only requiring stoma management input but also requiring acknowledgment to general and mental health problems they facing. We wake up each day and face the world with a smile on our face and that invisible magic wand we all carry polished up and ready to go.

Ka mihi ki a koutou katoa mo o koutou mahi, thank you well done everyone for your hard work

What's happening in the background

Look out for the NZNOCSTN Clinical guideline publication in near future. The guidelines are evidence based, peer reviewed and aimed to optimize safe and consistent patient care with a positive care outcome for all patients equally.

We are excited to announce that The NZNOCSTN Conference has been set and will be hosted in Auckland, 29 Feb and 1 Mar 2024. Please support YOUR conference and plan early to participate. Encourage/support your team of nurses to attend; it is not just a day out but a perfect way to generate awareness of the ostomy services, its speciality and significance in the multi-disciplinary team of care. It is a perfect opportunity to share your knowledge, present to your peers to gain recognition of your knowledge and hard work (not to mention the kudos for the portfolio!) Catching up with your colleagues from different regions is a high light and the perfect opportunity to learn and share skills and knowledge. Planning is well underway check the flyer in following pages, with more info to come via emails.

Please remember

This is YOUR journal and collage, it cannot function with just a few people supporting or contributing to it. The committee are all still working within their roles and putting in their own time to ensure these supports continue to be available to you all. PLEASE SUPPORT us through participating, submitting articles and/or profiles when approached. We are all fabulous storytellers and have a wealth of knowledge to share with a unique passion for what we do. We encourage and support all collage members to show case their work in The Outlet so other nurses can benefit and learn from your work. Please just give it a go.

Preeti Charan

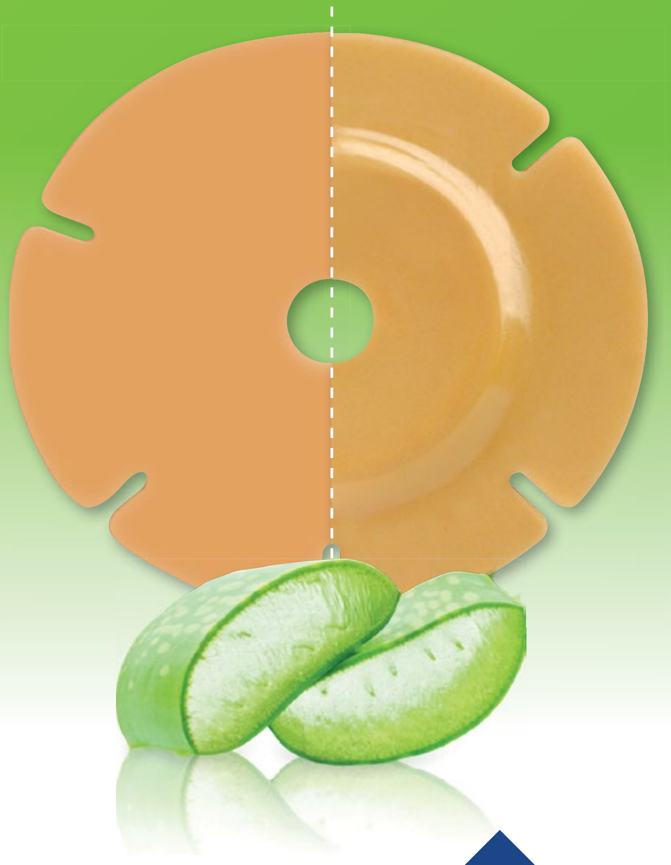
Marie Buchanan

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.
We would LOVE to hear from you.

Please send your submissions to either:

- Preeti.charan@waitematadhb.govt.nz or
- Marie.buchanan@waitematadhb.govt.nz



Reporting back on Perth Conference

ANGELA MAKWANA

STOMAL THERAPY NURSE / TE WHATU ORA WAITEMATA

The Australian Association Stomal Therapy Nurses (AASTN) & 10th Asia Pacific Enterostomal Therapy Nurses Association (APETNA) conference was recently held in Fremantle at the University of Notre Dame. The theme was Horizons: advancing Wound, Ostomy & Continence Practice.

Over 600 delegates, 1/3 being from outside of Australia, representing over 19 countries, attended the conference, which included a small band of NZ STN's. The conference was over 4 days with breakfast symposiums, plenary and concurrent sessions packed full of speakers covering topics from burns to intestinal failure to optimising peristomal skin to c diff pathogenesis to convexity consensus statements. With four concurrent sessions on at the same time, there was a lot of running between the different lectures rooms to try to get to all the presentations that I had highlighted in the programme.

On behalf of the NZNO Collage of Stomal Therapy committee, I presented a snapshot of Stomal Therapy Nursing in New Zealand. The presentation covered the history of stomal therapy nursing in NZ, which started in 1971 with Ruth Wedlake, the Knowledge and Skills framework, Ministry of Health service specifications, lack of Stomal Therapy training in NZ and the changes to the health service with the establishment of Te Whatu Ora and Te Aka Whai Ora. Today there are approx. 35 Stomal Therapy Nurses (STN's) in NZ providing expert care to around 8000 pts. An Australian presentation reported 47,000 people with a stoma and 490 STN's in Australia. **This is approximately one STN for every 95 patients whereas NZ has one STN for every 230 pts.**

There were several presentations on providing a stomal therapy service to remote areas of Australia. Western Australia (WA) covers more than 2.5 million square kilometres, with 1300 ostomates who live rurally. There are 25 employed STNs in WA however; all of them live and work within a 4 1/2-hour drive from Perth. Therefore, anyone outside of this 4 ½-hour drive has very limited access to an STN. A flying clinic may visit an area once a year. Many patients have been living with stoma issues for many years before they have access to an STN. It takes over 22 hrs to drive from Perth to Broome in northern WA. To put it into perspective the drive from Perth to Broome is the equivalent of driving from Cape Reinga to Oamaru and the only STN for that area based in Mangawhai.

Many of the presentations from Asia and Australia reinforced that stoma patients receive a very good service in New Zealand. Our patients have access to free products for what they need each month and are supported with access to an STN's when needed whom delivers expert care. While I acknowledge resource is always an issue and we are working in extremely challenging times, due to the dedication of those providing care, our stoma patients continue to receive a fantastic service while unaware of the stressors we are under on a daily basis.

One of the most thought provoking presentations for me was from an STN based in Singapore and her perspective on the Turnbull-Cutait pull through colo-anal anastomosis due to low rectal cancer. This surgery involves resecting the low rectal cancer, pulling the colon through the anus and securing it to the anal canal. The patient has a short length of colon protruding from their anus for 7 days. This section of protruding bowel is dressed with hypertonic dressings to keep moist and protected. The patient remains in hospital during this time, NBM on TPN and bed rest. One week later, a colo-anal anastomosis is completed. So far, numbers are very low; approximately five patients and the long-term outcomes are unknown. They reported no complications or continence issues post anastomosis. When questioned on how the sphincters were assessed prior to anastomosing the bowel, the answer was simply "the surgeon sticks his finger in to check the sphincters". The driving force behind the patient choosing this option over traditional surgery was the ability to avoid having a stoma.

The most inspiring talk was from Dr Andrew Browning on "Obstetric fistulae: The African Experience". Andrew spoke of his time in Africa helping women who have sustained devastating injuries during childbirth. Some of the photos he showed were of horrific injuries. Sadly, these women are ostracised by everyone around them and have often suffered for many years with debilitating symptoms pain and chronic incontinence only being some of these. He maintains that treating an obstetric fistula is one of the few operations that can completely transform someone's life. He is committed to helping the more than two million women estimated to be suffering with existing obstetric fistula throughout Africa by training surgeons, midwives and nurses, establishing hospitals and outreach fistula camps. He established the Barbara May Foundation in

2009 that supports hospitals in Tanzania, South Sudan, Uganda, Ethiopia and Nepal, at no cost to patients that aims to reduce the high incidence of maternal death and extreme injury in pregnancy and childbirth. (www.barbaramayfoundation.com). His talk was only 15mins but I am sure the whole room could have listened to him for many hours.

Professor Tom Riley presented on C Diff pathogenesis, diagnostics and management. He had us all feeling a little uncomfortable when he advised us that the park we had all just walked through tested positive for c diff on the 25 soil samples his students has taken last week. C diff is no longer an illness that is contained to hospitals, with 25% of cases now acquired in the community. He also spoke about the prevalence of c diff in animal populations with subsequent contamination of meat and vegetables grown in soil that contains animal faeces. After hearing this, you could be mistaken for thinking you were going to catch c diff from anything you ate. However, he reassured us that you have to be exposed to c diff and need something to change your gut flora (i.e. antibiotics) to become infected. His talk was certainly the most entertaining as he often had us laughing with his insight into C diff.

Margie Reid, Stoma and wound Nurse Consultant, Northern Adelaide, titled her presentation: "Rethinking the management of mucocutaneous separation: A "DIFFERENT' approach". She spoke about her struggle to manage mucocutaneous separation. She found that no matter how she treated the separation, the bag would always leak. Often the management would become so complicated with powder, seals, paste, dressings, and different appliances the patient could not be independent with their stoma management. The bag would leak; the patient would lose confidence in their pouching system and their ability to perform the necessary care adequately. Their anxiety levels would increase; they would have trouble adjusting to their stoma and not return to their usual daily activities. She decided to keep it very simple and made the decision to no longer actively treat the separation. This meant she did not apply anything other than the stoma bag, with the hole cut to incorporate the stoma and separation. She has been doing this for several years now and reports that the separation does heal. The patient experiences less bag leaks, finds management easier and they are more confident in their management system. For several audience members this was very challenging as it goes against what they were taught or their practice of many years. As we all know there is no one size fits all in stoma management and sometimes we have do to something that may go against the norm but it is done in the best interest of our patients. That is how we learn and share our experiences.

The exenteration session gave an insight into the service at Peter MacCallum Cancer Centre in Melbourne. The importance of having a dedicated specialist centre and multidisciplinary team involved cannot be underestimated. Improvements in neoadjavent therapies, surgical techniques and patient optimisation strategies, has improved post-operative and oncological outcomes for these patient's. The survival rates are 62-69% for exenteration surgery for locally advanced cancer, however for recurrent cancer the 5 year survival remains low at 35%.

The Gala dinner on Saturday night "Dinner with the Captain" was a fun night to mix socially with other delegates. There was the odd Pirate seen on the dance floor, which was packed with dancers from the time the band started until the time they finished. The delegation from China started the Conga line, which went multiple times around the room.

It was great to be able to attend an international conference, to network with colleagues from different countries and share experiences and knowledge. The organising committee had clearly been working very hard to plan and deliver an excellent conference and should be commended on their effort. The next AASTN is in Melbourne 2025 with planning already underway.

There was a little spare time in Perth and this was spent shopping and a day trip out to Rottnest Island. We spent the day riding bikes around the Island, taking in the sights, seeing the Quokkas and magnificent Pelicans and for a few having a swim in the clear waters of the Indian Ocean. There were a few tired legs at the end of the day. The opportunity to spend several days with past and present members of the committee was fantastic with experiences and knowledge shared and many laughs along the way.

I would like to thank the NZNOCOSTN for receiving the Bernadette Hart award so I could attend the conference. My fellow committee members past and present for their company at the conference.

Angela Makwana

Conference dinner group

Bowel function after colorectal surgery

BY SZE-LIN PENG, SUZANNE MARSHALL AND NICOLE FALKNER

Republished with permission from New Zealand Doctor Rata Aotearoa – www.nzdoctor.co.nz

This article, written by Sze-Lin Peng, Suzanne Marshall and Nicole Falkner, describes some common changes in bowel function after colorectal surgery, particularly for colorectal cancer. It also discusses management options, which are further illustrated by some case scenarios.

Patients may undergo colorectal resection surgery (CRS) for a wide variety of diseases. Common indications for CRS include malignancy, inflammatory bowel disease (ulcerative colitis and Crohn disease) and complicated diverticulitis.

The immediate surgical outcomes for patients undergoing CRS have improved markedly in the last decade. Potential reasons for this include improved surgical technique, enhanced postoperative recovery practices and advances in oncological treatment.

There is increasing recognition of the importance of balancing surgical and oncological treatment with quality of life. It is crucial that all healthcare providers are aware of potential long-term consequences to bowel function after treatment.

The figure illustrates the factors behind altered bowel function following surgery, all of which will be discussed in more detail.

EXPECTATIONS AND MANAGEMENT FOLLOWING COLONIC RESECTION

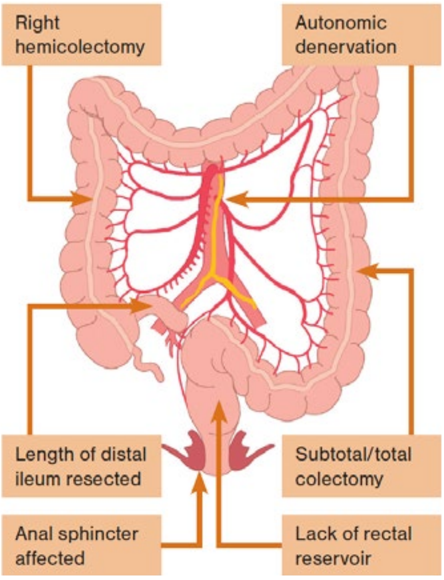
Colonic resection includes right hemicolectomy, ileocolic resection, total colectomy with ileorectal anastomosis, and extended right hemicolectomy

Diarrhoea, or increased bowel frequency with loose stools, is the most common symptom patients report after colonic resection, with risk factors as shown in Panel 1. The severity of symptoms depends on the extent of colonic and terminal ileal resection.

PANEL 1. RISK FACTORS FOR DIARRHOEA AFTER COLONIC SURGERY

- Long length of colon resected
- More than 10cm of terminal ileum resected
- Pre-existing bowel dysfunction

Brief anatomy of colorectal surgery and factors for altered bowel function



Right-sided colon cancer typically affects 20–30 per cent of patients with colorectal cancer. Patients who have undergone a right hemicolectomy are more likely to experience diarrhoea following surgery.

The incidence of diarrhoea after surgery for colon cancer varies from 15 to 45 per cent, with patients reporting approximately three bowel movements per day and/or more liquid bowel movements.[1,2] Some patients have normal frequency with only a change in consistency.[3] While many patients struggle with their altered bowel habit, some patients manage quite well and do not perceive these changes as a problem.

Diarrhoea is reported more in patients who have had more than 10cm of terminal ileum resected and in those who have less than 20cm of sigmoid colon remaining (refer back to figure).

The underlying cause of change in bowel function after CRS is multifactorial and not clearly understood. Four main mechanisms are discussed below.

Bile acid malabsorption (BAM)

Bile acids are produced in the liver and released into the duodenum to facilitate fat digestion. Approximately 95 per cent of bile acid is reabsorbed in the terminal ileum, and BAM should be considered when 30–100cm or more of the distal ileum is resected.[2] The majority of right hemicolectomy operations generally include only 10–15cm of the distal ileum.

BAM may cause diarrhoea via several mechanisms, such as impaired colonic fluid regulation, increased motility and changes in the gut microbiome.

Practically, the diagnosis of BAM is largely based on history and clinical suspicion. Described tests, such as 24-hour bile acid faecal measurements, various breath tests and the "gold standard" selenium-75 homocholic acid taurine (SeHCAT) nuclear medicine test, are not widely available nor validated. Results from such tests have not consistently correlated with severity of symptoms or treatment response.[2,4]

Therefore, in patients who are suspected to have diarrhoea due to BAM, an empiric course of cholestyramine (Questran) would be reasonable. Cholestyramine can be prescribed with a dose range of 4–36g per day.

However, there are issues with drug interactions, poor patient tolerance and a lack of evidence for optimal dose and duration of treatment with cholestyramine.

In New Zealand, another available resin or bile acid binder is colestipol (Colestid).

Dysbiosis/small intestinal bacterial overgrowth (SIBO)

One hypothesis is that SIBO is caused by altered growth of colonic microbiota in the small intestine.

SIBO has been reported in up to 20 per cent of healthy individuals, and a higher incidence has been reported in patients who have had CRS, especially those with ileocaecal valve resection.[2,4]

The accuracy of breath tests for diagnosing SIBO varies widely, and the results should be interpreted with caution. Duodenal aspirates and culture can be obtained but are invasive and not routine in New Zealand.

Patients who are suspected of having SIBO can be treated with a course of ciprofloxacin or rifaximin. Optimal duration of treatment is unclear, and the role of probiotics and dietary and lifestyle modification should be considered.

Reduced colonic water reabsorption

This mechanism is particularly relevant for patients who undergo extended resections, such as extended right hemicolectomy and total or subtotal colectomy. The proximal colon is the site of maximal sodium, chloride and water reabsorption.[5]

In contrast, patients who have undergone left-sided colonic resections (left hemicolectomy or sigmoid colectomy) report varying changes to bowel function – specifically diarrhoea or constipation.

Loperamide or psyllium husk can be trialled – to slow gut transit and improve symptoms of diarrhoea. When advising treatment, it is important to acknowledge that some patients report psyllium husk worsens diarrhoea and/or causes more bloating/flatulence. A degree of gut adaptation can be expected for up to one to two years following resection.

Altered gastrointestinal motility/ileal brake

The "ileal brake" is thought to reduce gastric emptying, prolong small bowel transit time, and reduce gastric and pancreatic secretions by a neural pathway activated by nutrient content in the ileum.[2] Thus, this is another reason why resection of the ileum may lead to faster gut transit times and symptoms of diarrhoea.

Regular loperamide is the mainstay of treatment and is safer and more effective than codeine phosphate. In our practice, patients are advised to try loperamide 2mg about 30 minutes prior to meals.

Some patients only need one to three tablets or capsules per day (2–6mg) and report significant improvement in bowel function. Some patients with faster transit times benefit from opening the capsules or crushing the tablets.

Dietary advice is given concurrently (Table 1).

Higher doses of loperamide (from 16mg upwards) may be associated with cardiac arrhythmias (prolonged QT interval), so a baseline electrocardiogram and ongoing monitoring should be considered, especially for at-risk patients.[6]

Table 1. Food chart which some patients find helpful

Foods that can cause gas	Foods that make stools firmer	Foods that may cause softer and more frequent stools
• Cabbage • Dairy products • Brussels sprouts • Spinach • Broccoli • Radishes • Cauliflower • Carbonated beverages • Onions • Beans • Corn • Cucumbers • Nuts • Beer	• Bananas • White boiled rice • White pasta • White bread (not high fibre) • Milk arrowroot biscuits • Marshmallows (white) • Tapioca • Peanut butter • Potatoes • Cheese • Yoghurt • Pretzels	• Vegetables: red capsicum, cabbage, onions, spinach, dried and fresh beans, peas, corn, Brussels sprouts and broccoli • Fruit: fresh, canned or dried fruit; grapes, apricots, peaches, plums and prunes • Spices: Chili, curry and garlic • Caffeine: Coffee, tea, cola and chocolate • Alcohol: beer and red wine • Sugar-free foods containing sorbitol or mannitol: sugar-free chewing gum, some mints, sweeteners and snack bars • Bran, other high-fibre cereals and breads, as well as some fibre supplements • Milk and other dairy products • Nuts and popcorn • Greasy foods • Prune, orange and grape juice

Continued on page 12

EXPECTATIONS AND MANAGEMENT FOLLOWING RECTAL RESECTION

Rectal resection includes low anterior resection and ultra-low anterior resection

Rectal surgery results in significant changes in bowel function. Historically, there was a tendency to regard "sphincter-saving" surgery as the gold standard surgical option. However, there is now more understanding that patients who have had sphincter-saving surgery can have significantly poor quality of life, and some may have benefited from a permanent colostomy.

Affected patients can have a wide range of symptoms, including incontinence, constipation and clustering of stool, all of which have a negative impact on quality of life. The term low anterior resection syndrome (LARS) is now used to describe this wide range of symptoms (Table 2), with risk factors as listed in Panel 2.

Table 2. International consensus definition of low anterior resection syndrome*

Symptoms	Consequences
• Variable, unpredictable bowel function • Altered stool consistency • Increased stool frequency • Repeated painful stools • Emptying difficulties • Urgency • Incontinence • Soiling	• Toilet dependence • Preoccupation with bowel function • Dissatisfaction with bowels • Strategies and compromises Impact on: • Mental and emotional wellbeing • Social and daily activities • Relationships and intimacy • Roles, commitments and responsibilities

* *LARS is defined as one or more symptoms with one or more consequences following anterior resection*

Adapted from Keane C, et al (Colorectal Dis 2020;22(3):331–41)

PANEL 2. Risk factors for LARS after rectal surgery

- Preoperative radiotherapy
- Longer time with loop ileostomy
- Anastomotic leak
- Very low coloanal anastomosis (small or no rectal reservoir)
- Pre-existing sphincter problem (eg, obstetric injury)

Before rectal surgery, it is crucial to discuss with patients the likely impact of LARS on their quality of life and to make a joint decision with them regarding the treatment option that would confer the best acceptable function.

A mixed pathophysiological model has been proposed for LARS.7 Bowel function and continence can be a complex interplay of anatomical, neurological, physiological and psychological factors. All of these can be altered following treatment for rectal cancer, which may involve any combination of surgery, radiotherapy and/or chemotherapy.

Surgical procedures

Rectal surgery typically involves a total mesorectal excision (TME), and patients who have sphincter-saving surgery usually have a neorectum created from connecting the proximal colon to the anal canal in either an end-to-side anastomosis or a colonic J-pouch. When there is insufficient colonic length, a straight end-to-end coloanal anastomosis is created.

As a result of TME, the reservoir function of the rectum is removed. In order to improve reservoir function, a partial mesorectal excision in appropriate patients may be performed. Additionally, surgery may result in autonomic denervation, reduced anal sphincter function and afferent sensory loss (refer back to figure).

A defunctioning loop ileostomy is often created to reduce the consequences of an anastomotic leak from TME surgery. There are increasing reports that a loop ileostomy may increase the risk of LARS, especially for patients who, for various reasons, experience delays to stoma closure.[7,8]

The complication of an anastomotic leak often leads to delayed stoma closure, but potentially lack of clinical team urgency or resources can also add to delays. Some centres offer early stoma closure about one week after surgery, but most surgeons aim to safely close ileostomies at eight to 12 weeks.

There is also ongoing research on "stoma refeeding" prior to ileostomy closure, which may improve factors that could worsen LARS, such as diversion colitis, enterocyte health and dysbiosis.[9]

Radiotherapy and chemotherapy

Modern neoadjuvant radiotherapy is highly targeted to the rectal cancer but still significantly impacts bowel function. This impact adds to the consequences of rectal surgery. Chemotherapy can cause diarrhoea, which usually resolves once treatment ceases, but some patients who develop chemotherapy-related colitis may have long-term changes in bowel function.

There is a shift towards organ preservation in rectal cancer management, where total neoadjuvant therapy with radiotherapy and chemotherapy is used to achieve complete tumour response. While a larger proportion of patients can avoid rectal surgery with this approach, it is important to note that even these patients can still experience LARS.

A study comparing organ preservation and surgery showed 36 per cent of patients in the organ preservation group experienced LARS, compared with 67 per cent in the surgery group.[10]

Treatment strategies

The following treatment strategies can be useful for patients experiencing LARS.

Consider organic causes

A thorough history and examination is useful to exclude problems such as delayed anastomotic leak, anastomotic stricture, tumour recurrence and colitis.

Review medications

Consider medication side effects. Sometimes, patients are treated for constipation when in fact the issue may be clustering or diarrhoea when having increased frequency. Excessive laxatives, opioids, certain antidepressants, proton-pump inhibitors and metformin could be contributing to symptoms.

Patient education and support

Patients who have rectal surgery or treatment for rectal cancer have often undergone at least six months of medical care. Many expect, at the conclusion of their treatment journey, to have "normal" bowel function.

While it is advisable to raise the issue of LARS prior to treatment, it should be noted that patients often have an overwhelming amount of information to process at the start of their diagnosis. It is important to discuss issues around quality of life consistently at every possible clinic appointment. Ideally, patients should have access to psychological, physiotherapy and dietitian support.

Diet, fibre, laxatives and loperamide

Almost all patients report changing their diet to manage their new bowel function. The standard advice is to increase fibre and reduce fatty foods, but, in our practice, each patient is encouraged to "try things out" and figure out what works for them.

Soluble fibre or psyllium husk can worsen LARS symptoms in some people, so it is important to warn patients they may need to try another strategy. In general, reducing alcohol, caffeine and fat consumption improves bowel function (Table 1). Additionally, patients often find that they should avoid large meals before bed, long car/plane trips or long meetings.

Some patients find the laxative or enema approach useful. A Microlax enema or glycerine suppository may be useful as stool can be cleared from the neorectum, and, in conjunction with dietary changes, the patient can avoid inconvenient bowel frequency. Similarly, other patients find intermittent use of laxatives (occasionally a small-dose bowel preparation) helpful in clearing the left colon of stool for a period of time in a day.

Loperamide is very useful in most patients and a relatively low dose of 2–6mg per day is most commonly needed. Patients and clinicians can be reassured that long-term, low-dose use is safe and effective. It can be very helpful to take loperamide about 30 minutes prior to when the patient is most symptomatic (eg, before bed if getting up through the night, or before a long walk).

Obesity is independently related to bowel dysfunction, specifically diarrhoea.[11] While there are few studies that comment on obesity and LARS, it is worth encouraging patients who are obese to lose weight to try to improve symptoms of LARS.

Simple supportive care

The perianal skin can get painful and excoriated with diarrhoea or increased bowel frequency, so advice about the use of barrier creams such as zinc oxide can be helpful. Other adjuncts include warm sitz baths and avoiding soap on the affected skin.

Affected patients can get problems such as inflamed skin tags, prolapsed haemorrhoids and anal fissures. Proctosedyl or Ultraproct can help with symptomatic relief of inflamed skin tags, and anal fissures should be treated with glyceryl trinitrate or diltiazem ointment.

'Complex' options

A small proportion of patients have debilitating LARS that requires specialist input. Patients who have no organic cause of bowel dysfunction and get little relief from the strategies described above can be considered for transanal irrigation, antegrade irrigation, sacral nerve stimulation and stoma formation. The irrigation options require a high degree of patient compliance and motivation as they can be time consuming and require some physical dexterity plus prolonged access to a toilet.

SUGGESTED APPROACH TO MANAGEMENT IN PRIMARY CARE

The following stepwise approach for primary care outlines the management of patients with changes in bowel function after colorectal surgery. Simple management strategies with supportive follow-up is often sufficient. This is further illustrated by five case studies.

1. **Review indication and type of surgery**

2. **Is there any underlying organic cause?**

   Medical:
   - infectious diarrhoea
   - medication side effects.

   Surgical:
   - recent discharge from surgery and the patient is unwell – consider readmission to exclude abdominal collection
   - rectal anastomosis – exclude anastomotic stricture.

3. **No organic cause identified**
   - Review the patient's lifestyle factors – diet, exercise, advise weight loss and daily routine.
   - Trial psyllium husk.
   - Trial loperamide.

4. **Refer to surgeon or gastroenterologist if there is any suspect organic cause or the patient requires more assessment for:**
   - microscopic colitisc
   - BAM
   - SIBO
   - more complex management options.

Continued on page 14

SUMMARY

CRS can cause changes in bowel function that significantly affect quality of life. While the focus of follow-up remains on detecting recurrent cancer, it is clear that many patients struggle with very difficult bowel function after treatment, so increased awareness among clinicians is vital. Patients should be given reassurance that their symptoms are expected and that simple strategies are often very useful.

CASE STUDY 1

A little can go a long way

Barry is a 79-year-old gentleman who is referred for a colonoscopy to investigate per rectal bleeding and an altered bowel habit – passing liquid stool three to eight times a day. His colonoscopy reveals a fungating mass in the sigmoid colon. Histology confirms adenocarcinoma, and there is no metastatic spread on CT.

Barry undergoes a laparoscopic high anterior resection, which is straightforward, and he is discharged five days later. He goes on to have six cycles of adjuvant capecitabine chemotherapy. While Barry tolerates his adjuvant chemotherapy very well (there are no reports of diarrhoea during treatment), it does interfere with his blood sugar levels, so he stops the chemotherapy two cycles short.

Barry's bowel habit

Four years later, a colorectal nurse specialist phones Barry as part of routine cancer surveillance follow-up. His carcinoembryonic antigen level has been stable and his latest CT, done only four months earlier, revealed no recurrence or new distant disease.

He reports that he is usually moving his bowels once to twice a day but, on occasions, could go four to five times in a clustering pattern, having to return to the toilet several times over a few hours. He describes the stool as being soft and sometimes loose. He has control but needs to know where the nearest toilet is when he ventures out.

While Barry is managing to put up with his bowel habit, he is keen to explore if it can be regulated and made more predictable.

Management and outcomes

We suggest Barry try taking loperamide and start off with just one tablet before breakfast to see how this goes.

Eight weeks later, Barry reports he is taking loperamide every morning before breakfast and that his bowel motions are "like normal". He is now moving his bowels daily, and the stool is firmer. He is delighted that just one tablet can make such a difference.

CASE STUDY 2

Getting the mix right

David is 71 when he is referred to the colorectal surgical team following a subtle change in bowel habit with some faecal urgency and per rectal bleeding. A subsequent colonoscopy reveals a rectal cancer at 15cm, with MRI and CT staging of cT3N1M0. David is referred for neoadjuvant long-course chemoradiation, which involves 50Gy and 25 fractions over five and a half weeks, in conjunction with capecitabine chemotherapy given concurrently to radiosensitise the area to the radiation.

The neoadjuvant treatment is completed in September and followed by an open low anterior resection with ileostomy formation in December. David completes his adjuvant chemotherapy in May and has his stoma reversed about four months later.

Following the reversal of his stoma, David is passing loose bowel motions about five to seven times a day. He starts taking one loperamide capsule three times a day, but his bowel habit becomes erratic. At times, he becomes constipated, requiring lactulose to get things back on track again.

Management and outcomes

We suggest that he could try psyllium husk with the loperamide.

David is now taking psyllium husk, one teaspoon full, twice a day, regularly. He has cut back his loperamide to one to two tablets daily. He says that his bowel function is feeling "more normal". The stools are firmer, he is having fewer accidents, and he is no longer clustering in the evening as he had been when taking just the loperamide.

For many patients with LARS, it is a case of trial and error; however, David is happy he persevered and has found a combination that works well for him.

CASE STUDY 3

The importance of reviewing other medications

Patricia is a 75-year-old woman who had a high anterior resection four years ago, for a sigmoid cancer picked up on the National Bowel Screening Programme. Following her surgery, Patricia had an erratic bowel habit with clustering, requiring six to eight visits to the bathroom most days.

Patricia has non-insulin-dependent diabetes and had been on metformin 500mg twice daily. Her GP recently reduced her metformin dose and started her on vildagliptin.

Outcomes

Patricia has noticed a marked improvement in her bowel function since. She says that she has reduced the amount of loperamide she is taking down to one tablet a day, and she is requiring only three visits to the bathroom.

This case highlights that other medications for common comorbidities might contribute to problematic bowel function.

CASE STUDY 4

Obesity can contribute to LARS

Mele is 58-year-old woman who had a mid-rectal cancer, requiring preoperative radiotherapy and an ultra-low anterior resection following that. After her loop ileostomy is closed, she struggles with all the classic symptoms of LARS.

Mele's weight was over 90kg preoperatively, and her BMI was 39kg/m2. She struggles with weight gain following her surgery due to erratic bowel function and a poor diet of highly processed foods.

We give her dietary advice and support, but also prescribe loperamide for symptom control. Ultimately, Mele self-resolves to stick to an 800–1000kcal per day calorie-restriction plan. She prioritises whole foods and drastically reduces her processed carbohydrate intake.

Eighteen months after her loop ileostomy was closed, she comes to clinic having lost nearly 20kg of weight. Amazingly, her LARS has improved so much that she no longer requires any loperamide.

Obesity itself can contribute significantly to LARS, and patients should be educated and supported to lose weight.

CASE STUDY 5

Excluding other bowel conditions

Frank is a 53-year-old man who had an ileocolic resection for perforated appendicitis. He did not have a colonoscopy prior to his surgery. Initially, his postoperative bowel function was reportedly normal, but six months after his surgery, he reports new-onset diarrhoea. Stool specimens for microbiology are negative.

A colonoscopy is performed, where endoscopic appearances of the anastomosis and mucosa are normal. However, random colonic biopsies from the residual transverse and left colon reveal microscopic colitis.

Review and outcomes

Frank comes to discuss potential gastroenterology review with regard to requiring medical therapy, such as budesonide. Interestingly, his symptoms improve after the colonoscopy and no further treatment is required.

This case highlights the importance of good history taking, noting any changes in bowel function and considering other organic pathology

DETAILS OF CASE STUDIES HAVE BEEN CHANGED TO PROTECT PATIENT CONFIDENTIALITY

Sze-Lin Peng is a colorectal and general surgeon at Middlemore Hospital, Te Whatu Ora Counties Manukau

Suzanne Marshall and Nicole Falkner are colorectal cancer nurse specialists at Te Whatu Ora Counties Manukau

REFERENCES

1. van Heinsbergen M, den Haan N, Maaskant-Braat AJ, et al. Functional bowel complaints and quality of life after surgery for colon cancer: prevalence and predictive factors. *Colorectal Dis* 2020;22(2):136–45.
2. Yde J, Larsen HM, Laurberg S, et al. Chronic diarrhoea following surgery for colon cancer-frequency, causes and treatment options. *Int J Colorectal Dis* 2018;33(6):683–94.
3. Larsen HM, Elfeki H, Emmertsen KJ, Laurberg S. Long-term bowel dysfunction after right-sided hemicolectomy for cancer. *Acta Oncol* 2020;59(10):1240–45.
4. Larsen HM, Borre M, Christensen P, et al. Clinical evaluation and treatment of chronic bowel symptoms following cancer in the colon and pelvic organs. *Acta Oncol* 2019;58(5):776–81.
5. Sandle GI. Salt and water absorption in the human colon: a modern appraisal. Gut 1998;43(2):294–99.
6. Nightingale JMD. How to manage a high-output stoma. *Frontline Gastroenterol* 2021;13(2):140–51.
7. Christensen P, Im Baeten C, Espín-Basany E, et al. Management guidelines for low anterior resection syndrome - the MANUEL project. *Colorectal Dis* 2021;23(2):461–75.
8. Croese AD, Lonie JM, Trollope AF, et al. A meta-analysis of the prevalence of Low Anterior Resection Syndrome and systematic review of risk factors. *Int J Surg* 2018;56:234–41.
9. Liu C, Ludlow E, Davidson RB, et al. Stoma-output reinfusion device for ileostomy patients: A feasibility study. *Dis Colon Rectum* 2021;64(11):e662–68.
10. Hupkens BJP, Martens MH, Stoot JH, et al. Quality of life in rectal cancer patients after chemoradiation: Watch-and-wait policy versus standard resection - A matched-controlled study. *Dis Colon Rectum* 2017;60(10):1032–40.
11. Ballou S, Singh P, Rangan V, et al. Obesity is associated with significantly increased risk for diarrhoea after controlling for demographic, dietary and medical factors: a cross-sectional analysis of the 2009-2010 National Health and Nutrition Examination Survey. *Aliment Pharmacol Ther* 2019;50(9):1019–24.

Table 2 adapted from: Keane C, Fearnhead NS, Bordeianou L, et al. International consensus definition of low anterior resection syndrome. *Colorectal Dis* 2020;22(3):331–41.

Gabriel, CeraPlus™ Product User

OMNIGON
SUPPORT GARMENTS

INTRODUCING
The **NEW** Omnigon
Support Garment

KomfortLite Support Belt

SUPPORT LEVEL

Rating 3 – MODERATE SUPPORT

SUITABLE FOR

- After surgery
- Wear during light exercise
- To help prevent or to support a small bulge

With handy pockets to help ostomates grip the belt, hold it against their body, and pull the belt together.

> “The comfort level for the KomfortLite support belt was beautiful, the fabric is very soft and felt smooth and delicate on the skin.”
>
> **JESS**
> **@ownyourbag**

For more information call Omnigon on 0800 440 027

OMNIGON

NZ **0800 440 027**

info@omnigon.com.au
www.omnigon.com.au

My Bowel Cancer Journey

BY JOCELYN RAYNES

I was not worried when I went for a colonoscopy in June 2022. In my mind, it was just to "rule out" anything serious. I certainly was not prepared for the shocking news that I had bowel cancer.

I had been experiencing some blood in my stool intermittently for a few months. I had a doctor's appointment but they did not seem too concerned so neither was I. Afterall, I was only 39 and had no other bowel cancer symptoms, no family history of cancer; I was very health conscious and considered myself pretty fit and healthy. My blood tests were described as all "normal and reassuring". The initial diagnosis was that it was most likely haemorrhoids. However, I decided that I wanted a definitive answer so I requested a colonoscopy – and thank goodness, I did!

My husband and my seven-year-old daughter had come to pick me up after the colonoscopy and that was when we were given the devastating and life changing news that I had a cancerous tumour in my bowel. We did not know how bad it was or if it had, it already spread to other organs. I immediately feared the worst and went into shear panic at the thought that I was going to die and leave my husband without a wife and my daughter without her mother. I had a CT scan and MRI quite quickly but waiting for those results was terrifying. Fortunately, the scans showed no metastasis and the tumour was confined to the bowel. I was stage 1 …for now.

Life became a whirlwind of various appointments as the cancer took over our lives. I was booked for surgery to remove the tumour and part of my bowel (Laparoscopic Low Anterior Resection Loop Ileostomy) in the same week that I turned 40 - I liked my friend's idea that I should just stay as 39 and celebrate turning 40 the following year! The surgery meant that I would have a temporary stoma bag. I took time off work, my husband took time off work, and we booked flights for family to come up and help. Our work colleagues, neighbours, friends and family showered us with the support we desperately needed. While the surgery itself went well, and I adapted readily to life with the stoma bag, I found the initial change in diet quite difficult (I had lot of green jelly in hospital and can remember how wonderful it was to eventually be allowed some crackers and cheese!). I was very careful with what I ate while my bowels healed and slowly introduced new foods until eventually I was eating normal again. I was very grateful for my wonderful stoma nurse who came to visit regularly. Those in-home visits were so beneficial throughout my journey. Not only did she patiently help with bag fitting, stoma cleaning and bag changes, my stoma nurse was a wealth of wisdom on practical dietary advice too and was there for support when things went pear shaped further down the track. I was also fortunate to have a close work colleague who had been through his or her own similar bowel cancer experience and was a tower of support.

I know some has trouble but, for me, living with the stoma bag was by far the easiest part of my bowel cancer journey. I learned a pattern of when my bowel would be active and when my bag would need emptying. I used clear stoma bags throughout as I found these the easiest to fit, empty and keep an eye on my output. I adjusted my wardrobe and mostly lived in baggy t-shirts and leggings with a stretchy waistband that I could pull right up over the bag. Most of the time I only found the bag a mild inconvenience… in fact my scientific mind found it fascinating to be able to track the output of certain foods I ate! I quite easily spent a day at the beach over summer and swam at the pools with my daughter.

Unfortunately, what was meant to be stage 1 done and dusted with surgery and get on with life did not quite go as planned. The biopsy of lymph nodes removed during surgery showed the presence of cancer. This meant I was upgraded to Stage 3 and began a 3-month course of chemotherapy (CAPOX). This was by far the hardest part of my cancer journey. I was determined to tough it out but right from the start my body struggled. The numerous anti-nausea medications did not shake the constant terrible gnawing and sick feeling in my stomach. Eating became difficult as I struggled to find any appetising foods, and things that I tolerated one day I could not stand the sight of the next.

I was almost halfway through chemo when I became unwell. Eating became a real struggle and then suddenly I was getting discharge from my bottom. When the discharge became more frequent and I started, having some stomach pain I reluctantly went off to the emergency department. I had a CT scan and blood tests, which showed nothing of concern, and I was discharged with some pain meds. Over the next couple of days, I deteriorated. My stoma output became a copious dark green watery liquid and I began vomiting, unable to keep any food or drink down. We thought perhaps I had just picked up a stomach bug but when we contacted my

oncologist, he instructed us to go straight to Auckland Hospital where I was admitted to the Oncology department. There I was diagnosed with severe chemo induced enteritis. I was nil by mouth for the first two weeks to allow my body to heal and wait for my stoma output to reduce. Those two weeks being stuck in hospital not really knowing what lay ahead were very hard emotionally and physically. I already had a PICC line in my left arm for chemo infusions and had a second PICC line inserted in my right arm for exclusive TPN nutrition support. I was so desperate for a nice cold orange juice but it was a long time (and lots of medication) before my bowel finally settled and I was allowed some fortified drinks, then soft food and then after almost 3 weeks I have to go home!

Because of my reaction to the CAPOX chemotherapy, I obviously could not continue with the treatment. This was disappointing as it had been presented as my best shot at beating the cancer and I felt as if things were half finished. After discussions with my oncologist I embarked on an additional 8 weeks of weekly bolus 5-Fluorouracil (5-FU) injections as an alternative treatment – one which I tolerated much better and had only minimal side effects.

I had my last chemo treatment and my PICC line removed the week before Christmas 2022. Best Christmas present ever! I then had surgery for the reversal of my stoma in February 2023. There was mixed emotions having this surgery – after 6months with the stoma I had settled into a routine with it and I had some concerns over how my new bowel would function. Recovery was much easier than my original bowel surgery and I am fortunate to have mostly good control. The hardest part of recovery was not doing too much too soon as I felt I was good to go… but had to remember I was still healing and couldn't lift anything heavy or bend over too much.

I am now so grateful to be enjoying the freedom that a normal life brings relishing everyday activities like taking my daughter to and from school and being back at work as a Crime Scene Examiner for the NZ Police (on light duties). There will still be a cancer cloud lurking over me for the next few years while I am monitored for recurrence but, for now, I am just extraordinarily happy to be living life and making the most of each small moment with family and friends.

NEW ZEALAND
NURSES
ORGANISATION
TŌPŪTANGA
TAPUHI
KAITIAKI O AOTEAROA

NZNOCSTN CONFERENCE 2024

NZ NURSES ORGANISATION
COLLEGE OF STOMAL THERAPY NURSING

INNOVATION

Please join us at our 2024 conference:

WHERE Ellerslie Racecourse, Auckland
WHEN February 29th and March 1st, 2024

KEY NOTE SPEAKER
Dave Letele – AKA Butter Bean
Remarkable motivational inspiring speaker

EARLY BIRD
$200
prior to 18th Dec 2023

FULL PRICE
$220
after 19th Dec 2023

Keep an eye out for email updates over the coming weeks.
Up to date information can be found on the NZNO College of Stomal Therapy Nurses website

NZNOCSTN CONFERENCE 2024 - INNOVATION

CALLING FOR ABSTRACTS FOR PEER PRESENTIONS

SUBMISSION CLOSE: 30 SEPTEMBER 2023

The NZNOCSTN committee would like to invite ALL members to submit an abstract for consideration to present at our "Peer Presentation" section of our 2024 conference.

We cannot stress how important this part of YOUR conference this call is. With delegate participation, we are sure to have successful conference; PLEASE support it with your submission. Share your knowledge, tell your story to show off the innovative work you are doing.

All presentations will automatically go in to a sponsored competition for "BEST PRESENTATION" (sponsorships and prizes TBA) and ALWAYS excellent to include in the PDRP.

TOPIC	Anything stoma, fistula management, experiential, task, knowledge and/or skills related, where you have used your innovation and/or your expertise.
TIME	15 minute presentation.
PROCESS	Submit abstract 100-200 words via email to the editors of "The Outlet", outlining your Topic, content and a snap shot about your role by 30th September 2023.

NZNOCSTN committee members will review ALL abstracts. Outcome of submissions will be advised end of October 2023.

CONTACT

Preeti.charan@waitematadhb.govt.nz
or **Marie.buchanan@waitematadhb.govt.nz**

Pyoderma Gangrenosum – When nothing else fits!

BY GLENDA, GAGGER NURSE EDUCATOR
DISTRICT NURSING SERVICE | TE WHATU ORA WAITEMATĀ

PRESENTATION

Pyoderma gangrenosum (PG) initially presents as a blister or pustule which rapidly enlarges to a very painful ulcer, commonly on a lower limb, at a peristomal margin (peristomal PG), or where the skin has been traumatised in some way. The ulcers can quickly evolve into partial to full-thickness wounds, often with erythematous, irregular borders.[1]

It is one of a group of auto-inflammatory disorders known as neutrophilic dermatoses.

The name pyoderma gangrenosum is really an historical misnomer. The condition is not an infection (pyoderma), and does not cause gangrene! However, these painful wounds are at high risk of becoming infected and frequently fail to heal using usual methods and wound dressings.[2]

DIAGNOSIS

Diagnosis is by exclusion. A suspicious wound should have an holistic medical assessment, including tissue biopsy to exclude all other causes- infection, malignancy, autoimmune processes, drug- induced vasculitis and vascular disease, taking into account the following:

- more common in women aged 40-60
- 50% of cases will have an underlying autoimmune disorder such as:
  - RA
  - Inflammatory Bowel disease/ Chrohn's
  - Multiple myeloma
- 15% of total PG cases are associated with stoma formation
- extremely painful-more than one expect from a similar ulcer
- exacerbates after debridement or biopsy (see practice point).[1]

Practice Point: Pathergy, the hallmark of PG, means that any physical action on the wound will cause it to deteriorate therefore pressure, debridement and any form of mechanical force or friction should be avoided.

PRACTICE POINT
Pathergy, the hallmark of PG, means that any physical action on the wound will cause it to deteriorate therefore pressure, debridement and any form of mechanical force or friction should be avoided.


Lower limb


Peri-stomal

Dermnet 2022
https://dermnetnz.org/search.html?q=pyoderma%20 gangrenosum

TREATMENT OPTIONS

Systemic Treatment Options

For larger ulcers due to PG systemic treatment may include:

- Oral prednisone for several weeks or longer, or intermittent intravenous methylprednisolone for 3–5 days
- Ciclosporin, which is as effective as prednisone and has differing adverse effects and risks
- Biologic agents: There is a growing body of evidence for success with the anti-TNF agents' infliximab, adalimumab, etanercept; there are case reports of success with other biologic agents including ustekinumab, guselkumab, canakinumab, and anakinra.
- Oral anti-inflammatory antibiotics such as doxycycline or minocycline[2,3]

Topical Treatment Options

- Topical local anaesthesia during dressing changes e.g. Lignocaine
- Non-irritant anti-microbial cleansers to prevent secondary infection
- Potent topical corticosteroid application as part of dressing regime
- Tacrolimus ointment (calcineurin inhibitors work by blocking calcineurin, a protein in our bodies that helps activate our immune system).
- Intra-lesional steroid injections into the ulcer edge
- Cyclosporine solution[2,3]

Dressing regimes

- Dressings to enhance autolytic debridement if slough present and exudate management
- Hydrocolloid
- Foam
- Gelling Fibres
- Protection from ongoing irritation and pressure
- Some evidence that autografting may enhance healing times and reduce scar formation
- Methylene blue and crystalline violet dressings indicated as antimicrobial, reduction in dressing frequency (pain associated with dressing changes), inflammation suppression.[4]

PPG SPECIFIC MANAGEMENT

- Remove pressure and friction such as convex pouching systems
- Use a soft, flat skin barrier/protectant
- Apply the above mentioned products beneath pouch as able.[1]

TREATMENT BARRIERS

Slough and biofilm/infection

- Typically, slough will form but any sharp or mechanical debridement, though tempting, can result in pathergy
- Antimicrobial dressings that enhance autolytic debridement should be utilised e.g. Methylene blue and crystalline violet.[4]

Wound pain

- Pain is generally severe with these patients limiting cleansing options
- Topical and systemic analgesia should be utilised prior to wound dressing/pouch change
- Use skin barrier films where possible to reduce friction.

Lower limb wounds

- Compression bandaging if indicated (ABPI within acceptable parameters) may not be tolerated due to pressure aggravating the wound and pain
- Encourage alternative venous/ lymphatic drainage such as elevation and ensure diuretic treatments are maintained
- Grafting and in severe cases, amputation, should be avoided during active disease as further PG can occur at vthe graft or stump site.[3]

Scarring

- Cribriform (criss-cross) scarring can be obvious at the site of the wound. Skin grafting can be undertaken in severe cases after recovery.[4]

Leakage around stoma

- Leakage around stoma due to wound dressings can be a problem
- Skin protectants and utilisation of pouches that require less frequent changes
- Good education around pouch changing technique's
- Support from the multi-disciplinary team is paramount.[1]

Continued on page 24

CONCLUSION

Pyoderma gangrenosum is an extremely painful erosion of the skin resulting in an ulcer or wound usually on compromised skin e.g. adjacent to a stoma.

Found more commonly in patients with pre-existing autoimmune disorders, its diagnosis is made through ruling out all other possible conditions and causes.

Treatment involves both a systemic and local approach to management, which is greatly enhanced by involving the full multi-disciplinary team.

REFERENCES

1 Hovan, H. (2022). Peristomal Skin Conditions: Pyoderma Gangrenosum. Wound Source. https://www.woundsource.com/blog/peristomal-skin-conditions-pyoderma-gangrenosum

2 Oakley, A.(2015). Pyoderma gangrenosum. Dermnet. https://dermnetnz.org/topics/pyoderma-gangrenosum

3 Pompeo M. Q. (2016). Pyoderma Gangrenosum:Recognition and Management. Wounds : a compendium of clinical research and practice, 28(1), 7–13. https://pubmed.ncbi.nlm.nih.gov/26779805/

4 Naughton, B. (2020). Weird Wounds Part 1: Pyoderma Gangrenosum. Wound Source https://www.woundsource.com/blog/weird-wounds-part-1-pyoderma-gangrenosum

AUTHOR’S BIOGRAPHY AND DISCLAIMER

Glenda Dagger is a nurse educator working for Te Whatu Ora, Waitemata within the District Nursing Service. She also works as a post-grad lecturer in Wound Management at Massey University.

Glenda is one of the Auckland Area coordinators for the New Zealand Wound Society and a member of the European Wound Management Association.

Glenda has accepted conference sponsorship from Ainscorp in 2023.

Stoma
Skin
Soul

A gentle push in the right direction

Introducing the NEW NovaLife TRE™ 2 Piece Soft Convex Barrier

A flexible and adaptable barrier that adheres to your patients' body the way you need it to

- Provides gentle pressure where it's needed, for extra protection against leakage
- Soft and flexible barrier to help you feel comfortable, yet fully supported
- 3 levels of skin health protection with TRE technology Adhesion, Absorption and pH balance

Comfort, flexibility and skin health combined. Choose healthy skin for your patients today.

Call 0800 678 669 to order a sample, or learn more at dansac.co.nz/tretechnology

Prior to use, be sure to read the Instructions for Use for information regarding Intended Use, Contraindications, Warnings, Precautions, and Instructions.

CE

dansac


convatec
— forever caring —
Healthy Bonds
Keep Us Strong


Natura®
& Natura® +
Premier line of 2-Piece
Ostomy Systems

Coloplast

Coloplast®
Professional

Welcome to the NEW *Coloplast® Professional online education platform*

Designed with nurses for nurses to boost your patient care and career with unique access to specialist knowledge in the field of Ostomy Care

Paired with our existing offering, our new Coloplast Professional online training and support platform allows you to stay up to date on all your educational needs anytime anywhere.

Solve issues on the go

- Troubleshooting tools
- Content created together with HCPs, based on real-world clinical challenges
- How-to videos and step-by-step guides

Develop your clinical expertise

- Learning modules for every level
- Expert insights and education
- Clinical evidence and publications

Improve patient care

- Help selecting the right treatment for your patient
- Tips and insights for managing patients' conditions

Whether you are learning a skill or training your team you can access tools, events, webinars and other educational resources to support you in your professional development.

Take a closer look at just some of what is on offer for Ostomy Care

- Practical tools & resources e.g. Body Check, Body assessment tool, Risk Factor Model Checklist
- Accreditated bite-size learning modules to earn CPD points at your finger tips
- Educational and professional events and webinars

Enrol now to stay up to date with the latest in education, evidence, and events

Use the QR-code and visit *www.coloplastprofessional.com.au*

Or contact your local Coloplast representative or USL Medical on *0800 658 814*

Ostomy Care | Continence Care | Wound and Skin Care | Interventional Urology | Voice and Respiratory Care

Coloplast Pty Ltd, PO Box 240, Mount Waverley, VIC 3149 Australia

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 ivs 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

Awards & Grants

Available to ALL members of NZNOCSTN.

Review full information on NZNOCSTN web site.

Patricia Blackley Postgraduate Education Scholarships 2023

The Patricia Blackley Postgraduate Education Scholarships honour the pioneering work of Patricia Blackley as a clinician, educator, author, and journal editor in stomal therapy nursing.

The scholarships are to enable nurses working in ostomy care to undertake postgraduate education in stomal therapy management or a related area of practice.

Three scholarships are available. The value of each scholarship is A$5000.

Closing Date: July 31st, 2023

Bernadette Hart Award

Section members may make application annually for the Bernadette Hart Award. The award is for conference or course costs. See full history of award on NZNOCSTN web site.

Applications close on 30 November annually.

Liberty "Beyond the Ostomy Clinic" funding

In support of improved outcomes for stoma patients and their whanau, or education of colleagues, Liberty Medical New Zealand is pleased to provide:

- Financial support for stoma nurses or resource nurses with a special interest in Ostomy
- The monetary amount of each award will be decided by the NZNO College of Stomal Therapy Nursing National Committee
- Examples of use include but are not limited to:
  - Further education/skill development through conference/symposium attendance
  - Textbook purchase
  - Membership of international ostomy societies.

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 30 NOVEMBER (ANNUALLY)

SEND APPLICATION TO:

Email: emma.ludlow@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: __________

NZ NURSES ORGANISATION
COLLEGE OF STOMAL THERAPY NURSING

The Outlet

NEW ZEALAND STOMAL
THERAPY NURSES

NGĀ MIHI NUI