The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

- Antegrade Colonic Enema (ACE) and the Chait Tube
- Could it be a life changer? The use of a two-piece ostomy pouching system in paediatrics
- Using the Insides System Chyme Reinfusion Pump

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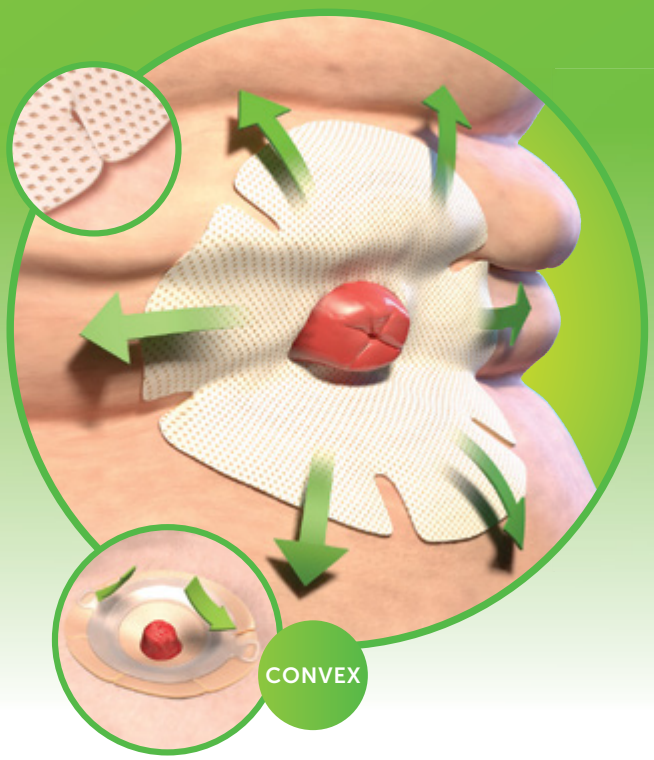

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The Outlet

New Zealand Stomal Therapy Nurses

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Your Executive Committee Members

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Chairperson's Report

NICKY BATES

Talofa lava, greetings to you all as we near the tail end of the year.

I would like to start with a "thank you" to Jackie Hutchings (STN Nurse Maude)for her work as the NZSTN representative on the Tripartite Colorectal Conference committee. Organising a conference in the unpredictable climate we are all in is not an easy task — we thank you for your ongoing commitment and hard work Jackie.

On the topic of the Tripartite Colorectal conference, I would like to provide an update. The conference is going ahead as planned. A final decision on how the conference will be hosted (virtual or hybrid) will be made on 10 November by the tripartite committee. An email will be sent out to the membership once the decision is made. The conference programme looks exciting with a diverse range of highly skilled, knowledgeable, and interesting speakers. The speakers I have approached have jumped at the chance to be a part of the conference recognising the opportunity presented.

The committee encourage nurses to submit your abstracts as soon as possible .Presenting your work at the Tripartite Conference is a great opportunity to gain exposure at an international event, share your wisdom and skills. Please submit your abstracts by email to Jackie Hutchings jackiehutchings@outlook.com.

The Tripartite Colorectal Conference is not to be missed – register now. A reminder early bird registrations close 15th November. Information on the conference can be found under the NZNO website — College of Stomal Therapy.

Rochelle Pryce and I attend the virtual NZNO conference and AGM in Sept as College representatives . The conference had a variety of speakers including Dr Michal Boyd who presented on End of Life from a Nursing Perspective and Stephen McKernan, Lead of the Transition Unit for Health reforms — Creating a sustainable health care system. Never quite the same virtually but was an interesting day.

In September Julia Anderson our NZNO PNA stepped away from her role with us . On behalf of the Stomal Committee I would like to acknowledge Julia's work and say a huge thank you for the knowledge, professionalism, guidance and support she brought to the successful running of the committee. Julia has also put in the hard yards at the bargaining table for nurses which as we know has gone on over a long period of time. Cathy Leigh will take over from Julia and we look forward to working with her.

The committee is due to meet virtually mid November . At this time, we will make a decision on whether the conference evening event for nurses will go ahead as planned. Other agenda items include reviewing the Bernadette Hart Policy and STN standards. We will be discussing the development of an STN guideline booklet (similar to AASTN), which would include common STN practices. We have previously discussed this and now the K & S framework is complete we can move to working on this in depth.

Finally I will close with a thank you… thanks to the committee for their ongoing commitment to Stomal Therapy and the College.

Best wishes to you all,

Nicky Bates
Chairperson NZNOCSTN

Editor's Report

DAWN AND ANGELA

Welcome to the November edition of "The Outlet".

As we sit and write this report Auckland remains in lockdown level 3 due to Covid-19, after five weeks of Lockdown level 4 we were able to enjoy some light relief by being able to enjoy takeaways and more importantly a barista made coffee. We have perfected the art of using zoom as the now preferred mode of communication and perfected the skill of using PPE with the "donning and doffing" of the gowns, gloves, N95 masks and eye covering multiple times per day. The challenges behind screening forever a challenge as the symptoms of Covid-19 grow to now include gastro-intestinal symptoms.

We are certainly in the midst in a new era, as we attempt to navigate a revised modality of care with the increased use of telehealth being incorporated into our practice. Stress, anxiety and feelings of isolation ever present for our patients, who are bombarded with a plethora of information which they are expected to retain in the absence of any support person within the hospital setting and for us specifically in Auckland this has been problematic at times. As nurses we are often on the receiving end of a persons' level of frustration and this is both challenging and upsetting. The need to be in three different places at the same time is a feeling I am sure we all share from time to time. I would like to acknowledge the high level of care and expertise that we all continue to provide in such challenging times, Stomal Therapy is such a niche specialty and we need to be mindful of the positive impact we have on how people live their lives.

I would like to thank those who have submitted their work for publication in the past year, I would like to encourage other nurses whether you are an experienced Stomal Therapist or someone with an interest in Stomal Therapy to showcase your wonderful work. We learn and benefit greatly from the work of others as many of our members work in their specialty in relative isolation.

Please remember the "Knowledge and Skills Framework" which is now ready for use as we encourage and develop nurses into the speciality of Stomal Therapy.

We are able to produce and distribute "The Outlet" to our members due to the ongoing support from our trades, so a bit thanks for your ongoing advertising and sponsorship - we greatly appreciate you all. We encourage our members to connect with the company representatives to keep ahead of the latest products and developments.

We are all hoping for a great attendance at the Tripartite Conference in February 2022, in whatever form this conference now takes.

Thank you for another great year from the committee and for your wonderful leadership Nicky. We hope to see you all at the conference and look forward to receiving submissions of your work for the March 2022 edition of "The Outlet".

We wish everyone a Happy Christmas and a safe New Year.

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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Profile Page - Satoko “Toko” Kaneko

OSTOMY CLINICAL NURSE SPECIALIST - NORTH SHORE COMMUNITY
WAITEMATA DISTRICT HEALTH BOARD

I am originally from the Fukushima region of Japan. This is a beautiful part of the country side of Japan. I moved close to Tokyo to attend University where I majored in Education and American History in Saitama University.

After graduation I ended up choosing to work as an IT sales assistant in Tokyo. I moved to New Zealand when I was 26 years old with my partner who was studying in New Zealand.

My first job in New Zealand was working in the medical records team in Auckland City Hospital. All my co-workers, many of them used to work as health professionals in their own countries, told me that I would make a really good nurse and I should get myself trained. With my kind boss in the medical records team, I was able to study nursing in AUT and work full time most of my student life.

Through studying nursing, I realised I needed to learn hands-on skill, so I also worked as a health care assistant on weekends with palliative care patients and the district nursing team.

Working with district nursing team made me interested in a career in district nursing. During my nursing training I asked to be placed with the district nurses and went to the district nursing team at Waitakere hospital. That is where I met Sandy Izard, the Ostomy Nurse Specialist at the time. I remember Sandy took time to go through explaining the different kinds of stoma, the different bags and how they work. I remember her visiting her patients and she listened, took time for her patients and solved her patient's issue in managing their stoma often with just one visit. Sandy made me feel confident in changing stoma bags and by the end of the day and I remember thinking “One day I will be like her, One day I will teach my own nursing students how to change a patients’ stoma bag”.

I was very lucky to get a NETP position as a theatre nurse when I graduated from AUT. One day when I took my patient to the theatre I noticed they had a stoma bag which was full with output. No other nurses knew what to do. But I could remember my time with Sandy and I quickly changed the patient’s bag prior to the all-day surgical procedure. On that day I emailed Sandy Izard asking “How can I come and work with you in district nursing team? " Surprisingly, she remembered me and recommended me to her team’s charge nurse manager.

I become the ostomy resource nurse as soon as I started working as a District Nurse. When Sandy retired, with all the support from my district nursing team, I had applied to work as an ostomy nurse. I have been in this role for the last year. I am also a busy mum of 2 girls aged 6 and 2.

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TRIPARTITE COLORECTAL MEETING 2022

21-24 FEBRUARY 2022, AUCKLAND, NEW ZEALAND

Looking Forward, Looking After | Mā Muri Ki Mua

The Tripartite conference is now a virtual conference due to the uncertainty of travel restrictions at this time.

REGISTRATION FEES:

Earlybird (nurses)	$360
Full Fees (nurses)	$435 – after 8 December 2021

If you have already registered you will be refunded the difference as the fees have reduced.

ABSTRACT SUBMISSIONS:

We still require more nursing speakers in our Stomal Therapy Innovations session so please consider submitting an abstract as soon as possible to **jackiehutchings@outlook.com**

POST CONFERENCE:

The conference recording will be available online for 3 months after the conference ends so you will be able to have access to all the surgical and stomal therapy sessions for that time. There will be a single device security attached to this.

FURTHER INFORMATION:

Please go to the Tripartite 2022 website if you require any further information and registration is also completed through this website **www.tripartite2022.com**

STOMAL THERAPY PROGRAMME

TRIPARTITE COLORECTAL MEETING 2022

21-24 FEBRUARY 2022, AUCKLAND, NEW ZEALAND

Looking Forward, Looking After | Mā Muri Ki Mua

TUESDAY 22 FEBRUARY 2022

0700-0830	Combined welcome and opening plenary session Looking Forward; Looking After
0830-0900	Morning Tea
0900-1100	Combined Plenary - Rectal Cancer
1100-1200	Lunch
1200-1300	Cancer, PTSD and the unexpected teachings of drag racing *Kate Oliver – Keynote speaker*
1300-1315	Pre operative preparation and impact on discharge *Wendy Sansom, Stomal Therapist*
1315-1330	A stomal therapists experience of a novel chyme reinfusion device for high output enterostomies *Emma Ludlow, Stomal Therapist*
1330-1400	Afternoon tea
1400-1430	Ovarian cancer, dilatation and intimacy issues *Amanda Tristram, Gynaecologist*
1430 -1530	Gratitude and Kindness workshop *Kate Oliver*

STOMAL THERAPY PROGRAMME

TRIPARTITE COLORECTAL MEETING 2022
21-24 FEBRUARY 2022, AUCKLAND, NEW ZEALAND
Looking Forward, Looking After | Mā Muri Ki Mua

WEDNESDAY 23 FEBRUARY 2022

0700-0830	Combined session (could choose either session) Pre op optimisation / Colorectal Neoplasia
0830-0900	Morning tea
0900-1000	Introduction to Mindfulness workshop *Kate Oliver*
1000-1030	Managing the High Output stoma and clostridium difficile *Dr Corina Behrenbruch, Colorectal Surgeon*
1030-1100	Intestinal Failure – *Andrew Xia, Dietician*
1100-1200	Lunch
1200-1215	Measuring Adjustment Outcomes Among New Stoma Patients; final results from a nine month follow up study - *Julia Kittscha, Stomal Therapist (Virtual)*
1215-1245	VACTERL syndrome – Paediatrician
1245-1310	Medico legal issues – *Kiri Rademacher, NZNO*
1310-1330	Medicinal Cannabis - *Dr Graham Gulbranson, GP, Cannabis Consultant, Addiction Specialist*
1330-1400	Afternoon tea
1400-1530	Stomal Therapy Innovations Abstracts (10 min each)
1530	NZNOCSTN BGM AASTN AGM

STOMAL THERAPY PROGRAMME

TRIPARTITE COLORECTAL MEETING 2022
21-24 FEBRUARY 2022, AUCKLAND, NEW ZEALAND
Looking Forward, Looking After | Mā Muri Ki Mua

THURSDAY 24 FEBRUARY 2022

0730-0745	How compliance laws can affect your interactions with industry – *Paris Purnell, Liberty Medical*
0745-0805	Rectal Trauma from Enema Administration *Fiona Lee Gavegan, Stomal Therapist*
0805-0835	Exenteration and VRAM Mike Hulme-Moir, Colorectal Surgeon
0835-0900	Early reversals – *Michael Johnston, Colorectal Surgeon*
0900-0930	Morning tea
0930-1100	Combined plenary - Parastomal Hernia
1100-1200	Lunch
1200-1225	Mitrofanoff – *Hazel Ecclestone, Urologist*
1225-1245	Faecal transplant – *Fiona Williams, CNS Gastroenterology*
1245-1315	Tips for addressing stomal complications NZNOCSTN committee
1315-1330	Stomal Therapy Close
1330 -1400	Afternoon Tea
1400 – 1530	Closing Plenary Looking Forward

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

Antegrade Colonic Enema (ACE) and the Chait Tube

ROCHELLE PRYCE, BN, RN, PGCERT, PGDIP, MNURSING, PGCERT STOMAL THERAPY. CLINICAL NURSE SPECIALIST, CAPITAL & COAST DISTRICT HEALTH BOARD, WELLINGTON

INTRODUCTION

As practicing Stomal Therapists we need to have excellent knowledge and skills pertaining to all aspects of stomal therapy care. This not only includes management of colostomies, ileostomies and urostomies but also other surgical procedures that patients choose for their bowel management. This article will discuss Malone Antegrade Continence Enema (MACE), Antegrade Continence Enema (ACE), appendicostomy and cecostomy, management of the chait tube (trapdoor), troubleshooting and education needed to assist patients to continue with improved quality of life.

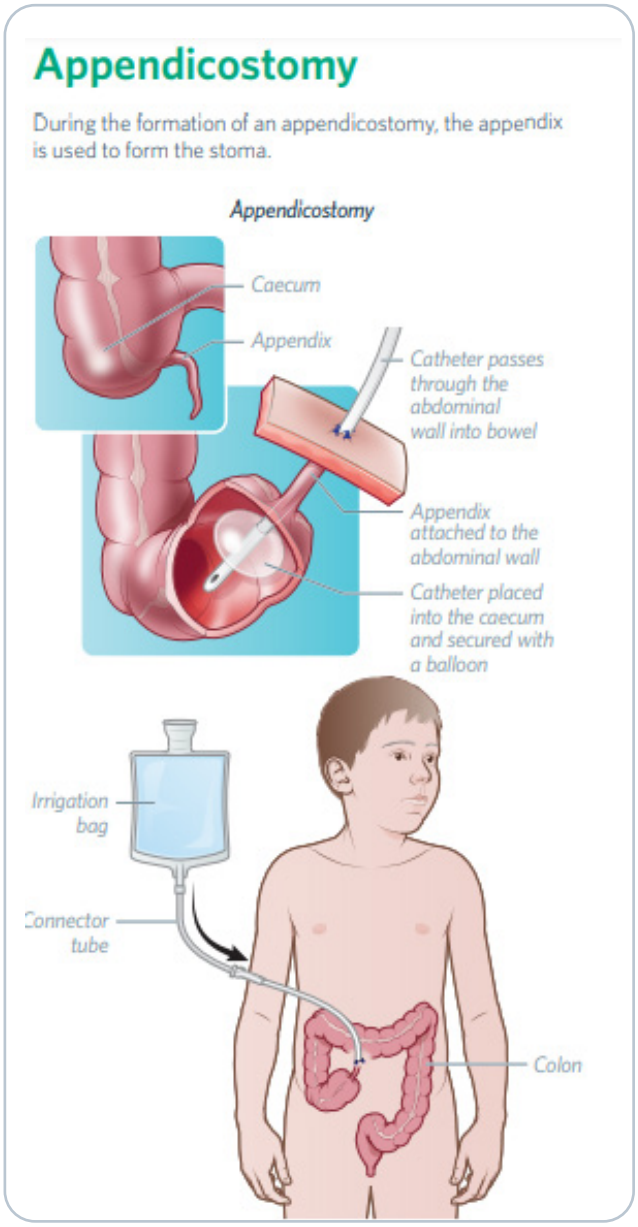
ACE or chait patients are not common in the writer's demographic region, however in recent months we have had several created for the adult patient. Therefore, in response to limited knowledge regarding this topic, I felt I should undertake some research and share my findings to assist other stomal therapist nurses (STNs) who may be caring for this specific group of patients.

BACKGROUND

Patients who experience fecal incontinence, loss of anal control or severe constipation could benefit from a Malone Antegrade Continence Enema, (MACE) or Antegrade Continence Enema (ACE).[1,8] The term antegrade refers to "forward moving" suggesting an enema is inserted at the beginning of the large intestine and moves the stool to the end, and out through the anus.[2] This procedure is an alternative to receiving a stoma and is ideal for patients diagnosed with anorectal malformations, Hirschsprung's disease, myelomeningocele (defect in the backbone and spinal cord), spina bifida and quadriplegia.[3,6] The purpose of this surgery is designed to assist patients with emptying of their bowel in a timely manner preventing unexpected leakage, eliminating embarrassing situations and enabling them to gain greater independence to improve their quality of life.[2,7]

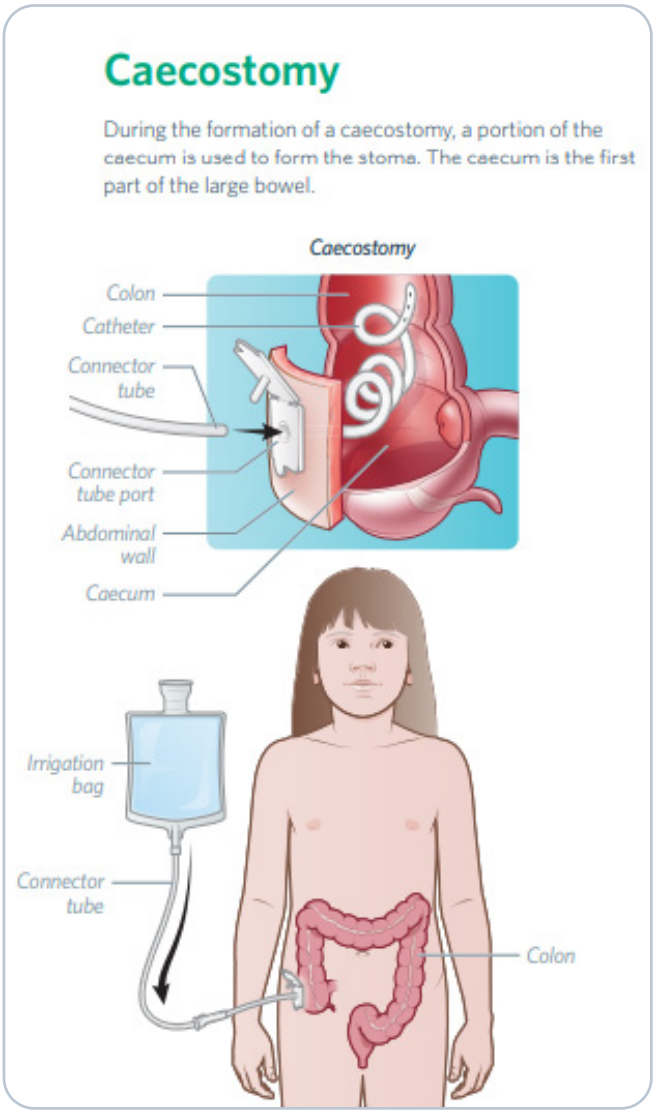
Initial management strategies may have included dietary manipulation, bowel training, and a variety of medications.[4,7] In addition, prescribed rectal enemas and suppositories can become problematic to some patients and may cause discomfort and create challenges when self-administering.[7] If these interventions fail, doctors may recommend an ACE procedure with formation of either an appendicostomy or cecostomy, and insertion of a chait tube to administer antegrade enemas which will significantly reduce difficulties encountered during rectal enema administration.[5] Today, the fluid used for irrigation is generally tepid tap water, but historically phosphate (fleet) enemas and normal saline were utilized.[5] Patients who prefer to still use a salt solution, can make their own. It is recommended to use cooled boiled water, and for every 500mls 1 teaspoon of salt should be added and allowed to dissolve.[4]

Originally titled MACE was introduced in 1990 and founded by Dr Malone.[5] He discovered a method that involved the creation of an intestinal conduit for antegrade enema administration via the appendix or caecum.[5,9] Today, the term is more commonly known to us as an ACE. Dependent on the part of the bowel used defines whether the patient receives an appendicostomy or cecostomy.[11] If the appendix is used, an appendicostomy is formed, if the patient no longer has an appendix, then the cecum is used and referred to as a cecostomy.[11] Both are also referred to as an "continent ostomy" which means that fluids are only inserted into the opening.[3] The successful ACE procedure avoids patients receiving a colostomy and therefore not needing to wear an ostomy pouch.[7] Additionally, the chait button is very discrete and hidden under patients clothing. Both surgeries involve the placement of a C tube or Chait tube (which has a trapdoor) which is used to insert the antegrade enema into the colon.[1] The formation and differences between the appendicostomy and the cecostomy will now be discussed.



Left Picture 1: Formation of appendicostomy

Below Picture 2: Formation of cecostomy



THE APPENDICOSTOMY

The Appendicostomy pronounced (ah-pen-di-koss-toh-me) is performed laparoscopically.[2] The surgeon will make a small cut into the right lower quadrant of the abdomen and bring the appendix out to the surface to make an outer opening. The appendix is a small finger like tube attached to the cecum.[11]

The surgeon inserts a tube known as a chait or trapdoor into the new appendix opening which will enable water or an enema to be inserted, assisting the patient to empty their colon. The chait tube acts as a one-way valve limiting the amount of stool and body fluids that may come out onto the abdominal wall.[6,11]

There are some risks associated with this surgery which will be discussed with the patient prior to surgery. They may include infection in the abdomen, abscess, skin excoriation, bleeding or injury to the colon or surrounding structures.[12]

CECOSTOMY

A cecostomy, pronounced (see-koss-toe-me) is also done laparoscopically.[2] This is when a portion of the caecum (the first part of the large bowel) is brought to the surface of the abdomen wall and secured into place and the chait tube is placed.[11]

The chait keeps the cecostomy open, has a one-way valve which prevents leakage and enables a convenient channel for antegrade enemas to be inserted.[6,1]

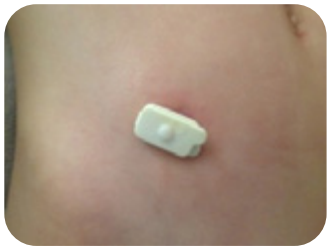
THE CHAIT TUBE

Both surgeries described above, are created laparoscopically under a general anesthetic (GA) or using interventional radiology.[2] The chait is described a soft plastic tube made from ultra-thane, which has been in widespread use for gastrostomy and nephrostomy tubes.[10] One end has a curly tail (like a pig's tail) which coils around and secures the tube in place within the cecum, the other

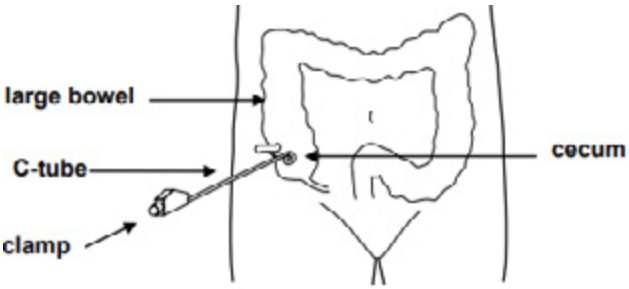
end is secured to the abdomen with two small dissolving sutures and has a trap door that opens and closes (see picture 3 and 4).

In some circumstances, the surgery is done in a two-step process. This involves the initial placement of a temporary C tube catheter which is held in place in the cecum with an inflated balloon (see picture 5). After approximately four weeks, the C tube is removed and replaced with the Chait trapdoor (see picture 3).

Picture 3 - Chait tube with coil



Picture 4 - Trap door on abdomen



Picture 5 – Temporary C Tube placement

POST-SURGERY MANAGEMENT

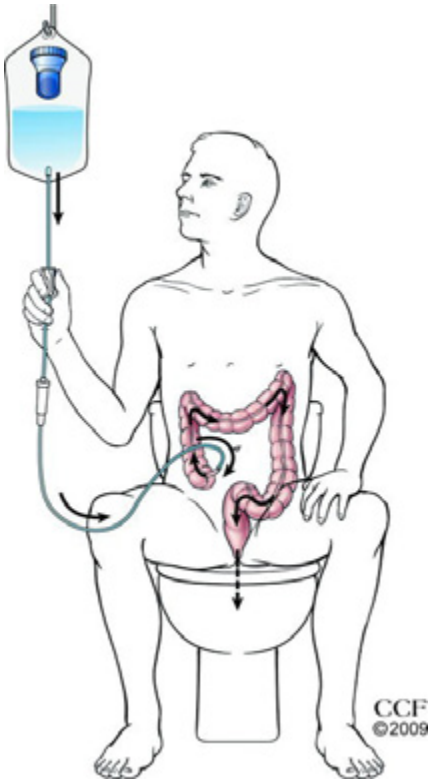
Post-surgery management involves a course of antibiotics to prevent infection around the chait[11,12] and teaching the patient how to attach the chait adaptor to the chait trapdoor. The patient should return from surgery with their chait adaptor (this is very important). Initially as an inpatient, the new chait will need to be flushed daily with approximately 20mls of tepid tap water with a catheter tip syringe to keep the chait tube patent.[7]

After one or two weeks and clearance from the surgeon, the STN will visit the patient at home and teach irrigation directly into the chait and begin training of the colon for evacuation of stool into the toilet. The irrigation process from start to finish can take from 30 minutes to an hour, and patients need to be aware a great deal of commitment is necessary to establish a reliable washout routine.[4,13] Results are not instantaneous, and it may take several weeks for the bowel to settle into a good regime. Ideally, irrigation should occur at the same time each day, and half an hour after eating is best, as this is when the colon has increased activity and will maximize the likelihood of good bowel clearance.[13] In conjunction with the above, patients should also be advised to keep the chait tube clean and dry, ensure it is well secured to the skin, keep well hydrated and prevent constipation by eating a diet high in fibre.[7,13]

TEACHING IRRIGATION – STEP BY STEP

1. All equipment should be shown and explained to the patient ensuring they understand
2. Close the clamp on the water bag and fill with approximately 800mls of tepid tap water (this can be increased as needed)
3. Hang the water bag above the toilet (using a hook, towel bar or shower rod) – ideally at shoulder height, the water bag needs gravity to work
4. Attach the chait adaptor to the end of the tubing of the water bag
5. Open both clamps on the water bag tubing and chait adaptor to prime and remove any air bubbles, then clamp them both off
6. Ensure patient comfort on the toilet
7. Gently open the chait trapdoor
8. Attach the chait adaptor (which is connected to the tubing and water bag) into the small hole in the chait tube trap door
9. Open the clamps on both the chait connector and the water bag
10. Using the hand controller, slowly allow the water to flow into the bowel checking patient comfort throughout

At the conclusion of irrigating, wash the water bag, tubing and chait adaptor with warm soapy water and then rinse with clear water. Let all equipment dry before putting away and store in a clean dry place. If the equipment is cleaned daily, it should last for approximately six months. Replacement irrigation kits can be sourced from STNs in conjunction with Ministry of Health Guidelines who specify one kit will be provided every six months.14 For patients who have had their chait removed but continue to irrigate daily with an in/out catheter, can source their supplies from the continence nurse.



TROUBLE SHOOTING

Like most surgeries, there can be some complications that may arise. As STNs we need to be aware of some common problems patients may experience when managing their ACE/Chait tube.

From personal experience these are some of the problems I have encountered when teaching chait irrigation to patients under my care.

PROBLEM	DESCRIPTION	RESOLUTION
Skin around the opening is red, swollen or sore	Skin around the opening is red, swollen or sore	• If the skin is red, clean the area more often, cover the site with a dry dressing, change the dressing often. • If severe, refer to GP for antibiotics.
A buildup of skin around the opening that is shiny, thick and bumpy	Granulation tissue, this is a normal body function in relation to a foreign body	• Continue with daily skin care, STN may need to apply silver nitrate to the area
Constipation	Some medications can cause constipation	• STN to be aware of what medications cause constipation
	Patient is not getting enough oral fluids and fibre	• Advise patient to drink plenty of water and eat foods high in fibre such as whole grain bread, cereals, fruit and vegetables
Leaking around the chait/ trapdoor	Leaking can irritate the skin and cause pain and discomfort	• Check the tube is securely in place at skin level • Continue with skin care and keep area as dry as possible, trial crusting technique if skin is severe • Check amount of water being used for irrigation, too much may result in backflow • Trial the use of a stoma cap to contain excess fluids
Water not going easily into Chait	Water is leaking out and not flowing into the chait	• Check patient position on toilet, ensure sitting upright • The tip of the chait may be blocked, trial using syringe tip catheter with 20mls water to flush to dislodge any foreign matter
Chait tube becomes dislodged	Tube has come out	• Cover the hole with a clean dry gauze • Place a small catheter into the opening to keep open • STN to contact surgeon for re-insertion
Chait trap door becomes cracked	Chait tube lid is unable to close or becomes split or cracked	• Chait tubes are replaced every 12 months, if trapdoor is split or cracked, contact surgeon for replacement of tube

(Continues next page)

PROBLEM	DESCRIPTION	RESOLUTION
Cramps when administering irrigation fluid	Abdomen feels crampy and uncomfortable	• Ensure water temperature is tepid, if too cold will cause abdominal cramps, if too hot will burn the colon • Check speed of water being instilled, if too fast can also cause abdominal cramps
How much water do I use to irrigate?	Amount of water being used for irrigation	• This varies for each person, initially STNs should start with 800mls and increase to a total of 1200mls – keep in mind each person is different
I've misplaced my ACE adaptor	Unable to irrigate due to no adaptor	• STN to contact surgeon or outpatient clinic to obtain new adaptor
Chait irrigation is not working for me	Water is not going in easily, too much back flow, spending too much time on the toilet	• In some instances, the chait trap door can be removed and the patient can be taught how to irrigate directly into the hole with a small in/out catheter and then covered with a small dry dressing • The hole will need to be accessed each day with the catheter to avoid it closing over and an ACE stopper placed between irrigations
My chait was removed and my opening is closing over	Unable to get catheter into the opening	• The bodies instinct is to try and heal the opening, the STN should ensure the patient has an ACE stopper (small plastic bung) which should be inserted into the hole to prevent closing over

CONCLUSION

Irrigating the bowel regularly with antegrade continence enemas via a chait will significantly improve a patient's lifestyle who experience fecal incontinence, loss of anal control and severe constipation. The ACE procedure is a minimally invasive surgical procedure that can have a positive outcome enabling patients to become more confident, active and independent and is an alternate to having a colostomy.

As practicing stomal therapists our roles can be complex and as a result we need to adopt many different roles including excellent knowledge and understanding relating to all aspects of bowel management and alternate therapies. This article has enabled the writer to research and share information relating to MACE, ACE and the chait.

Hope you have found it useful 😊

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Insides Out: Using the Insides System Chyme Reinfusion Pump

CHRISTINA CAMERON, STOMAL/CONTINENCE CLINICAL NURSE SPECIALIST
WAIRARAPA DISTRICT HEALTH BOARD

Permission granted from the patient prior to writing this article. Patients name has been changed to Kay to protect the patients identity.

Kay was initially diagnosed with adenocarcinoma of the rectum. Prior to surgery Kay had neoadjavent radiotherapy for six weeks to shrink the tumour.

She then underwent an anterior resection with formation of ileostomy. Kay had a long post-operative recovery and was unfortunate to have wound dehiscence requiring a VAC dressing for a number of weeks.

Kay adjusted to her ileostomy well and soon became independent with her stoma cares.

Post-surgery Kay had chemotherapy for six cycles. Kay tolerated both treatments extremely well and once finished was placed on the waiting list for ileostomy reversal.

Kay proceeded to her next surgery being the reversal of the ileostomy. Post-operative recovery was once again prolonged and 10 days after the surgery Kay developed an obstruction due to a stricture leading to another ileostomy being formed.

Once again Kay went for another reversal of her ileostomy. Initial recovery was good and Kay was discharged after 10 days. Four days later Kay presented to the emergency department with faecal matter coming through her vagina. After some discussion with consultants it's was decided that Kay had developed a rectovaginal fistula (probable cause from radiotherapy) and once again Kay had another ileostomy formed.

Kay then went on to having lipofilling of the peritoneal bullae and closing of the anal fistula.

(Please note that all these procedures have happened over approximately 3 years.)

After the fistula repair Kay was very keen to try again in having her ileostomy reversed.

The decision was made to trial The Insides System medical device.

THE INSIDES SYSTEM

This system is used to reinfuse chyme into the intestine for enterostomy and enterocutaneous fistula patients.

Reinfusing chyme has clinical benefits of improving nutritional status, preventing dehydration in high output ileostomies and also allowing the bowel to prepare for ileostomy reversal especially after a rectovaginal fistula repair, or a lengthened time before an ileostomy has been reversed.

Training site can be accessed through www.insidescompany.com (used with permission from The Insides Company)

HOW THE INSIDE SYSTEM WORKS.

1. The tube is inserted into the distal lumen of the loop ileostomy
2. The insides pump is attached to the end of the tube and placed inside the drainable bag
3. The Insides Driver machine is coupled to the pump when it's required
4. The Insides Driver assists the pump to draw up the chyme out of the stoma bag and reinfuse this down the distal lumen.

Kay was first approached by the consultant to see if she would like to trial this system and Kay whole heartedly agreed.

Ileostomy appliances used were Hollister 13403 flange, Hollister 18013 drainable high output bag and Hollister belt 7300.

Initially the Insides Tube was placed in the distal lumen by the consultant.

Kay then pumped the chyme once a day for a couple of days and then started to increase this procedure until she was pumping each time the ileostomy bag was half full. This was done over a period of weeks. Occasionally Kay got some abdominal discomfort but this reduced quickly. There was much excitement from Kay when she had her first liquid soft bowel action approximately 8 hours after the first reinfusion procedure. With fingers and toes crossed each day Kay checked that she had no faecal discharge from the vagina, and none came. The fistula repair had proved successful, Kay was elated!

One of the problems that Kay experienced was trying to keep her ileostomy output thin in consistency. If too thick the pump was

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WAIRARAPA DISTRICT HEALTH BOARD

unable to be used effectively. The pump lasted between two to three days so was changed at each bag change.

After a number of weeks using the Insides System, Kay had her ileostomy reversed. This time the reversal was successful, no obstructions and no fistula leakage. Kay is now back to living a normal life.

Without the Insides System we may never have reached this great outcome for Kay.

I am now about to start my third patient on it.
The system is easy to use for patients.

Helping change the pump for some patients may be necessary. There is also incredible back up from The Insides Company especially from Emma Ludlow who is so knowledgeable.

Just of note, if changing the bag and pump for your patient, just make sure they haven't just used the pump prior to your visit, let's just say it leads to some undesirable stuff coming out under a bit of pressure. A sense of humor from both parties was very helpful!

SPECIAL ACKNOWLEDGEMENTS

Emma Ludlow for The Insides Company. Great knowledge and always available.

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Could it be a life changer? The use of a two-piece ostomy pouching system in paediatrics

EMILY COUNSELL, COMMUNITY CHILDREN'S NURSE
WAITEMATA DISTRICT HEALTH BOARD

INTRODUCTION

The excitement and expectations of new parenthood can be quickly crushed when a newborn is diagnosed with a life-threatening condition which requires immediate surgery.

This case study will follow the journey of Rhys and his parents Jasmine and Michael after he was diagnosed with Mosaic Down's syndrome and Hirschsprung's disease.

In the hope that their experience may help others, Rhys's parents have consented to the sharing of their story. At their request, pseudonyms have not been used in this case study.

MOSAIC DOWN'S SYNDROME AND HIRSCHSPRUNG'S DISEASE

Down's Syndrome is due to either extra genetic material or even a third copy of the chromosome 21 complex. It is the second most common human chromosomal disorder [1] A wide variance in the characteristics of Down's syndrome presentation makes each child, born with this condition, totally unique. [1]

Commonalities which can present included:

- The posterior of the head is flat in line with the neck
- A flat nasal bridge
- Epicanthal folds (a fold of skin in the inside corner of the eye)
- Almond shaped eyes
- A protruding tongue
- A single crease across one or both palms
- Short fingers with a single flexion on the fifth finger (two knuckles instead of three)
- Short toes and a large space between the first and second toes
- Short stature [2]

The life expectancy and social achievements of those born with Down's syndrome have risen significantly over the last two decades. [3] By 2002 the life expectancy of a child born with Down's syndrome in Australia was 60 years. [3]

Mosaic Down's syndrome is diagnosed when there is a mixture of two different types of cell structures. Some cells will have the usual 46 chromosomes, and some will have 47. Children born with a mosaic mix of cells, some with 46 chromosomes and some with 47, can demonstrate fewer characteristics of Down's syndrome. [4]

Approximately 5% of those born with Down's syndrome will have an associated digestive malformation. [1]

The most common digestive malformations associated with Down's syndrome are imperforate anus 3% and Hirschsprung's disease 1%. [1]

Hirschsprung's (HD) disease is characterised by the absence of parasympathetic ganglia in the distal bowel resulting in intestinal obstruction due to lack of motility. [5]

More than a third of infants born with HD will require a stoma prior to definitive surgical resection. [5]

WHO IS RHYS?

Rhys is Jasmine and Michael's 1st child. He was born at full term via a caesarean section. At two days of age, Rhys developed abdominal distension and bilious vomiting. An abdominal x-ray confirmed dilated loops of bowel indicating an obstruction. Following bowel biopsies, a diagnosis of Hirschsprung's disease was confirmed.

Within two weeks of birth, Rhys was also diagnosed with Mosaic Down's syndrome.

For Rhys's parents, who had no antenatal awareness of his conditions, the shock and anxiety must have felt overwhelming. Their expectations of new parenthood had been dramatically changed.

Rhys, lives with his parents and his 1-year-old brother Kyle. Jasmine is the family's principal income earner while Michael is primarily responsible for childcare.

PMHX

- At 10 days of age Rhys underwent a sigmoid colectomy with formation of an end colostomy
- At 9 months of age, he had a Soava procedure (see fig 1.) with reversal of colostomy. Following this procedure, he experienced abdominal pain and pain on defecation. He returned to surgery for formation of an end ileostomy with a mucous fistula.
- In 2020 a second attempt at reversal of ileostomy with parastomal hernia repair rapidly led to a return of rectal pain and re-formation of a new ileostomy, Rhys's third stoma.

Jasmine and Michael had sourced international review of Rhys future surgical options. There are provisional plans for surgery in the USA or Australia however due to Covid 19, these are on hold. If any future surgery does not achieve the desired outcome they will wait until Rhys is old enough to articulate his preference either for or against further surgical intervention.

Could it be a life changer? The use of a two-piece ostomy pouching system in paediatrics

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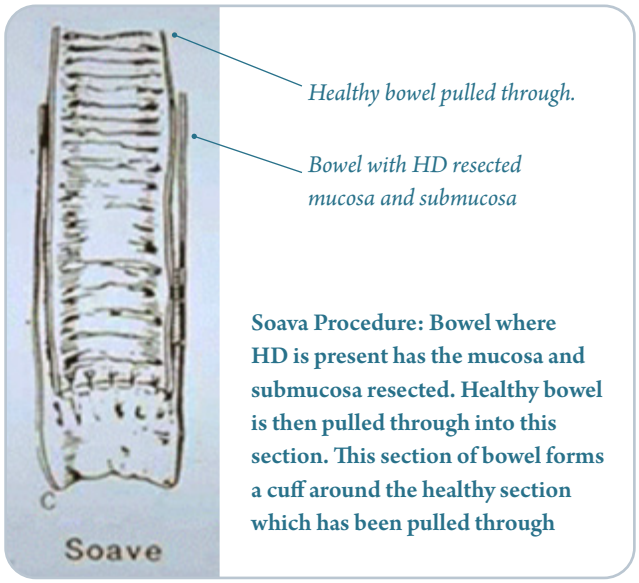

Figure 1 - Soava Procedure

STOMA ASSESSMENT

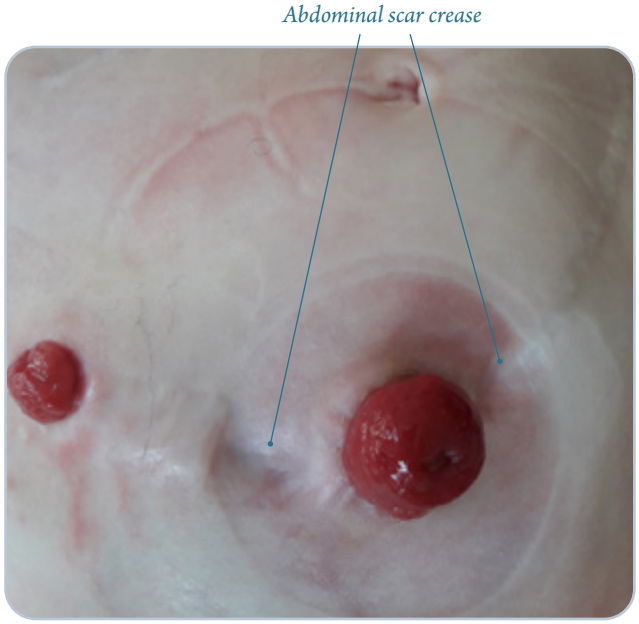

Figure 2 - End ileostomy and mucous fistula show scaring and abdominal creases.

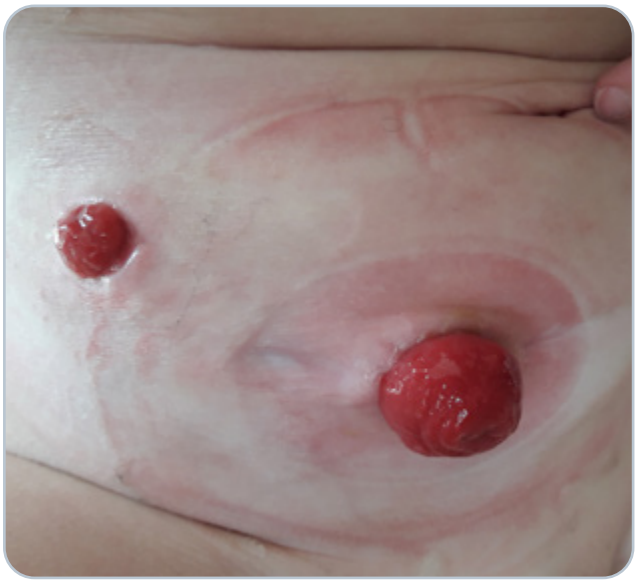

Figure 3 - Rhys in the sitting position, skin slight red immediately after pouch removal.

- Skin: Due to the incredible care from his parents and despite multiple leaks Rhys's skin was intact at this first review
- Abdominal Contours: Rhys has the expected child abdominal shape with a narrow, rounded contour.
- Parastomal contours: In the sitting position, Rhys has a surgical scar crease at the 3 o'clock position directed towards his umbilicus, and another in the 9 o'clock position directed towards the mucous fistula
- Mucocutaneous junction: intact
- Output: normal consistency and volume

THE ISSUE

Through-out Rhys's complex stoma journey there has been a plethora of issues in sourcing a pouching system which would meet his needs. While an acceptable pouch wear time in paediatrics is shorter than for adults, Rhys's parents have trialled five to six different pouching systems with various accessorises however, none have achieved an acceptable wear time. At worse, they were changing the pouch up to six times per day. The stress caused by leaks, constant pouch changes, product reactions, the constant need to check the pouch for leaks, the

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variable deteriorating condition of Rhys's skin, and his increasing reluctance to participate in painful pouch changes have been very challenging for the family. The social isolation that resulted from the constant need to address Rhys's needs was testing on Jasmine and Michael's resilience.

Having trialled nearly all paediatric pouch ranges and with Rhys now outgrowing most of these, options were becoming limited. I reached out to Omnigon's Territory Manager and we agreed to do a community visit and assessment.

THE SOLUTION

Objective:

To achieve an acceptable pouch wear time (at least 24 hrs.) which would allow this family social engagement and relief from constant pouch care.

PRODUCT SELECTION AND RATIONALE

Welland Adhesive Remover Wipes

Rationale:

The fragile nature of children's skin and their well-conditioned pain response to pouch changes has made remover wipes mandatory in my paediatric practice. The Welland Adhesive Remover wipes reduce trauma, pain (no alcohol), skin stripping and the damage which can be caused by pouch changes. Because the product does not need to be washed off and will not reduce the adhesion of a new pouch, it extended the opportunity to complete a pouch change before Rhys's abdomen became a moving target vanishing off at speed.

Welland Hyperseal Washer with Manuka Honey

Rationale:

The leak point was the deep crease at the 3 and 9 o'clock which only became apparent when Rhys was in the sitting position. Although Rhys's skin at our first review was intact, he had a long history of eroded skin issues. The Welland Hyperseal with Manuka Honey was introduced to fill the crease and potentially prevent recurrence of the skin damage.

Eakin Dot Two Piece Baseplate and Pouch

Rationale:

The Eakin Dot 2-piece skin smart technology has achieved predictable, secure, and extended wear times in adults, all of which we hoped to achieve for Rhys. This was my first use of the product on a child.

The Eakin Dots hydrocolloid baseplate has a foam backing which is soft and flexible aiding in moulding to the abdominal contours. This was the feature that we needed to conform to Rhys's creased abdominal surface. It was also likely to increase his wearing comfort. The fluted edges of the baseplate allowed it to mould over the narrow-rounded body shape of a child.

We also needed a product that would stand up to everything that an active two-year-old could throw at it. We expected that Rhys would explore and challenge the coupling mechanism. The coupling mechanism on the Eakin Dot proved resilient to withstanding these challenges.

Removal of the Eakin Dot did not leave hydrocolloid residue on Rhys skin which facilitated faster pouch clean ups when changing.

The oval shape of the Eakin Dot baseplate allows the baseplate to be turned having the longer axis either vertically or horizontally depending on the shape of the abdomen. This gave us more options to custom fit the baseplate to Rhys abdominal shape.

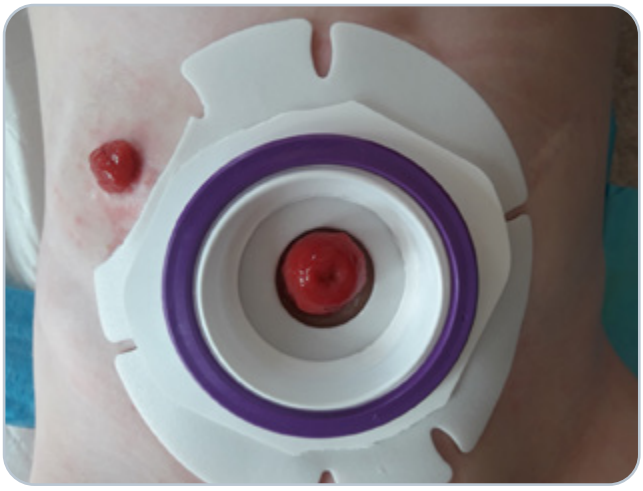

Figure 4 - Rhys with Eakin Dot adapted to accommodate the mucous fistula and not rub on his thigh when sitting. Fluted baseplate edges have moulded over rounded belly.

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THE OUTCOME

Our initial goal of achieving a 24-hour wear time for Rhys has been exceeded with the Eakin Dot two piece. He now has an achievable wear time of three days. The impact of this has been far reaching.

Rhys is now three years old and has been using the Eakin Dot two piece for a year. Rhys attends kindy with his younger brother four days a week. While slightly delayed in achieving some milestones, Rhys is doing exceptionally well at kindy. He is sociable, keen to participate in all activities and to explore his world. Attending kindy had not been possible prior to the use of Eakin Dot. Overall, the use of Eakin Dot has allowed this family to lead a more normal life and to socialise outside their home.

CONCLUSION

From my experience in caring for Rhys and his family, I take forward validation of my existing practice, new knowledge and practice, and a deeper awareness of the psychological impact that repeated appliance failures can have on a patient and their family. In sharing the impact that these failures had on their ability to cope, socially, psychologically, and emotionally, Jasmine and Michael have made me more aware of how critical the right pouch at the right time is. For them this was the Eakin Dot two piece.

Since using the Eakin Dot with Rhys, I have successfully replicated its use with other paediatric patients. I now have the confidence to explore beyond the obvious choices in product selection and employ the wider network of ostomy specialists to help create better patient outcomes.

It has been a privilege to be involved in Rhys's care. I remain in awe of his parents, Jasmine and Michael, and thank them for allowing me to share their experience so health professionals can learn and improve practice.

The final words belong to Rhys parents "Love the bag the only bag truly had success with".

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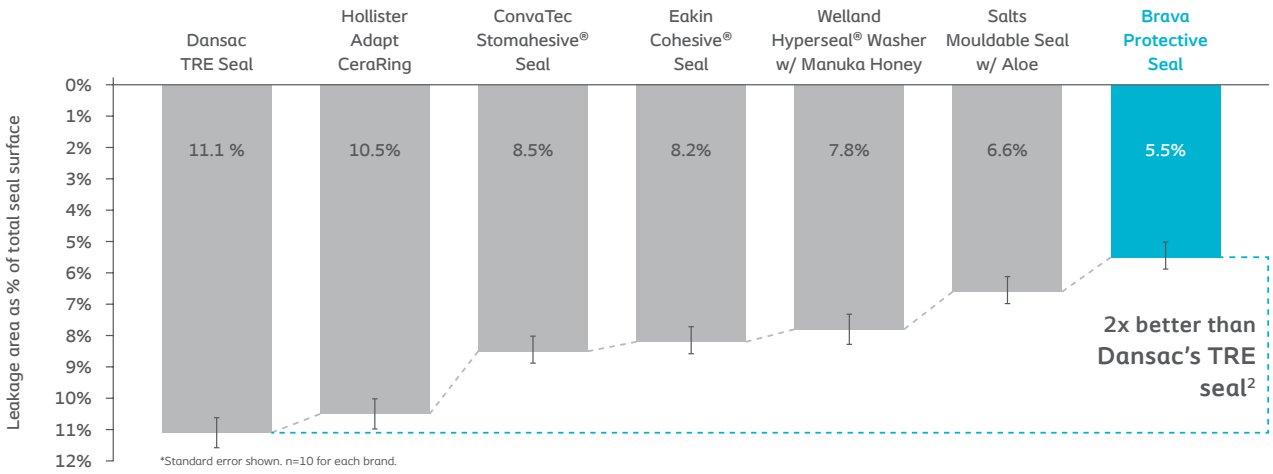

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- The NZNOCSTN Executive Committee will consult and award the BHA within one month of the closing date
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- All applicants will be notified of the outcome, in writing, within one month of the closing date
- The monetary amount of the award will be decided by the NZNOCSTN Executive Committee. The amount will be dependent on the number of successful applicants each year and the financial status of the BHA fund
- The name of the successful applicants(s) will be published in the NZNOCSTN Journal The Outlet
- The BHA Policy will be reviewed annually by the NZNOCSTN Executive Committee.

Criteria

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

Feedback

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

and/or

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

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

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

APPLICATIONS CLOSE 30TH NOVEMBER (annually)

SEND APPLICATION TO:

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

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

_____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership ◯ FULL ◯ LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

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

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

_____

_____

EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ _____

Transport: $ _____

Accommodation: $ _____

Other: $ _____

Funding granted/Sourced from other Organisations

Organisation:

_____ $ _____

_____ $ _____

_____ $ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

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

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

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

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

Signed: _____ Date: _____

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

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[1]Maria Teresa Szewczyk, MD, PhD; Grazyna Majewska, RN, ETN; Mary V. Cabral, MS, FNP-BC, CWOCN-AP; and Karin Holzel-Piontek, RN; The Effects of Using a Moldable Skin Barrier on Peristomal Skin Condition in Persons with an Ostomy: Results of a Prospective, Observational, Multinational Study, Ostomy Wound Management 2014;60(12):16–26.

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The Outlet

New Zealand Stomal Therapy Nurses