NZ NURSES ORGANISATION
COLLEGE OF STOMAL THERAPY NURSING

The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

MARCH 2022

Leakage Prevention, Essential to Healthy Skin

8 in 10 ostomates have experienced leakage within the last six months[1].

88% of ostomates using an ostomy product have peristomal skin complication[2].

We know there is a common link between skin issues and leakage.

It is essential to protect ostomates skin from the everyday wear and tear associated with bag changes. The right products can help prevent leakage and many peristomal skin issues.

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For more information about this leakage prevention set to make life easier for your patients, please contact your local Coloplast Territory Manager.

Remove

Cleanse

Protect

Secure

References:
1. Ostomy Life Study 16/17, Coloplast, Data on file. 2. Ostomy Life Study 2019, Coloplast, Data on file

The Outlet

New Zealand Stomal Therapy Nurses

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ENCOURAGING MEMBERSHIP

EASY MEMBERSHIP SUBSCRIPTION CAN NOW BE GAINED ON THE WEB SITE
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IF YOUR ADDRESS HAS CHANGED PLEASE CONTACT

Emma Ludlow

Email: emma.ludlow@middlemore.co.nz

Your Executive Committee Members

COMMITTEE CONTACTS

CHAIRPERSON

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

SECRETARY

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

TREASURER

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

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Chairperson's Report

NICKY BATES

We want you!
New Committee Members

Hi Everyone

Given the annual report was presented at the recent NZNOCSTN BGM , I thought it was a good opportunity to opt out of writing yet another! Instead, I have decided to bestow upon you the positives of being a national committee member in anticipation of recruiting 4 new members to come on board in November. We **need** one of these 4 members, to be a **South Islander,** to ensure the committee has wide geographical representation.

I will be upfront, being on the committee does require additional work on top of our busy work and home lives. However, the commitment is not without a multitude of positive gains and experiences. Below are statements from current members on why they have enjoyed being part of the committee:

- Great team comradery with a high level of collaboration, laughs and banter!
- Promoting and advancing Stomal Therapy into the future
- Meet like-minded colleagues, in a supportive environment, from all over the country
- Learn and gain insight into how NZNO works representing and promoting nursing
- Great for your portfolio
- Can attend NZNO conference, College and section days
- Work in collaboration with a professional nurse advisor
- Publish a high quality journal which is a valuable resource to share innovative nursing practice and record the high level of skill in Stomal Therapy Nursing
- Organising and being part of a Stomal Therapy conference
- Challenge yourself and learn many new skills

So what's not to like about becoming a committee member?

Committee meetings are held 3- 4 times per year with a mix of Zoom and face to face. Meeting dates are set by the committee based on members availability. It is anticipated committee members will attend all meetings. Travel to (and from) face to face meetings is paid for/reimbursed by the College . The committee decides meeting locations based on distance and ease of travel for all members. Meetings are usually 1 day and do not require an overnight stay.

The committee consists of a chair, secretary, treasurer, Outlet publishers (this is usually 2 people) and a 6th committee member who helps out with tasks. Administration and accounting support, for the committee, is available from NZNO. The NZNO National Committee Handbook is a valuable tool to guide the roles and responsibilities of the committee. In addition there are 2 current members who will be staying on the committee . They will be a great resource and fountain of knowledge!

Please contact me, or any of the committee, with any questions and your nominations!

Nicky

Editor's Report

DAWN AND ANGELA

Welcome to the first edition of The Outlet for 2022.

The whirlwind of our covid-19 journey continues, at the time of writing the surge of Omicron cases is increasing New Zealand wide with the increasing stress on our health system. Many of us have been seconded to other roles to support the wider healthcare teams as staff shortages hit an all time high especially in the Auckland region. All of this along with dealing with delays in the provision of supplies has been challenging for us as Stomal Therapists.

Covid-19 has led to a number of firsts for many of us, which includes the attendance of the Tripartite Colorectal meeting 2022 which was held virtually in February 2022. We appreciate how much work and effort bringing this conference to fruition was and we wish to thank Jackie Hutchins for being an integral member of the organizing committee. After a couple of delays, a change in venue and then trying to co-ordinate speakers from across the globe across multiple time zones the conference was a wonderful success for those that were fortunate enough to be able to attend. We will be presenting a precis of the conference in our July edition.

A big thank you to Emma Ludlow, Shirley Roberts and Sharryn Cook for submitting their wonderful work for this edition of The Outlet. It is wonderful to be able to showcase the work that our Stomal Therapists do, and the impact this has on positive outcomes for the lives of the people who are recipients of our care. We further invite other members to submit work for publication, being a small college with a unique set of skills we can learn from each other.

We wish everyone well as we navigate this current health crisis and look forward to some form of normality in the not-too-distant future, albeit, whatever that normality will be.

Stay safe and stay well.

Kind Regards,

Dawn and Angela

CALLING FOR SUBMISSIONS

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

Please send your submissions to either:

angela.makwana@waitematadhb.govt.nz or

dawn.birchall@middlemore.co.nz

WE would LOVE to hear from you.

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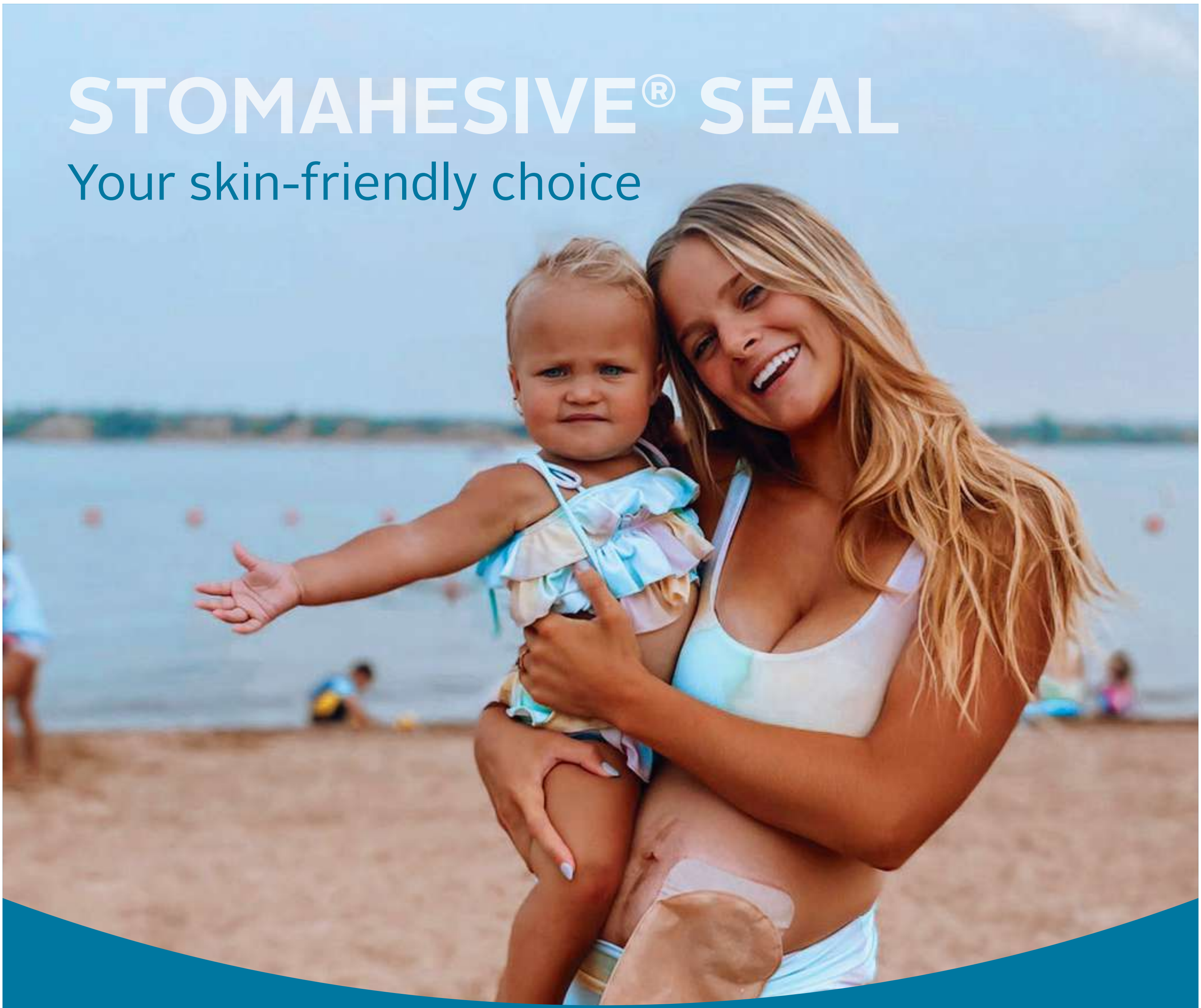

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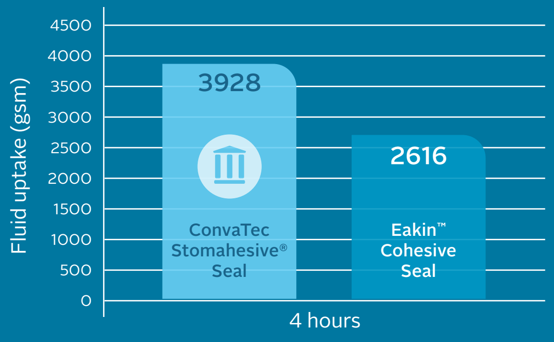

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February 2022 O623

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Profile Page - Pravin Deo

COLORECTAL CNS/STOMAL THERAPIST - COUNTIES MANUKAU DHB

As a colorectal CNS and stomal therapist I help to provide specialist care to the patients and support to health professionals to ensure that clients receive most UpToDate and efficient care where necessary.

I have been in this role for 3 years now and find it very self rewarding as it helps me to support clients to independently manage their stoma and help trouble shoot stoma related issues that they may have.

Prior to stepping into stomal therapist role, I worked with stoma patients across Middlemore hospital and found helping them to be able to manage their stoma independently very satisfying. After working with patients with stoma I realised that these patients have a unique physical and psychological needs due to effect of diseases like cancer, ulcerative colitis, diverticulitis and crohn's.

Having to live with stoma brought further challenges in their and their immediate caregivers and families and it was not long working with these patients I witnessed that professional support by trained stoma therapists not only helped these patients to recover faster post-surgery, but also improved their quality of life.

This made me realised how important the role of stomal therapist was in lives of people with stoma and became the driving force towards wanting me to choose this as a speciality in order to be able to help these patients and make a difference in their life.

As a colorectal CNS I also get opportunity to see variety of other patients who don't have stoma but have other bowel related issues and be part of their management while in hospital recovery which broadens my own knowledge and perspective. Later over the years I have also picked the role of Home Parental Nutrition (HPN) Coordinator which requires me to coordinate cares of patients with multidisciplinary team who are discharged home on parental nutrition and report their progress to New Zealand Intestine Failure and Rehabilitation Service NZIFRS.

Application for Liberty "Beyond the Ostomy Clinic" Funding

(ACCESS TO FUNDS RECEIVED FROM LIBERTY EDUCATION EVENT)

CRITERIA FOR APPLICANTS

- Must be current full or life member of the NZNO College of Stomal Therapy Nurses
- Present appropriate written information to support application
- Abide by policy criteria guidelines in attached document for this fund
- Provide a receipt for which the funds were used
- Use award within twelve months of receipt
- Be committed to presenting a written report on how funds were used by submitting an article for publication in The Outlet (the NZ Stomal Therapy Journal)

APPLICATIONS OPEN

Send application to: Nicky Bates
Email: nicky,bates@wdhb.org.nz

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 NZNOCSTN

____

____

Please indicate below your intention: (NB 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).

Signed: ______________________________ Date: ______________

Policy for use of Liberty "Beyond the Ostomy Clinic" Funding

PROCESS

- The fund will be advertised in the NZNOCSTN Journal "The Outlet".
- Applications will be received until funds are depleted. Notification of closure of fund will be via email, circulated to members.
- The NZNOCSTN National Committee will consult and award funds within one month of receipt of application.
- The monetary amount of the award will be decided by the NZNOCSTN National Committee. Therein, partial or full funding of requested amount depending on volume of applicants.
- All applicants will be notified of the outcome, in writing, within one month of receipt of application.
- All applicants will receive an email acknowledgement of their application.
- The amount will be dependent on the number of successful applicants each year and the financial status of the fund.
- The fund policy will be reviewed annually by the NZNOCSTN National Committee until fund is depleted.

CRITERIA

- Available to stoma nurses/resource nurses/special interest in Ostomy.
- Member of the NZNOCSTN.
- Application must benefit stoma patient outcomes and their whanau or education of colleagues. This must be outlined in the application.
- Examples of use:
    - Furthering education/skill development by attending conferences/symposiums
    - For improving ostomy patient and their whanau outcomes -
    - Textbooks
    - Belonging to international ostomy societies.
- Provide receipt of use of funding to NZNOCSTN upon use
- Funds are to be used within one year of receipt of funds

FEEDBACK

- The successful applicant(s) agree to submit an article (inclusive of photos) to "The Outlet" within six months of receiving the funding.

Implemented: January 2020
Reviewed: January 2021

Innovations in the management of complex Enterocutaneous Fistula: can a small rural hospital deliver the care needed to manage abdominal fistula?

SHARRYN COOK. CLINICAL NURSE SPECIALIST FOR WOUND AND STOMA SERVICES,
SHIRLEY ROBERTS CLINICAL NURSE CO-ORDINATOR. WAIRAU HOSPITAL, BLENHEIM
NELSON MARLBOROUGH DHB

INTRODUCTION:

An enterocutaneous fistula (ECF) is an abnormal tract between the bowel (enteral) and the skin (cutaneous). An enteroatmospheric fistula (EAF)is a small catastrophic subset of ECF, where the bowel migrates to the skin surface and is visible to the atmosphere. Due to the high flow of chyme passing though, In most cases, duodenal, jejunal and proximal Ileal bowel are generally the locations of this catastrophic event.

The distance into the gut of the atomical point of exit from the gastrointestinal tract will determine the volume of output. This is imperative information needed to plan goals of care for a successful outcome.

One of the most challenging and resource demanding aspects of fistula management is local control of the effluent output. (1) The consequences of an inability to contain fistula output have a significant morbidity for patients. This includes moisture associated skin damage (MASD), unpredictable leaks which are detrimental to quality of life, pain, and prolonged hospital admissions. The aim of fistula management is to devise and implement a plan of care, in partnership with the patient and their family that achieves the following goals:

- Prevents skin breakdown.
- Contains the chyme output.
- Is comfortable for the patient.
- Optimises both physical and psychological condition before definitive surgery or leads to spontaneous closure.

This case study will follow the care pathway of Ray and his wife Pat through their journey with a fistula. With the ever-changing challenges that fistula care can present it is unlikely that one strategy will be successful for the duration of care delivery. This paper with detail an innovative containment strategy and the benefits of a revolutionary re-feeding device in fistula care.

Conflict of Interest: nil

Disclaimer: the opinions and practices in this paper represent our personal practice reality only.

Confidentiality: the clients whose care is detailed in this paper have consented to the sharing of their personal information and pseudonyms have been used.

Gastrointestinal Fistula

Factors which can contribute to gastro-intestinal fistula occurrence include:

- Malignance
- Inflammatory bowel disease particularly Crohn's disease
- Mesh placement
- Radiation enteritis
- Diverticulitis particularly with abscess formation and perforation
- Iatrogenic injury during surgery
- Anastomotic breakdown

WHO ARE RAY AND PAT?

Aged 73 years Ray is a retired dairy farmer from the West Coast. He worked on and owned farms for most of his working life. Ray has 4 children and gained 2 stepchildren when he married Pat in 1992. Ray and Pat now live a short distance from the small rural hospital which is undertaking his care.

Surgical History

Ray presented with a change in his bowel habit. A colonoscopy confirmed a rectal cancer. He was also found to have multiple polyps however, biopsies confirmed that none of these were cancerous.

Following long course chemo-radio therapy the associated risks and complications of low anterior resection verses an abdominal perineal resection (APR) were discussed with Ray and Pat. Ray and Pat believed that he wound have a better quality of life with an AP resection and permanent end colostomy.

Surgery

- Elective AP resection
- Post-operative ileus
- Total parental nutrition
- Wound dehiscence of both the abdominal and the perineal wounds.
- Small bowel fistula

By day 12 post operatively Ray's abdomen laparotomy and perineal wounds had dehisced, his colostomy was dusky.

Two enterocutaneous fistulae were sited at the top of the wound and were discharging bowel effluent. see Fig 1&2.

Containment was achieved with the use of an Eakin wound pouch.

Products used and rationale for selection.

Eakin Cohesive seals and Skin Barriers (Fig 1)

One of the fundamentals of fistula care is skin protection. With Ray the wound was framed with Eakin cohesive seals and Eakin skin barriers. In the highly wet environment of a fistula, we needed the most absorbent seal available, at 4 grams of absorption per gram of seal this was the Eakin cohesive range. By absorbing any free contaminant into the Eakin seal enzyme irritants are removed from contact with the skin. This mode of action helps return the skin pH to its normal slightly acidic range. The Eakin seals are highly mouldable adapting to fill any creases in the abdominal surface.

Eakin Wound Pouches

The Eakin pouch range offered us all the features of cohesive as well as 15 different pouch sizes to select the most suitable one for Ray's needs. Different pouches were needed as healing occurred.

The ability to add a window to the Eakin wound pouch became essential at a later date.

Figure 1,
Day 12 Wound dehiscence

Figure 2,
Day 23 Further dehiscence

By day 46 post operation Ray was on parental nutrition when his wound dehisced further to be the entire length of his laparotomy wound. The lower wound was covered in biofilm with areas of hypergranulation, wound healing appeared to be stalled. . The new area of dehiscence was approximately 2cm in depth with an enterocutaneous fistula visible. The distal side of the fistula was not visible at this stage. Ray was experiencing distressing periods of confusion and containment was becoming more problematic.

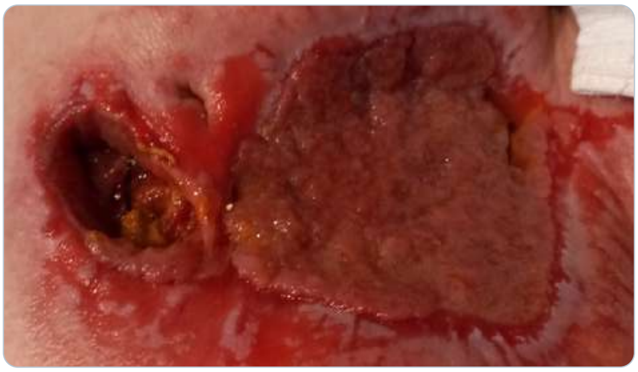
Negative Pressure Wound Device and Segregation of Fistula

With the aim of kicking starting wound healing again we began to consider the use of a negative wound pressure therapy with segregation of the fistula through the sponge. As negative pressure wound devices (NPWD's) have become common place in managing chronic or acute wounds, it is not surprising that they are also becoming an option for the management of fistula (1)

The goals of using NPWD were:

- To provide a closed moist wound healing environment with protection from secondary infection
- To reduce wound oedema
- Remove exudate while removing the biofilm and suppressing the hypergranulation.
- Increase cell replication and granulation.
- To approximate the wounds edges so the wound could heal by secondary intention.
- Effectively protect the surrounding skin edges
- Provide security with predictable dressing wear times while reducing frequency of dressing changes.

One of the characteristics which define expert practice is the ability to acknowledge your own practice limitations. Never having used a NPWD on a fistula wound or segregated a fistula we reached out to the Omnigon Territory Manager for assistance.



A, Fistula

B,

Figure 3a, b&c Segregation of Fistula with baby teat &NWPD

Figure 4, NWPT in place

Figure 5,one week after NPWT reduced in size.

Evidence of improvement was obvious after one week of NWP therapy. The wound has reduced in length, width and depth. The fistula has now bubbed above skin level and the distal loop is now visible. Access to the distal loop opened the option of re-feeding.

THE INSIDES SYSTEM: A CHYME REFEEDING MEDICAL DEVICE.

Two of the most important elements in preparing for definitive surgery to close a fistula are nutritional support and management of fluid and electrolyte balance. While enteral feeding has significantly less risks than parental feeding use of enteral feeding is limited by the following:

- Obstruction
- Radiation damage
- Inflammation
- Strictures
- Short bowel
- High fistula.(4)

Parenteral nutrition tends to be the mainstay of nutritional support for those with an ECT. This can lead to long enforced hospital admissions. There are also recognised detrimental psychological effects from long term, enforced periods of nil per mouth.

The goals of re-feeding chyme were:

- Earlier return to oral feeding
- Improved nutritional outcomes.
- Improved wound healing
- Restoring the gut function and preventing dehydration.
- Reduced risk of renal and liver dysfunction
- Possibly facilitate periods of leave from hospital or even discharge

With the distal limb of his fistula now visible Ray was assessed as a candidate for re-feeding with the Insides Re-feeding device. A CT scan determined that Ray had no distal obstructions or enterotomies and there was sufficient length of bowel for re-feeding to be successful. Once again, acknowledging that we have never undertaken this procedure before we reached out to the Insides Company Nursing team who reviewed Ray and initiated re-feeding.

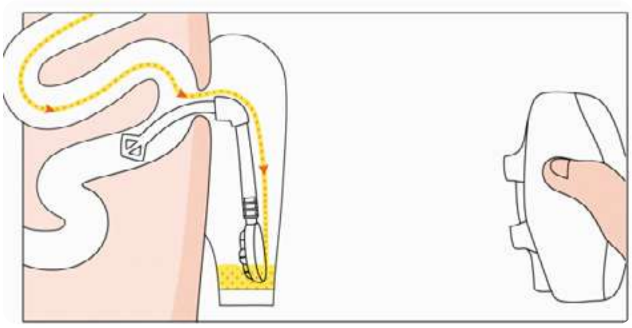


Figure 6, Insides re-feeding device showing tube, diver and chyme in pouch.

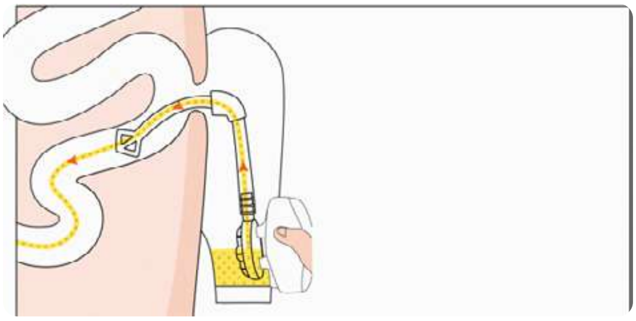


Figure 7, Showing pump attached to outside of pouch & re-feeding down distal limb of fistula

Key Features of the Insides Re-feeding Device.

- It has three components, a driver, a tube and a pump. The Insides System performs bolus chyme refeeding.
- It is a closed system with no need to remove a stoma pouch to re-feed. The pump attaches to the outside of the pouch. The tube is inserted by a health care professional into the distal outlet of the fistula. The little pump is attached to the end of the tube and sits immersed in the chyme. The driver magnetically couples with the pump, through the bag to 'drive' the chyme up the tube and into the distal intestine intermittently.
- The driver has multiple speed settings that can deal with a range of viscosities of chyme to refeed. The driver has a 2-week battery life.
- The Insides System is approved for use in NZ, UK, EU and has break through clearance with the American FDA.

Figure 8, The Inside re-feeding tube in situ surrounded by Eakin skin barrier. Eakin Dot colostomy pouch in use

Figure 9, Eakin pouch with window

Re-feeding with the Inside Pump has revolutionized and simplified Ray's care. He is now on a full diet with his colostomy fully functional. Parenteral nutrition has been stopped and his albumin is with in normal range. He has started short periods of hospital leave.

The Small Things that Make a Huge Difference

The rapport that can develop between the patient with an ECF, their family and the nursing team who share their experience can be a deciding factor in the patient's psychological resilience to endure to recovery. (5)

For Ray some of the small things we did made a huge difference. Ensuring that both he and Pat were engaged as partners in his care was imperative. With a bed in his room Pat was free to stay as she wished with out becoming exhausted herself. Having his small dog in to the ward on visits was one way of keeping Ray aware that he had a life to return to.

Ray has an engaging, cheeky sense of humour, with his banter and jokes we had many a laugh over his memories of his life as a young man. With Ray's old-time music on his radio, we had an opportunity to incorporate a few dance moves into a dressing change.

CONCLUSION.

It is often assumed that a wound will not heal if bathed in faecal effluent. Our experience in this case study has shown us that the opposite is true. Wounds do heal in the presents of faecal effluent.

Caring for Ray has been a huge and at times frustrating learning curve for our whole team. At times we wondered if our small rural hospital had the resources to manage his care. In spite of these doubts, we have been inspired and in awe of the way our small nursing team embraced and delivered the complex care that Ray needed.

Ray and Pat's journey continues however we take forward from this experience new learning regarding containment with fistula segregation, new skills in pouching using Eakin wound pouches and a new appreciation of the difference and hope that re-feeding with the Inside Pump brings to fistula care.

ACKNOWLEDGEMENT:

We would like to acknowledge, that Ray's care has only been achieved with in put from our entire multidisciplinary team. In particular, we wish to acknowledge the nursing team on the surgical ward at Wairau hospital who have been outstanding in raising to the challenges of Ray's complex care.

We also wish to acknowledge Emma Ludlow, from the Insides Company for her assistance in teaching us about re-feeding and Lorraine Andrews from Omnigon for her assistance with pouching and segregation of fistulas.

Last but never least in this journey many thanks to those known here as Ray and Pat. Thank you for allowing us to learn and to share your story so others can also learn from your experience.

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Leveraging the pH Buffering Concept to Help Optimise Patient Outcomes Proactively

Paula Moran RN STN,
Flinders Private Hospital, South Australia

Abstract

Peristomal skin complication (PSC) rates remain at significantly high rates of 76% for ostomy patients despite improved surgical techniques and newer ostomy products.[1] These PSCs are shown to negatively impact health related quality of life[2] as well as social connectivity.[3] Ostomy patients deserve to have a good quality of life and stoma care clinicians can have a direct impact on this aspect of patient care by ensuring healthy peristomal skin. Unfortunately, many clinicians may consider that PSCs are inevitable rather than preventable. Patients should not have to endure such preventable challenges and proactive decision-making concerning skin protection should be a key goal of the clinician in all instances. Simply put, if the skin is in poor condition, other pouch features quickly become irrelevant. Understanding the concept of skin pH and the important role pH buffering plays in helping maintain healthy skin can help guide the stoma care nurse in the right direction and achieve their care goals.

This case study reviews the benefit of proactive recommendation of an ostomy skin barrier with pH buffering properties to help ensure peristomal skin health is maintained even in the presence of other existing skin conditions and surgical complications.

Background & Surgical History

Mrs. Y (initial changed to protect privacy) is a sixty-eight-year-old married female living independently at home. She has a considerable medical and surgical history which includes asthma, sleep apnoea, skin sensitivities, diverticular disease, rheumatoid arthritis, abdominoplasty, gastric banding, hysterectomy, hypertension, and varicose veins and associated venous ulcers. Specific to this admission, she presented after developing increasing abdominal pain and distension one-week post-surgery for varicose veins. Her bowels had not opened for seven days, and no flatus was passed for 24 hours. Abdominal CT scan revealed a large bowel obstruction with sigmoid luminal stenosis suggestive of obstructive malignancy. There was no lymphatic involvement and no malignancy seen elsewhere. Inflammation was noted in her descending colon and surgery was determined to be necessary.

Surgical Interventions

Mrs. Y underwent an exploratory laparotomy, low Hartmann's procedure, and formation of sigmoid end colostomy. Intraoperative findings revealed numerous intestinal adhesions with a significantly inflamed sigmoid colon and rectum. There were multiple loops of oedematous and inflamed bowel compacted with faecal matter. Dissection of these loops and adhesions was difficult resulting in significant abdominal faecal contamination necessitating in 3 litre abdominal cavity washout.

Nursing Interventions

Post-operatively Mrs. Y experienced abdominal wound breakdown at her midline incision which required negative pressure wound therapy (NPWT) to hasten healing. (*See Figure 1*) She also had moderate mucocutaneous separation of her colostomy with a slightly recessed stoma. (*See Figure 2*)

During her admission she discussed her history of skin sensitivities to adhesives and other irritants and had some concerns regarding the use of a continuous adhesive on her skin. Dansac TRE™ seals and a two-piece convex skin barrier were chosen proactively in the first instance for their pH buffering abilities and promotion of a healthy skin environment. Convexity was selected as her stoma was slightly below skin surface. The Dansac two-piece system was selected for ease of use and teaching purposes by the patient and ward staff. The floating flange was easy to use and reduced the potential for causing pain from pressure during pouch coupling, as these were applied directly over the mucocutaneous separation and to the peristomal skin.

Of secondary note, she suffers from obstructive sleep apnoea which requires the use of continuous positive airway pressure (CPAP) at night. CPAP has been shown to increase air in gastro-intestinal tract through aerophagia (air swallowing).[4] This may be of concern after surgery where a two-piece might be a consideration so the pouching system can be easily 'burped'. A high air flow filter in the pouch would also be a consideration to help reduce ballooning. Here the two-piece coupling and the NovaLife™ filter can add additional benefits for the patient.

Patient Outcomes

Mrs. Y's skin began healthy and intact and remained so despite the skin challenges she had on admission and after surgery. By selecting a pouching system proactively from the beginning, this positive outcome was achieved quickly. Her mucocutaneous junction separation granulated and ultimately resolved. Mrs. Y stated she was happy with results and the condition of her skin. (*See Figure 3*) One week later she was reviewed again in clinic and her skin appeared even further improved. (*See Figure 4*)

Conclusion

As part of an overall care plan, using the Dansac NovaLife TRE™ barrier and seals post-operatively and in a proactive manner may help prevent peristomal skin issues before they begin. By helping maintain a skin surface pH level that promotes healthy peristomal skin, PSC development may be mitigated, while also managing other challenges such as mucocutaneous separation.

Figure 1: Midline wound dehiscence

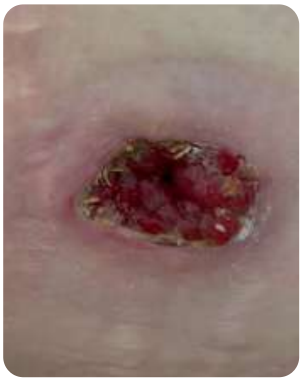

Figure 2: Recessed colostomy with mucocutaneous separation

Figure 3: Mucocutaneous separation resolution. Peristomal skin appears visually healthy at the point of discharge two weeks later

Figure 4: Skin appears further improved visually one week later post discharge at clinic review

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2003

Adapt™ Convex Skin Barrier Rings

2011

Adapt™ Oval Convex Skin Barrier Rings

2013

Use of Convexity in Pouching: Supported Publication

Hoeflok J, Kittscha J, Purnell P. Use of convexity in pouching: A comprehensive review. J Wound Ostomy Continence Nurs. 2013;40(5)506-512.

2015

Premier™ One-Piece Drainable Pouch with Soft Convex Skin Barrier

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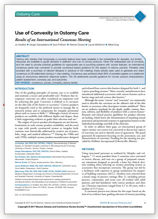

2017

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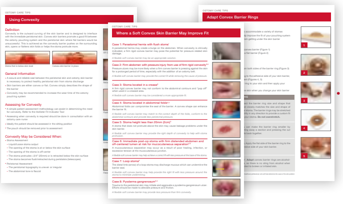

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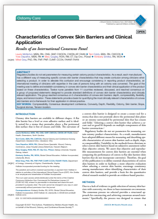

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McNichol L. et al. Characteristics of convex skin barriers and clinical application. J Wound Ostomy Continence Nurs. 2021;48(6);524-532.

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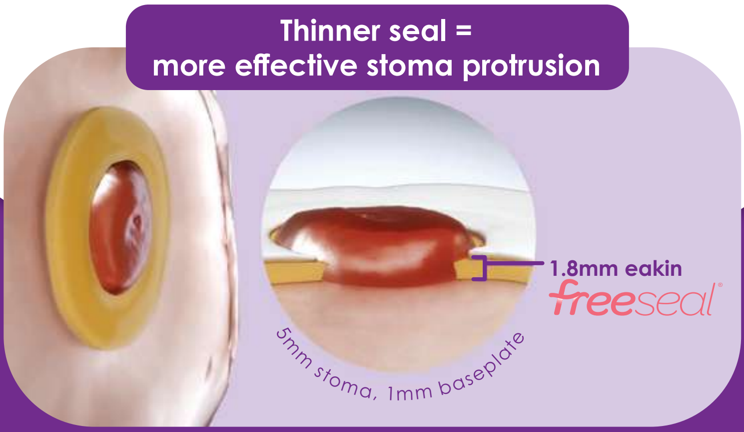

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The Psychological Impact of a New Bowel Cancer Diagnosis Across the Lifespan

EMMA LUDLOW, CNS STOMAL THERAPIST

Bowel cancer is one of the leading causes of cancer death in New Zealand (NZ) and globally. The prevalence of bowel cancer is extending to younger age groups, with an increasing incidence in the 30-50 year old demographic (Denost, 2020). The psychological impact of a bowel cancer diagnosis differs across the lifespan. The cancer journey that each patient experiences, brings forth a range of emotions and coping mechanisms. This paper will firstly look at the current bowel cancer statistics in NZ, broken down into age, demographic, and risk factors. Then, the results of an integrative review on the psychological impact of a new bowel cancer diagnosis will be outlined and briefly discussed. Finishing with a discussion synthesising the results, the implications for health care professionals and colorectal and stomal therapy nurses.

BOWEL CANCER IN NEW ZEALAND

NZ has one of the highest rates of bowel cancer in the world and it is the second highest cause of cancer death (Best Practice Advocacy Centre, 2020; Ministry of Health, 2019a). Men have a slightly higher incidence of bowel cancer than women (BPAC, 2020). Every year 40 in every 100,000 New Zealanders are diagnosed with bowel cancer, compared with 94 for breast cancer, and 103 for prostate cancer in men. Although the diagnosis rates of bowel cancer appear lower, the mortality rates are higher in comparison (BPAC, 2020). In NZ, 16 of the 100,000 New Zealanders (40% of total diagnosed) or over one third of the diagnosed, die from bowel cancer every year (BPAC, 2020). For comparison, breast cancer claims 16 in every 100,000 (17% of total diagnosed) and prostate cancer claims 16 in every 100,000 (15.5% of total diagnosed) in NZ (Ministry of Health, 2019a). These statistics are due in part to the non-specific symptoms of bowel cancer that are easily attributed to other benign diseases (Ministry of Health, 2019a). Currently, the five year risk of death by bowel cancer is 59% for Pacific people, 47% for Māori and 39% for other ethnicities in NZ (Sharples et al., 2018).

AGE AND BOWEL CANCER DIAGNOSES

Bowel cancer has incidence across the lifespan from 18 years onwards (Denost, 2020; Kasi et al., 2019). Of the 11,428 diagnoses between 2013 and 2016 in NZ, 733 (6%) were between 18-49 years, 1371 (12%) between 50-59 years, 4434 (39%) between 60-74 years and 4890 (43%) were above 75 years (Ministry of Health, 2019a). Bowel cancer has empirically identified as an 'older persons' disease. However, between 2013 and 2016 in NZ, as shown, almost one fifth of the presentations were under 60 years of age (Ministry of Health, 2019a). Denost (2020) has identified a marked increase in bowel cancer presentations globally for the under 50's specifically, a 90% increase for colonic and 124% increase for rectal cancers in the 20 to 34 age group and 27.7% and 46% increase respectively for the 35 to 49 year age group. There is a decreased incidence for the over 70's, which has been attributed to increased awareness and regular screening with polypectomies for the over 60's (Denost, 2020; Kasi et al., 2019). It can also be assumed that the population viewing bowel cancer as an older persons' disease has impacted the 18-49 year old rate of emergency presentations totalling 32.6% of their total presentations (Ministry of Health, 2019a). This high statistic can also be attributable to first being investigated by GP's with significant time spent ruling out other diseases and health literacy levels of individuals and younger individuals being unaware of the symptoms of bowel cancer (Al-Azri et al., 2019; BPAC, 2020). Another sad truth is generally the younger the age of diagnosis, the more advanced the disease, therefore requirement for more aggressive treatment resulting in a longer life of disablement (BPAC, 2020; Ministry of Health, 2019a; Denost, 2020; Kasi et al., 2019). Denost (2020) has hypothesized that by 2030, a quarter of all new bowel cancer diagnoses will be under the age of 50.

DEPRIVATION AND BOWEL CANCER DIAGNOSES

Sharples et al. (2018) demonstrates that deprivation has a role to play in diagnosis and survival rates of bowel cancer. Deprivation is a lack of material basics that society deems necessary for life such as health and housing (Sharples et al., 2018). The NZ Index of Multiple Deprivation measures deprivation by encompassing the seven domains of employment, housing, education, income, health, access and crime (Yong et al., 2017). They are weighted by level of importance in creating an overall picture of socioeconomic deprivation for an area of NZ in comparison to another (Yong et al., 2017). New Zealand is broken up into data zones to measure as accurately as possible the immediate area of deprivation, with data zones generally being only a few streets wide, by a few streets long (Yong et al., 2017). Subsets that are pertinent to this section are health, housing, and access. Health deprivation is a measurement of mortality, hospital presentations and respiratory and cancer diagnoses (Yong et al., 2017). Housing deprivation is a measurement of overcrowding (Yong et al., 2017). Access deprivation is a measurement of distance to GP's, supermarkets, and service stations (Yong et al., 2017). Across NZ, there are stark differences in overall deprivation ratings and subset deprivation ratings in different DHB's (Yong et al., 2017). The cases of bowel cancer diagnosed between 2013 and 2016 were spread almost evenly across the five quintile deprivation levels (low deprivation quintile one 2049 cases and high deprivation quintile five, 2125 cases) with level three and four the highest at 2494 and 2643 cases respectively (Ministry of Health, 2019a). However, there was a noticeable inverse relationship for how bowel cancer presentations occurred between high deprivation and low deprivation areas (Ministry of Health, 2019a). For example, if you lived in a high deprivation area, you were more likely to present acutely than seek a GP consultation thus reducing long term positive health outcomes. This is another example of an extensively researched topic on the relationship between high deprivation and poor health outcomes (Bécares et al., 2013).

RISK FACTORS AND BOWEL CANCER DIAGNOSES

Currently, the risk factors for bowel cancer are as follows; over the age of 50, diet high in red meat and animal fats and low in fruit and vegetables, obesity, sedentary lifestyle, smoking and alcohol, personal or family history, inflammatory bowel disease and previous bowel cancer (Ministry of Health, 2019c). A high proportion of bowel cancer risk factors are modifiable (Ministry of Health, 2019b). High rates of obesity and subsequently a poor diet high in red meat and salt, correspond with high deprivation of housing, education and income, which are some of the strongest risk factors for bowel cancer (Ministry of Health, 2019b; BPAC, 2020; Ministry of Health, 2019c). It is a well-known that NZ has high rates of obesity and the latest Annual Data Explorer, presented by the Ministry of Health, showed that 30.9% or 1.22million adults over the age of 15 were obese (2019c). On top of this, Māori adults are 1.6 times more likely to be obese than non- Māori and Pacific adults, and 2.5 times more likely to be obese than non-Pacific (Ministry of Health, 2019c). This has been acknowledged by the National Bowel Cancer Working Group (NBCWG), and over the last 10 years many innovations, such as the bowel screening programme, are currently being rolled out across NZ (Ministry of Health, 2019a).

INTEGRATIVE REVIEW

An integrative review was completed exploring current knowledge on the psychological impact of a new bowel cancer diagnosis across the lifespan. An extensive search of Ovid Psych info, PubMed, Embase and CINAHL, along with a hand search of the studies, was undertaken on the 4th April 2020. Studies met the inclusion criteria if they detailed participants experiences of their new bowel cancer diagnosis in English. Studies focusing on people with stomas and survivorship of bowel cancer were excluded. A thematic analysis was performed with a total of eight articles meeting inclusion criteria. Of the eight studies, seven were qualitative and one was a case study. They had all been written in the last 20 years and were from the United States of America, United Kingdom and Australia. The data was synthesized into four themes including reaction to diagnosis, making sense of the diagnosis, support, and quality of life.

REACTION TO DIAGNOSIS

A person's gender, age and life experience and personality, shock and anxiety, cancer care pathway process interpretation, and family and friend protection tended to define their reaction upon receiving the diagnosis. The following is a generalised selection of participant responses from the eight studies.

In respect to gender and age, many male participants had a male bravado reaction, such as taking it on the 'chin' due to the societal pressure of not wanting to be labelled as less of a man (McCaughan et al., 2010; Northouse et al., 2000; Worster & Holmes, 2008;). To older participants tending to have more philosophical responses and felt they had had a good life, so this was inevitable to a degree (Houldin & Lewis, 2006; Worster & Holmes, 2008). Many participants commented on what they thought would be the outcome of the clinic appointment before they went in and how this formed the basis of their reaction in the clinic once they were told (Taylor, 2001; Houldin & Lewis, 2006; McCaughan et al., 2010). The overarching emotion of anxiety was focused around the cancer spreading, with limited knowledge of bowel cancer and previous family members experiences of non-specific cancer compounding their own perceived journey (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; Northouse et al., 2000; Taylor, 2001; Worster & Holmes, 2008).

Regarding the cancer care pathway process, there was a marked difference in perception of the process to diagnosis and first treatment that was dependent on how advanced the bowel cancer was (Dunn et al., 2006). Participant's that had more advanced bowel cancer diagnoses felt staging scans and any surgical treatment that shortly followed being told their diagnoses, was either too fast for them to process or not quick enough (Dunn et al., 2006; Houldin & Lewis, 2006; Worster & Holmes, 2008). The participants that stated the process was too fast for them to process generally felt they had no time to reflect or adjust (Dunn et al., 2006; Houldin & Lewis, 2006; Worster & Holmes, 2008).

Lastly, there was a wide range of responses when it came to telling friends and family, from not explaining the extent of their disease due to the taboo nature, not saying anything at all, to explaining in great detail what was going on for them and what to expect. These reactions hinged on the pre-existing relationships they had with their family and friends (Dunn et al., 2006; Houldin & Lewis, 2006; Worster & Holmes, 2008).

MAKING SENSE OF THE DIAGNOSIS

Most of the studies detailed how their participants made sense of the diagnosis and what their state of being was, living with the diagnosis. Feeling alone and loss of control were significant themes that came through. The following is a generalised selection of participant responses from the eight studies.

Half of Dunn et al. (2006), Browne et al. (2011) and Worster & Holmes (2008) participants admonished the fact they had lived a relatively healthy lifestyle, and they still got bowel cancer. Whereas the other half had either not lived a healthy lifestyle or were elderly and felt that cancer was an inevitable outcome for them (Dunn et al. 2006; Browne et al., 2011; Worster & Holmes, 2008). The uncertainty of the trajectory of their disease made participants feel even more alone (Browne et al., 2011; Luke, 2012; Houldin & Lewis, 2006; Taylor, 2001). This uncertainty may have evolved from either feeling like they did not receive all the information or being told their prognosis was poor (Browne et al., 2011; Luke, 2012; Houldin & Lewis, 2006; Taylor, 2001). Being consumed by uncertainty, brings about a hopelessness of the situation that Northouse et al. (2000) warns against as a negative predictor of outcomes. If patients are in a cycle of hopelessness, then this tends to permeate to close loved ones and the distress can be felt equally by their spouse further elevating the distress (Dunn et al., 2006; Northouse et al., 2010).

Many participants from Luke (2012), Houldin & Lewis (2006) and McCaughan et al. (2010) studies felt a complete loss of control over their bodies, sexuality and sleeping patterns due to the disease itself and chemotherapy. Participants felt it was a complete disruption to their lives as they knew it (Luke, 2012; Houldin & Lewis, 2006; McCaughan et al., 2010). This diagnosis brought their lives and careers to a halt, and they could not contemplate looking into the future because they had to get over this seemingly insurmountable hurdle, that many didn't know if they would (Houldin & Lewis, 2006, McCaughan et al., 2010; Worster & Holmes, 2008).

SUPPORT

The theme of support can be broken down into family and friend, marital, and health care professional. The following is a generalised selection of participant responses from the eight studies.

Many participants touched on practical support from family and friends versus emotional support (Browne et al., 2011; Dunn et al., 2006; Luke, 2012; Worster & Holmes, 2008). Although they appreciated the practical support of having meals provided, child minding and house cleaning, they would have also appreciated a 'chat' about how they were doing and feeling at the time (Dunn et al., 2006; Worster & Holmes, 2008).

Northouse et al. (2000) outlined a role adjustment that occurs with patients and their spouses in the form of reallocating household tasks, and how different levels of support are now shown when confronted with this type of diagnosis. Northouse et al. (2000) found that historical relationship protocols dictated how the couple moved through the new and uncharted environment.

The consensus from most of the studies was that the colorectal clinical nurse specialists (CCNS) were extremely helpful, gentle and supportive of the participants (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Participants from the Worster & Holmes (2008) study were split on their assessment of information provided, half felt they received more than enough information from their health care professionals, and what they were provided was at their level of understanding, so they had a good grasp of what they needed to know. A small proportion of this group found the information overwhelming and found it too graphic, with many stopping the health care professional from going any further (Worster & Holmes, 2008).

QUALITY OF LIFE

Health related quality of life, with the loss of mental and physical functioning, and the coping strategies participants employed to deal with events and preservation of their mental health, are the two sub- themes that make up the overall theme of quality of life. The following is a generalised selection of participant responses from the eight studies.

Half of Browne et al. (2011), Dunn et al. (2006), Houldin & Lewis (2006) and McCaughan et al. (2010) participants reported little or no change to their level of function, however, their rehabilitation took many months to return to base line, with some requiring family and friends assistance until they had the strength to complete tasks. This interpretation of their level of function could be reflective of their state of mind that is presented in the next sub- theme. Conversely, the other half reported a reduced level of function owing to fatigue and loss of strength (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010). This reduced level of function affected their socialisation, with many finding they were too tired to maintain their previous level of social interaction (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010). In some studies there were mixed responses to sexuality, some participants saying it did not distress them because they didn't feel like it, and other participants saying it negatively impacted on their psychological and sexual health (Dunn et al., 2006; Houldin & Lewis, 2006; Luke, 2012; McCaughan et al., 2010).

Almost all of Dunn et al. (2006) participants 'learned to live with cancer' and found they had 'inner resources' to assist them to do so and felt accomplished in achieving this. Houldin & Lewis (2006) termed this 'active coping,' and found many of their participants described finding this. Active coping could entail making small achievable goals, changing how they spoke about their disease or doing one positive activity each day (Houldin & Lewis, 2006). In general, life is uncertain and having the added burden of a bowel cancer diagnosis could exacerbate the distress of uncertainty. However, if a participant framed the diagnosis the same way they frame the uncertainty of life, then they generally did not succumb to too many negative thoughts (Dunn et al., 2006; Houldin & Lewis, 2006; Worster & Holmes, 2008). Many participants coping strategies in regaining control was to maintain or salvage routines as much as possible and purposively focusing on the positives in life, this mindset gave them the determination to recover (Dunn et al., 2006; Houldin & Lewis, 2006; Taylor, 2001). Benefit finding is the act of finding the positives or benefits of their situations, which participants found to be an effective coping strategy (Dunn et al., 2006; Houldin & Lewis, 2006; Taylor, 2001).

DISCUSSION

The discussion will examine and discuss the results of the integrative literature review on the psychological impact of a bowel cancer diagnosis across the lifespan. The chapter will focus on the principle findings that gender, life experience and historical personality traits mediate a patient's response to receiving the diagnosis. It will identify and discuss the levels of support that the patient requires from various formal and informal sources, and how coping strategies are implemented following this support. The limitations of the studies and the implications for health care professional and colorectal and stomal therapy nurses will be defined.

Receiving a cancer diagnosis is a life halting experience. The reaction a patient has can be defined by gender, their life experience and historical personality traits (Dunn et al., 2006; Houldin & Lewis, 2006; Luke, 2012; McCaughan et al., 2010; Northouse et al., 2000; Taylor, 2001; Worster & Holmes, 2008). This is also supported by non-specific cancer studies from Hubbard et al. (2010), McGregor et al. (2018), Hernandez et al. (2019), Mor et al. (1994) and Sales et al. (2014). Societal pressures and the subconscious impact they have on the individual when receiving the diagnosis, appear to completely control what is shown and the initial interpretation of the information (Dunn et al., 2006; Houldin & Lewis, 2006; Luke, 2012; McCaughan et al., 2010; Northouse et al., 2000; Taylor, 2001; Worster & Holmes, 2008). The time gap between the Mor et al. (1994) study, the studies in this integrative review, and Hernandez et al. (2019) study, illustrate a continued theme and the perpetuation of societal pressure on a person's reaction to an assault on their health that is happening to them alone. In society today, there is increasing awareness, acceptance, and understanding of the fluidity of gender, which highlights the need for ongoing qualitative research into the impacts of a bowel cancer diagnosis on an individual to see if the correlation continues to be substantiated.

The support patients identified that they required and received was varied. It was dependent on their personality and the historical relationships, but more importantly on how they interpreted the support they did receive (Browne et al., 2011; Dunn et al., 2006; Luke, 2012; Northouse et al., 2000; Worster & Holmes, 2008). Most of the participants in the studies referred to how their friends and family made them feel, and what they said and did was expounded positively or negatively 'in their eyes' (Browne et al., 2011; Dunn et al., 2006; Luke, 2012; Northouse et al., 2000; Worster & Holmes, 2008). The practical support versus emotional support from friends and family was also a pivotal point noted by the Browne et al. (2011), Dunn et al. (2006), Luke (2012), Worster & Holmes (2008), studies. How the participants interpreted the two types of support and the understanding they placed on that type of support that their friends and family supplied, infers a link to personality and historical relationship parameters too (Browne et al., 2011; Dunn et al., 2006; Luke, 2012; Worster & Holmes, 2008).

For the participants in the eight studies to make some sort of 'headway' into dealing with their bowel cancer diagnosis and getting through their therapy, coping mechanisms need to be employed to be able to achieve this and allow them to adjust to their 'new normal.' Many participants in Dunn et al. (2006), Houldin & Lewis (2006) and Worster & Holmes (2008) participants felt a sense of accomplishment at transitioning into this mindset and not allowing the turmoil of an existential threat take over.

The resilience of some of the participants in the studies shone through with their approach to coping and living with cancer, such as active coping and benefit finding, which afforded them more positive outcomes in the long term (Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Northouse et al., 2000; Taylor, 2001; Worster & Holmes, 2008). This concept is also supported by non-specific cancer studies from Mor et al. (1994), Hernandez et al. (2019), Janse et al. (2015) and Sales et al. (2014). Pragmatic measures such as making small achievable goals, framing thoughts differently, creating and sticking to routines and having a sense of humour helped establish a more positive mindset (Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Northouse et al., 2000; Taylor, 2001; Worster & Holmes, 2008; Mor et al., 1994; Hernandez et al., 2019; Janse et al., 2015; Sales et al., 2014). Janse et al. (2015) found that over time, making small achievable goals became easier to make and easier to achieve because they had been consciously practising and had past successes to reflect on and bolster future goals. This had a flow on effect for reducing illness related handicaps because patients were able to see 'clearer' and had a higher chance of attaining the goal because the disablement was not the focus, rather a low barrier to circumnavigate (Houldin & Lewis, 2006; Janse et al., 2015).

STRENGTHS AND LIMITATIONS

To the researcher's knowledge, this is the first integrative literature review completed on the psychological impact of a bowel cancer diagnosis across the lifespan. Another strength of this literature review is the use of thematic analysis that could comprehensively group the themes that were prevalent across the studies (Polit & Beck, 2018). This research, however, is subject to several limitations. The studies in this review are from 10 to 20 years ago and there has been significant advances in gender and cultural understanding, acceptance, and integration over the last decade that may change the results presented in this integrative literature review. The studies included in this integrative literature review are limited to English which reduces the possible impact these results could have because there is not the breadth and diversity of data that other studies written in different languages may provide. This highlights a further limitation in that the eight studies have been completed in developed, well known countries and the ethnicities noted in some participant groups, is not diverse. The generalisability is low due to these three limitations. Therefore, there is a reduced applicability to the NZ population. The Māori and Polynesian populations, whom have the highest morbidity and mortality rates associated with bowel cancer in NZ, are not represented by the data shown in this integrative review.

IMPLICATIONS FOR HEALTH CARE PROFESSIONALS

This integrative literature review on the impact of a bowel cancer diagnosis across the lifespan provides the evidential basis for implementing targeted strategies and therapies to help this special population of patients. It is evident that gender, personality and life experience impact on how a person responds to their diagnosis and being conscious of this, will help develop a more cohesive working relationship between health care professionals and the patient (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Gaining an understanding about the level of support a patient requires from a health care professional and following their cues, will further contribute to building trust between health care professional and patient (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Health care professionals need to ensure their assessment of psychological adjustment and level of support required incorporates the whole family, not only the patient (Northouse et al., 2000; Tuinstra et al., 2004). The loss of control of their body and having to rely on health care professionals sometimes tends to be forgotten by the well-intentioned health care community (Browne et al., 2011). So, having regular education updates and really taking the time to listen to patient concerns and discuss options is vital to optimising patient outcomes and making them feel heard in this tumultuous period of their lives (Browne et al., 2011). With this in hand, there could be targeted programmes to increase the uptake of Māori, Pacifica and other indigenous populations in bowel screening. Taken further, programmes directed at different personality types to increase the capacity and resilience of patients to improve their health outcomes could be developed. However, ultimately, to gain a deeper understanding of how a bowel cancer diagnosis impacts different cultures and the younger population.

IMPLICATIONS FOR COLORECTAL AND STOMAL THERAPY NURSING PRACTICE

Colorectal and stomal therapy nurses are recognised as having the highest amount of contact points with patients and as evidenced in the results chapter, are the most appreciated, supportive and empathetic of the health care professionals involved in a patient's care (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Colorectal and stomal therapy nurse specialists therefore need to be cognizant of the various impacts a bowel cancer diagnosis can have on a patient when tailoring their care and approach to their patients (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). When educating patients on their new diagnosis, what is going to happen and what to expect, the level of information shared and pace at which it is delivered, need to be matched with the patient for optimal understanding (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Further study and experience will grow and develop this skill to ensure holistic care is maintained (Browne et al., 2011).

As illustrated in the results and discussion thus far, a patient's support system and their ability to cope are intricately intertwined and a colorectal or stomal therapy nurse are perfectly positioned to objectively evaluate whether the patient requires more assistance, or they are progressing as expected (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; Luke, 2012; McCaughan et al., 2010; Northouse et al., 2000; Taylor, 2001; Worster & Holmes, 2008). This can be defined by either alleviating physical symptoms by arranging a medication review, supply of consumables to assist with physical side effects, listening or identifying a need to refer onto specialists (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Active listening may appear to be the simplest form of therapy but possibly the most effective therapy for a patient to cope and make sense of their journey (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Completing further education in recognising hopelessness and destructive thought patterns will provide the nurse with a more comprehensive skill base and promote holistic care for their patients (Browne et al., 2011; Dunn et al., 2006; Houldin & Lewis, 2006; McCaughan et al., 2010; Taylor, 2001; Worster & Holmes, 2008). Along with further education, gaining confidence to have constructive conversations with bowel cancer patients around sensitive topics such as sexual health and intimacy will help to break down the barriers for patients to share their thoughts, worries and questions in a supportive environment (Houldin & Lewis, 2006; McCaughan et al., 2010; Luke, 2012; Worster & Holmes, 2008).

SUMMARY AND CONCLUSION

There is a paucity of literature on the psychological impact of a new bowel cancer diagnosis across the lifespan. Of the studies found, there is a low generalisability to the global population, with the data mostly detailing the experiences of the older population in westernised countries. The limitations of the literature review highlighted the need for a diverse range of cultures and age groups to share their experiences of the psychological impact of receiving their bowel cancer diagnosis.

The incidence of bowel cancer globally, and in NZ, is increasing and extending into younger age groups. The psychological impact of receiving a bowel cancer diagnosis and coping with it to produce a positive health outcome is quickly becoming a health priority for health care professionals working in this speciality. Health care professionals need to identify, support, and encourage their patients through this diagnosis and empower them to move on with their lives. It is paramount further research into what the psychological impact of a bowel cancer diagnosis is for all cultures and age groups, so that targeted coping strategies can be implemented to enhance patients' capabilities and health outcomes.

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3M
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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

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

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EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ ______________

Transport: $ ______________

Accommodation: $ ______________

Other: $ ______________

Funding granted/Sourced from other Organisations

Organisation:

______________________________ $ ______________

______________________________ $ ______________

______________________________ $ ______________

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

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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: ______________

The Outlet

New Zealand Stomal Therapy Nurses