



# The Outlet

*New Zealand Stomal Therapy Nurses*

## **In this issue:**

- **Introduction profile and roles of new committee**
- **Enterocutaneous Fistula Management**

MARCH 2013



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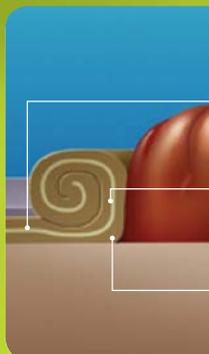


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<sup>1</sup> Scott V, Raasch D, Kennedy G, Heise C. Prospective assessment and classification of stoma related skin disorders. Poster presented at: 41st Annual Wound Ostomy and Continence Nurses Society Conference; June 6-10, 2009; Orlando, Florida.

<sup>2</sup> Hoeflok J, Guy D, Allen S, St-Cry D. A prospective multicenter evaluation of a moldable stoma skin barrier. *Ostomy Wound Manage.* 2009;55(5):62-69.

\* U.S. Patent No. 6,840,924 B2

# The Outlet

*New Zealand Stomal Therapy Nurses*

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**39TH AUSTRALIAN ASSOCIATION OF STOMAL THERAPY NURSES (AASN) CONFERENCE**  
20th-22nd March 2013, Hotel Grand Chancellor, Hobart, Australia

**NZNO CANCER NURSES SECTION: ONCOLOGY/HAEMATOLOGY CONFERENCE**  
21st - 23rd March 2013, Dunedin, New Zealand

**NZNO WOMENS HEALTH SECTION CONFERENCE**  
**LIFE, FULL CIRCLE: A WOMEN'S JOURNEY**  
18th - 20th April 2013, Wellington, New Zealand

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# Our Committee

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Stomal Therapy Section.

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## Chairperson's Report

Hello and welcome to our first edition of *The Outlet* for 2013. Thank you to the outgoing committee for all their professional input into the NZNOSTS over the last few years. Thank you too for what has been reported as an enjoyable conference held in Wellington. Conferences always involve considerable time, planning and a team effort, so again thank you.

As we all know the only sure thing is change and the outgoing committee have kept up with these changes over their time to help insure the NZNOSTS is current for our membership. There is a sub-committee assisting with the change process for the NZNOSTS to become a College in the near future which is very exciting.

The AGM was held in November 2012 and saw a new committee voted in and so there has been a change in people on board for the NZNOSTS committee and I am looking forward to working with the newly elected team. I would like to extend our thanks to Nicky Bates who has agreed to stay on the committee for another term in the role as treasurer. The rest of us will benefit from her current knowledge of committee business.

We held a teleconference call as the new committee in late November, with the various committee positions being filled as you will see in this edition of the Journal. We also discussed the annual plan and the Bernadette Hart Award. Two successful applicants received funding toward their goals.

By the time you receive this Journal we will have not long attended our first face to face meeting with a fairly full agenda, and we will provide updates in forthcoming editions of *The Outlet*.

Remember this is your journal as members, and we are keen to have your input.

Enjoy the read, and we look forward to a rewarding 2013.

Maree O'Connor.



**MAREE O'CONNOR**  
*Chairperson NZNOSTS*

## Introduction profile and roles of new committee

### MAREE O'CONNOR

*Chairperson NZNOSTS*



Hi, I am Maree O'Connor and I work as a Clinical Nurse Specialist for Stomaltherapy and Colorectal in the Southern DHB (Otago).

My Stomaltherapy practice includes all aspects of Stomaltherapy nursing; pre-operative education and siting of patients, in-patient education and care, advice for those with fistulae, community patients, rural clinics, outpatients, product provision and we work with people across the lifespan (birth to the very elderly) and so on.

I am a NZRGON (1986) and completed my Stomaltherapy education way back in 1990-1991, since then I have completed my

Bachelor of Nursing, and Post-Graduate Diploma in Professional Nursing Practice.

I have served on the NZNOSTS committee several times in the past and have always found it interesting and varied and a good way to network with other nurses with the same interests from around the country.

I am married with four children; we have a black lab who we all adore.

I enjoy reading, mosaic/beading craft and keeping in touch with my family and friends.

After many years in Stomaltherapy nursing I am now expanding my role to encompass colo-rectal which I find makes a great duality as they are closely aligned and my knowledge dovetails very well across the two roles.

I look forward to again working on the committee and hope to bring my passion and commitment to the position of Chair.

---

### LORRAINE ANDREWS

*Position on the Executive Committee: Co-editor The Outlet*



I currently practise as a Colorectal Nurse Specialist with in Counties Manukau DHB.

This is a position that I have held since 2000. Prior to taking up this position I was a Charge Nurse, then Unit Manager in various Auckland hospitals on both surgical and medical wards.

In 1999 motivated by the desire to return to clinical practise and re-connect with the patients I completed the Post Graduate Certificate in Stomal Therapy Nursing through the New South Wales College of Nursing.

While I predominantly work in South Auckland's hospitals I have also under taken two periods of community practise.

I currently support two adolescent daughters and two cats.

I strongly believe that, as a vehicle for governance the NZNOSTS should be recognised as representative of and inclusive of its membership. Thanks you to those members who voted me on to the Executive Committee, I hope that I can live up to the position and met your expectations.

## Introduction profile and roles of new committee

### MAREE MCKEE

*Committee Member and Co-editor of the Outlet*



Hi, thank you to all who voted me to the position of committee member for the NZNOSTN section.

I have been a Stomal therapist for the last 20 years and have worked in both the acute setting and community service during my career. In 1992 I was privileged to set up the Stomal therapy service at Auckland hospital (acute service) then in later years moved into the community taking over from a long time Stomal therapist when she retired. My move to Counties Manukau

Home health care was in 2005 in which I job shared with a colleague then took on full time specialist for the community later that year. I now work part time, job sharing with another Stomal therapist solely community focused. I have been a committee member / Secretary for the section in the mid 1990s which I enjoyed, getting to see a different perspective on the role of the section; I believe that it is something all of us as Stomal therapist should undertake some time in our career.

My passion is Stomal therapy, predominantly stoma care, fistula management and wounds. Being part of the section committee and co editor of the Outlet for me is a way to promote the excellent work we all do as Stomal therapist throughout New Zealand.

---

### GINNIE KEVEY-MELVILLE

*Committee Member*



Kia ora from beautiful Northland. My position is Clinical Nurse Specialist Stomal Therapy/ District Nurse.

I have three roles within my position  
- stomal therapy, continence and district nursing.

I work four days a week, and practice stomal therapy two days and district nursing two days. The stomal therapy role involves caring for clients and whanau in the hospital and community setting Northland wide. Our stomal therapy team consists of

three nurses who are passionate about stomal therapy, and ensuring clients receive comprehensive assessment, education and holistic care.

In 1995 I commenced district nursing for Northland Health in Whangarei. I met the Stomal Therapy Nurse, Marie Oldridge, who became, and still is my mentor. In 2001 I completed the Certificate in Stomal Therapy at Waiariki Institute of Technology. This was the last stomal therapy course to be run in New Zealand.

I have continued to complete and update my Clinical Career / Professional Development Recognition Programme portfolio [Expert Level] every three years. I am enrolled at The University of Auckland this year and begin my Post Graduate Certificate in Health Sciences. I am looking forward to the challenges, exciting learning opportunities and team work involved in being on the NZNOST committee.

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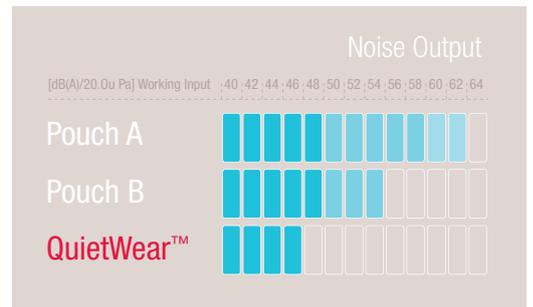
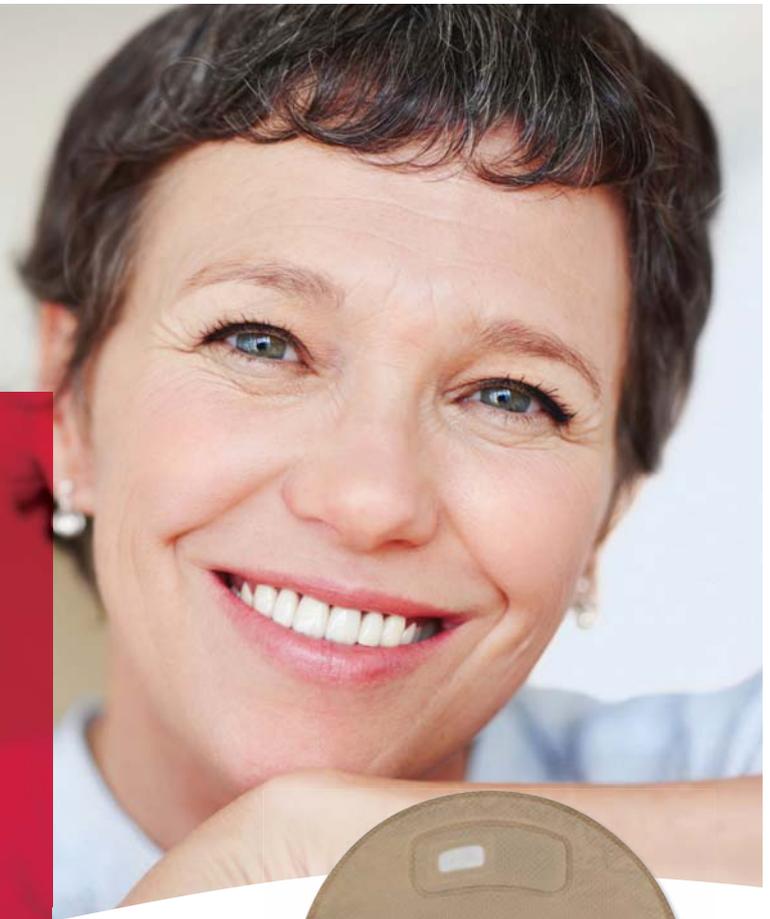
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## Bernadette Hart Award

Bernadette Therese McTigue (known as Tiggy) was born in Southland on 12th October 1933. Before marrying Bernadette completed her General and Obstetric training at the Southland School of Nursing. With a passion for surgical nursing Bernadette worked in Southland hospitals surgical wards from 1958 to the mid 1960's when she left to complete her maternity training at Timaru Hospital. The following year in 1965 she completed the post graduate Diploma of Nursing in Wellington.

On returning to Southland, Bernadette was appointed ward sister to men's surgical (ward 9) a position that she held until her death in 1985.

Bernadette was a foundation member of the inaugural Enterostomal Therapy Committee becoming treasurer when the National committee was formed.

Although Bernadette was sponsored by the Southland District Health Board to attend the first Enterostomal Therapy course run in New Zealand in October 1984 ill health prevented her attending. Diagnosed with a terminal illness, Bernadette chose to be cared for at home by her family. She died aged 52 years and is buried over looking the sea in Green Point Cemetery in Bluff. Bernadette was an outstanding nurse who had a passion for surgical patients, their care and the education of the nurses who cared for them.

Always an inspiration to others, Bernadette established the Bernadette Hart Award to assist the education of New Zealand Stomal Therapist. Nearly sixty years later Bernadette's generosity continues to assist us to follow her dream.

## Bernadette Hart Award Recipient's 2012

**Jackie Hutching**, stomal therapist in Southland has been awarded \$1000 from the Bernadette Hart Fund to assist her in attending the AASTN conference in Hobart this year. Jackie has diligently and conscientiously served the stomal therapy community over several years with her work on the executive committee.

**Leeann Thom**, from Dunedin has been awarded \$500 from the Bernadette Hart Fund to facilitate completion of the Post Graduate Certificate of Stomal Therapy. Good thanks with your studies Leeann.

**Application for the Bernadette Hart Fund 2014 will close in November 2013.**

From this...to this, in 8 weeks\*



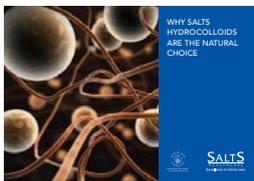
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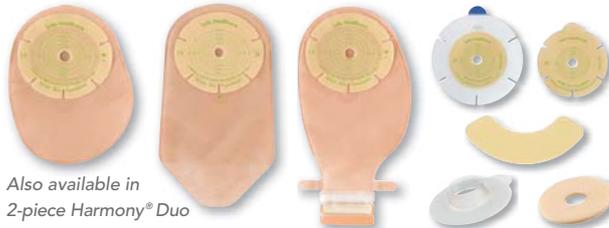
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# Fathoming Fistula

LORRAINE ANDREWS

Colorectal Nurse Specialist, Counties Manuka District Health Board, South Auckland



Despite advances in nutritional support, improved peri-operative care and wider choice of containment appliances the development of an enterocutaneous fistula (ECF) still represents a major therapeutic challenge with significant morbidity and mortality. With prolonged hospitalisation, a long recovery and rehabilitation periods, many patients with ECFs will suffer significant psychological morbidity.

Establishing best practice for the nursing care of patients with ECFs is challenging as the area is poorly researched (Burch 2003, Thompson, M. & Epanomeritakis, E. 2008). This article will describe the etiology and classification of ECF before examining treatment strategies.

Lloyd, D. & Gabes. & Windsor, A. (2006) defined an enterocutaneous fistula as an abnormal communication between the gastro intestinal tract and the skin.

15-25% of ECFs will occur spontaneously and have an etiology associated with conditions such as inflammatory bowel disease, malignancy, diverticulitis, or radiation enteritis. (Evenson & Fischer 2006, Lloyd et al 2006).

The remaining 75-85% of ECFs have a surgical origin and are associated with trauma, iatrogenic enterotomy, anastomotic failure, abdominal wound dehiscence, or mesh erosion of the bowel. (Evenson & Fischer 2006, Lloyd et al 2006).

Periods of post operative hypotension, the presences of malnutrition and the use of steroids pre surgery are likely to contribute to the development of an ECF.

There is no universal accepted classification of ECFs.

Reed, Economon & Wierseman-Bryant 2006, classified ECFs depending on output. (See table 1)

High output >500mL
Moderate output 200-500mL
Low output <200mL

Table 1

ECFs with a low output are three times more likely than those with a high output to achieve a spontaneous closure. (Slade and Scott 2005),

Burch (2004) classified ECFs based on the anatomy of the tract. (See table 2)

Simple	Single tract exiting to skin
Multiple	Multiple tracts exiting to skin
Complex	Complete disruption of bowel

Table 2

ECF's which are single tract generally have a less complicated treatment pathway.

ECFs can be classified as acute, which are under 30 days duration or chronic if they have been present for longer than 30 days. Acute ECFs are more likely to achieve spontaneous closure.

Several studies ranging over a period of 44 years document a fall in the mortality from ECFs from between 43-65% in the 1960s down to 6.5-20% in 2004. (Edmund et al 1960, Foster & Lefor 1996, Hollington, P, Maudsley, J, Lim, W, Gabe, S, Forbes, A, Winsdor, A. 2004). Advances in the radiological drainage of abdominal sepsis and the development of parenteral nutrition are likely to have made a significant contribution to a decrease in mortality from ECF's.

Dowsett (2009) argued that assessment is an area of practice which is often carried out poorly or at best, is done sporadically. The choice of treatment pathway and containment system to manage an ECF relies heavily on regular expert assessment of a constantly changing clinical picture.

The acronym SNAP assists with ECF assessment. (See table 3)

<b>SNAP</b>
Drain Sepsis
Protect Skin
Nutrition and Fluid Resuscitation
Define Fistula Anatomy
Plan either a surgical procedure or spontaneous closure

Table 3

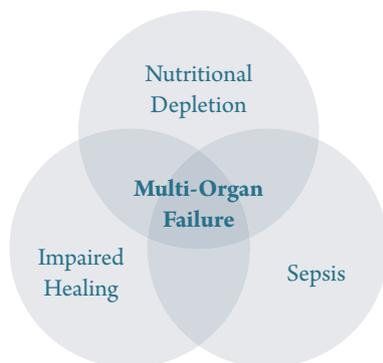
# Fathoming Fistula ...continued

LORRAINE ANDREWS

Colorectal Nurse Specialist, Counties Manuka District Health Board, South Auckland

## Sepsis NAP

While there are multiple factors to be considered in predicting outcomes for patients with ECFs, abdominal sepsis is the number one cause of mortality. Lloyd (2006), & Kaushai & Carlson et al (2012) maintain that achieving control of abdominal sepsis is the single most important determinant in achieving successful management of an ECF. Failure to gain control of abdominal sepsis accounts for at least 80% of deaths in patients with ECFs (Kaushai & Carlson 2012) Poor nutrition, the presence of sepsis and impaired healing are causal factors leading to multi organ failure and mortality.



## S Nutrition AP

Malnutrition is easier to prevent than treat once established. Debate regarding the best route and method to provide nutrition to patients with ECFs is ongoing. Central to the debate is whether periods of bowel rest are adventitious or detrimental (Lloyd 2006) and if parenteral or enteral feeding is the method of choice.

Enteral feeding maintains integrity of the gut, is more easily achieved in the home environment and is more cost effective than parenteral nutrition. However, to be successful enteral feeding requires 75-100cms of fully functioning small bowel. Factors such as ileus, obstruction, insufficient length of bowel, high output and feed intolerance are unfavourable to successful enteral feeding.

Fistuloclysis, which is enteral feeding by infusing feed directly through the fistula is safer and less expensive than parental nutrition. It may be a viable alternative to parenteral feeding if naso / oral feeding route is not available.

Ham, M. Horton, K. Kaunitz, J. (2007) observed that gastrointestinal secretions reduced by 30-50% when parenteral nutrition was used. Any reduction in fistula output should assist with containment and may contribute to spontaneous closure.

However, parenteral nutrition is associated with an increased incidence of life threatening sepsis (Sicc, J. Burch, J. 2007). In an already compromised patient this could lead to mortality.

The body is generally extremely efficient at the process of digestion. The ileum transports 7-9 litres of fluid daily. 80% of that fluid has been reabsorbed before it reaches the colon. In ECFs if a significant length of small bowel is distal to the fistula and therefore redundant management of fluid and electrolyte balance and containment of output can be problematic.

Pharmaceutical agents such as octreotide assist with reducing fistula output and fluid loss. Octreotide reduces the volume of fluid in the gut by inhibiting the release of gastrin and other gastrointestinal secretions. Octreotide also relaxes the gut's smooth muscle which both increases the gut's length and its capacity. This allows greater re-absorption of fluids and electrolytes by slowing the transit time of the gut.

Anti-motility agents such as loperamide & codenine also slow transit time allowing greater re-absorption of fluid and electrolytes in the gut. (Lloyd, et al 2006)

## SN Anatomy P

Establishing the anatomy of the fistula via a radiological fistulogram provides information which is imperative to planning a treatment strategy. Information which is particularly pertinent is the length of the ECF, entry point in the gut, width of the fistula and the width of the deficit in the bowel wall.

## SNA Plan

### Spontaneous Closure

Only 20-40% of well selected ECFs will achieve a spontaneous closure.

Factors likely to diminish the likelihood of achieving spontaneous closure are:

- Origin of ECF was spontaneous
- The presence of obstruction distal to the fistula
- Presence of ongoing uncontrolled sepsis
- High volume output
- Fistula is complex

Spontaneous closure is likely to occur after a 4-6 week hospital admission.

# Fathoming Fistula *...continued*

LORRAINE ANDREWS

Colorectal Nurse Specialist, Counties Manuka District Health Board, South Auckland

## Surgical Closure

Surgical closure of an ECF is also likely to require a prolonged hospital admission. Once the patient's condition has been stabilised there is likely to be a prolonged period waiting either for the abdomen to become a less hostile environment for surgery or for a major abdominal wall deficit to heal allowing primary closure. Ideally the optimal time for surgical closure of an ECF will be 3-6 months after the last surgical procedure.

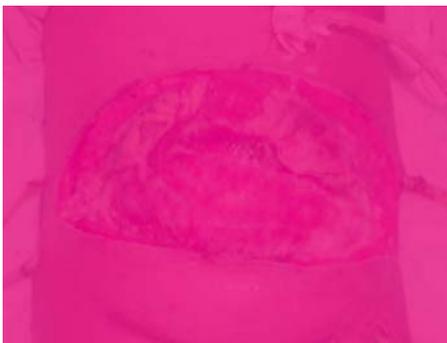
## ECF Management

The management of ECFs is not traditional pouching verses negative pressure wound devices. Both have a place in the management of ECFs and could be utilised in the journey of any individual ECF.

## POUCHING

### Case Study

29 year old male post pancreatectomy for necrotising pancreatitis who developed a high output duodenal fistula.



1. Wound immediately post surgery



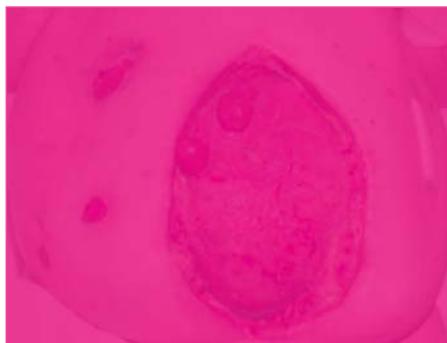
2. Wound pouched with two large Eakan wound pouches



3. 44 days after admission on day of discharge

## SEGREGATION

Segregation utilises the advantages of a negative pressure wound device to achieve wound healing while segregating the fistula to drain into a pouch.



1. 75 year old male with ulcerative colitis and complex multi tract ECF



2. Negative pressure wound deficit in place with fistula exposed to drain into pouch

# Fathoming Fistula ...continued

LORRAINE ANDREWS

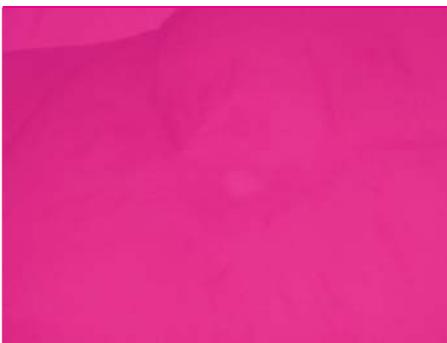
Colorectal Nurse Specialist, Counties Manuka District Health Board, South Auckland



3. Discharged 219 days after admission post surgical closure

## STRANGULATION

**Aim is to close ECE using negative pressure wound device**



1. Dense open pore foam directly onto fistula outlet



2. Negative pressure wound deficit in place

Developing an ECF is a devastating experience. Recovery and rehabilitation aren't assured and may only be achieved after a prolonged period of institutionalization. These are often long admissions, with a painful continuum of care which disrupts

every facet of the patient's life. Very few patients with chronic ECFs or their families will get through this experience without requiring referral for supportive counselling. Anxiety, depression, dependency, loss of confidence, procedural pain, and issues related to poor body image are some of the issues that may develop. The rapport that can develop between the patient with an ECF, their family and the nursing staff who share the experience can be a deciding factor in the patient psychological health.

If the patient does not survive the experience of an ECF the impact on the nurses who shared the journey can be devastating. There may be a period of healing required to re-establish the emotional integrity of nurses who have shared such an experience.

The management of enterocutaneous fistulas continues to represent a major challenge for patient, family and health care professionals. There may well be a place in the future where we will see more and more patient's with ECF's nursed in the community.

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 **Coloplast**

# Enterocutaneous Fistula; wholistic assessment and care planning, the whole journey

MEGAN TOMKINS

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In order to develop a plan of care, the assessment of a patient with a wound must be holistic. A variety of systemic, etiologic and local factors need to be considered (Nix, 2007:130), in order to develop a plan of care.

Mrs T is a 40 year old woman admitted acutely to a surgical ward following transfer from a hospital in Samoa. She has an abdominal wound with an enterocutaneous fistula requiring assessment and care planning.

## HISTORY

In 1992, Mrs T had undergone a caesarean section. A short time later, a wound infection and incisional hernia developed. These were treated, the latter with an open mesh repair. In 1999, after returning to her native Samoa, Mrs T noted small lesions had developed in the hernia scar; these began to discharge purulent liquid and faecal material. For several years Mrs T had managed this with sanitary pads taped over the area. These required changing two or three times per day. Due to embarrassment and shame Mrs T had not sort medical assistance. The need to seek such assistance became unavoidable when she developed a large collection in the abdomen, and became systemically unwell. Mrs T was admitted to hospital in Samoa where she underwent a laparotomy, small bowel resection, removal of mesh, debridement of non viable tissue and muscle from the abdominal wall. With insufficient muscle and tissue to close the abdominal wall the wound was left open to close by secondary intention. Findings at surgery were of a small bowel fistula, secondary to erosion by the mesh. After three weeks of hospitalisation in Samoa with large volumes of liquid faecal material discharging from the wound, Mrs T's condition had stabilised and accompanied by her husband, she was transfer to New Zealand. On arrival the Consultant indicated to Mrs T that it would be several weeks before a surgical closure would be attempted.

The mechanism of Mrs T's injury was surgical trauma. Yamada et. al (cited in Pontieri-Lewis, 2005:68) describes the use of mesh for reconstruction of the abdominal wall as "...being associated with the development of GI (sic) fistulas, presumably because the mesh can attach to the adjacent bowel wall and cause erosion."

## SOCIAL

With Mrs T's consent, her husband remained present for the assessment. My experience of Samoan culture has given me an appreciation of the importance, to patients of family support and participation, whenever possible in care.

Financial circumstances for Mrs T and her family were stressed; however they had supportive extended family and a local church group. Their two eldest children were living independently. As is part of traditional Samoan custom, their third child had been cared for by extended family since birth. He was considered a nephew rather than their own child. A mobile phone kept them in regular contact with family in Samoa.

Mrs T vocalised feeling anxious about her treatment. She indicated that the past weeks had been very stressful. I reinforced the information given to her by the consultant; recovery would be a long process involving further surgery and an extended hospital stay. I provided support and encouragement and assured her that several patients in similar situations had had successful outcome.

## ASSESSMENT

Since her surgery in Samoa Mrs T had been on a liquid diet. Undigested, solid food would pass out the fistula. According to Mrs T she had not received any nutritional support since surgery. Intravenous fluids had only been in use for short periods and had stopped completely prior to her transfer to New Zealand. Mrs T had small infrequent rectal bowel motions.

Mrs T appeared to have generalised oedema in all extremities. Her lips and skin were dry and her urine was concentrated. Mrs T' was afebrile with stable vital signs however her systolic blood pressure remained between 88 and 95. Although able to mobilise she did so infrequently due to severe dizziness.

Blood results on admission revealed significantly elevated urea, creatinine, phosphate and urate. Also evident were lowered folate levels, anaemia and a low albumin.

# Enterocutaneous Fistula; wholistic assessment and care planning, the whole journey ...continued

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## WOUND ASSESSMENT

On assessment there was a large volume of exudate from the wound. The dressing pads were heavy with thick, malodorous faecal material. Mrs T's fistula was high output with greater than 500ml in 24 hours (Doughty, Broadwell and Jackson, cited in Carville, 2005:30). The wound was an open cavity, measuring 70mm long, by 60mm across the distal edge and 30mm deep. The base of the wound consisted of approximately 90% bowel tissue, peristalsis was clearly visible. In the three corners of the wound there was bumpy granulating tissue as described by Carville (2005:14). There was no slough present. The epithelial wound edges curved into the open cavity, a demarcation line between the epithelial and the granulating tissue was not evident. The peri-fistula skin was denuded, with erythema close to the fistula extending approximately 40mm from the wound edges. The peri-fistula skin contours included several deep creases which ran horizontally from the three corners of the wound. The outlet of the fistula originated under the distal edge of the wound and was not visible. Mrs T's fistula was high output, sub atmospheric with what appeared to be one tract. A CT scan was planned to confirm the length, location and extent of the bowel wall deficit of Mrs T's fistula.



The functions of the skin are summarised by Caville (2005:12) as to: protect from trauma and pathogen invasion, to prevent dehydration, for communication and sensation, for thermoregulation; metabolic synthesis of melanin, keratin and vitamin D; and for cosmetic and body image functions.

Mrs T's abdomen showed marked variation from the normal anatomy and physiology of skin. As a result of the full

thickness skin loss, which included the underlying structures and muscle, Mrs T was now vulnerable to mechanical and thermal trauma to the exposed bowel and the wound edges. Exposure to faecal material will cause further trauma to the wound edges and surrounding skin. The open wound represents a risk for pathogen invasion and sepsis. Prolonged high output and fluid loss from the fistula will lead to dehydration, electrolyte disturbance and renal failure (Carville,2005:131). Altered sensation had occurred due to tissue loss, and the chemical trauma caused by prolonged exposure to effluent. Thermoregulation by the remainder of the skin was adequate, as was the metabolic synthesis of melanin, keratin and vitamin D. The wound had a huge impact on Mrs T's body image. Her perception of herself, her interactions with others and her husband had all been effected by its presence. Odour and the threat of leakage were constant fears which negatively impacted on Mrs T's quality of life.

Ideally, a full thickness wound heals by secondary intention by undergoing a process of inflammation, followed by proliferation, and then maturation (Doughty and Sparks-Defriese, 2007:68) before healing is completed. The edges of Mrs T's wound were rolling down into the wound; this is known as epibole (Doughty and Sparks-Defriese,2007:68). Epibole is caused by premature keratinisation of the wound edges preventing migration of the epithelial cells across the wound.

Lloyd,Gabe and Windsor (2006;1046), maintain that spontaneous closure of an enterocutaneous fistula can be predicted by assessment of the following factors:

- etiology of fistula was surgical in origin
- free distal flow without obstruction
- healthy surround bowel
- a simple fistula without associated abscess formation
- a fistula tract >2cm
- a tract with no epithelialisation
- an enteral deficit of >1cm and with no bowel discontinuity
- low output
- no significant co-morbidities

# Enterocutaneous Fistula; wholistic assessment and care planning, the whole journey ...continued

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Mrs T was not a candidate for spontaneous closure. Factors which negatively impacted on Mrs T's wound healing were; anaemia, prolonged inadequate nutrition, dehydration, acute renal failure, hypotension, hypovolemia, oedema, stress, infection and sepsis.

Anaemia "reduces the supply of circulating red blood cells and thus oxygen carrying capacity of the blood to the wound" (Carville, 2005:40).

A number of essential nutrients have been identified by Lansdown (2004:1199) as needed for skin repair following injury these are:

- Protein
- Amino acids: proline, hydroxyproline, cysteine, methionine, tyrosine, lysine, arginine, and glycine
- Carbohydrates; glucose
- Lipids; linoleic and linolenic acids, arachidone acid, eicosanoids, fatty acids
- Vitamins: A, B complex, C, D, E, K
  - Minerals; sodium, potassium, copper, calcium, iron, magnesium, manganese, zinc, nickel, chromium
- Water

Mrs T's nutritional status was compromised due to an extended period of limited intake without supplementation. Fischar (cited in Lloyd, Gabe and Windsor, 2006;10490) states, 'significant loss of protein, electrolytes and fluids can occur with fistula effluent as a result of loss of small bowel secretions that would ordinarily be reabsorbed.'

Blood test results indicated Mrs T was in acute renal failure secondary to uncompensated fluid losses. This increased fluid retention resulting in oedema, electrolyte imbalance and increases catabolism of protein (Andres, 1998:80). Dehydration and acute renal failure increase uraemia causing hypovolemia and hypotension which are factors that will adversely affect tissue perfusion (Doughty and Spraks-Dfriesse, 2007:76). Hypovolemia and hypotension contributed to the dizziness that Mrs T was experiencing. An elevated blood urea level, "retards granulation of the wound" (Carville, 2005:41).

Mrs T had expressed increase anxiety and stress levels. Psychological stress has been shown to be detrimental in the healing process (Carville, 2005).

Chronic wounds are commonly colonised with multiple microbes. This creates an inactive biofilm that enhances both the pathogenic effect and the potential for infection which will in turn delay healing (Percival and Bowler, 2004). The presence of biofilm puts Mrs T at risk of infection and sepsis.

The goals that were explained to Mrs T and her husband included;

- correction of both renal failure and fluid and electrolyte disturbance
- containment and reduction of fistula output
- control of odour and protection of the pre-fistula skin
- prevention of sepsis
- provision of nutritional support
- patient comfort and psychological support

Fluid and electrolyte replacement may be oral, enteral or parental (Carville, 2005:132). To reduce fistula output and promote bowel rest Mrs T was to be Nil Per Mouth for the four to six weeks prior to surgery. Cultural factors always needed to be considered with sensitivity. My personal experience of Samoan tradition is that giving food shows love and caring promoting health and well being. Mr, and Mrs T and their support network required significant education to understand the rationale and importance to her recovery of maintaining NPM. Correction of nutritional deficits and maintenance of nutrition support was provided for Mrs T with total parental nutrition via a peripherally inserted central catheter. Excessive fluid loss via the fistula was replaced with a secondary intravenous line.

# Enterocutaneous Fistula; wholistic assessment and care planning, the whole journey ...continued

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Reduction of the fistula output assists in maintaining a stable fluid and electrolyte balance, and facilitates skin care by reducing the volume of irritant (Lloyd, Gable and Windsor, 2006:1047). Somatostatins such as Octrotide are especially effective in reducing small bowel secretions (Elson and Iqbal, cited in Colwell, Goldberg and Carmel, 2004:382-383). Other methods of reducing bowel output include antimotility agents, such as loperamide and codeine (Lloyd, Gabe and Windsor, 2006:1048).

Containment of fistula output will facilitate protection of peri-fistula skin, assist with measurement of output and odour control and promotes patient comfort (Toth, Hocevar and Landis-Erdman in Colwell, Goldberg and Carmel, 2004:18). Choice of containment system will be based on the patient's abdominal contours, location of the fistula, amount and viscosity of output and the best possible barrier for skin protection (Pontieri-Lewis, 2005:70).

To prevent sepsis Mrs T continued on antibiotics intravenously.

Ongoing psychological support was offered by the stomal therapy nurse, the social worker, the cultural support team and on a daily basis by the ward staff. These services also supported Mr T. Carville (2005:132), maintains that patients should be involved in choices to promote their participation and to enhance their quality of life.

Two months after admission Mrs T returned to surgery for a definitive procedure to close the fistula. She was successfully discharged and returned to Samoa.

## CONCLUSION

The implications of a high output enterocutaneous fistula can be overwhelming. Multi-disciplinary team input for surgical, nursing, nutritional, social, psychological services are imperative to a positive outcome. Clearly defined flexible goals are needed to deal with the changeable nature of the care required by patients with enterocutaneous fistulas.

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# Clinical Stories

MARIE BUCHANAN

*Clinical Nurse Specialist - Ostomy, Waitemata DHB, North Auckland*

## CO- EDITORS NOTE

Clinical Stories is a new section in The Outlet. The aim of this section is to encourage publication of the real, lived experiences of our patients and the stomal therapists / nurses who care for them. It is the opportunity to show case and share those interesting stories that all nurse tell. This section can include stories which may not be academically researched but which represent the essence of what stomal therapists / nurses do. It is hoped that both experienced and first time authors will work with the co-editors and consider contributing to this section of the journal.

## NORMALITY WITH A POUCH

Marie Buchanan

Recently I was asked by Omnigon to present a case study at the New Zealand Nurses' Association Ostomy section conference in Wellington. The only requirement was that the case study profile the features of the Welland Flair Active biogradable ostomy pouch.

Prior to writing the case study I met with Shane the patient and explained what I had been asked to do and requested to use his case study. I explained that I would ensure his privacy and maintain confidentiality by using a pseudonym. Shane was more than happy for me to share his journey, but stated he didn't want me to change his name. He insisted on using his own name and hoped that by sharing his journey that he may help someone else.

This is not a case study focusing on surgical procedures or the disease process. If it were, it would be a lengthy dramatic thesis. There are no big words, graphic pictures or wonderful posters to show or present. This is a case study from a true humanistic perspective, sharing just one part of the journey Shane had to travel. I feel privileged and richer for having met and shared this part of Shane's life. It is purely how the right product made a significant change in Shane's life and provided him with what he calls "some normality in the bathroom".

## SHANE 2007

Shane was in his mid 50's, married with two teenage sons at university. He was self-employed in a high profile, career with a large clientele base that included many elite and famous entities both national and international. It was a very demanding and stressful career which involved regular socialising and entertaining. Along with this went a fairly high social alcohol intake, frequent travel and no regular routines. His main hobby was fishing. Frequent weekend fishing trips with friends were a very common occurrence.

Prior to 2007, Shane's medical history was unremarkable, but he did have a high BMI, hypertension, DVT following a THJR, a dislocated shoulder requiring a surgical repair and an arthroscopy to his right knee.

In April 2007 Shane noticed blood on the toilet paper after he had passed a bowel motion. Realising that this was not normal he made an appointment and went to his GP who suggested it was probably haemorrhoids, he also suggested making an appointment for a colonoscopy to "just check things out". As Shane had medical insurance, this appointment was made promptly and performed within a few weeks. Unfortunately a large ultra-low rectal tumour was discovered and Shane was diagnosed with rectal cancer in June 2007. He went on to have 3 months of chemo/radiotherapy to reduce the tumour load prior to surgery. In November 2007 Shane had an abdominal perineal resection and the formation of a permanent end colostomy.

I first met Shane in his home at the end of November 2007, following his surgery. We quickly developed a very good rapport and professional partnership. At each visit we spent a lot of time discussing good fishing spots and general family activities, which appeared to relax Shane and allowed an in-depth patient nurse relationship to develop. It was immediately apparent that he hated his stoma but even more so hated "the bag". He stated he felt dirty and smelly which ultimately resulted in him becoming socially withdrawn and isolated. He was very conscious about his body image and felt the "bag" was very obvious. He constantly referred to his bag as a "bag of s@#\$. He made constant jokes about his bag, these often demonstrated distaste and self-loathing.

Shane stopped going into the office and was only doing minimal work at home. A major role of his work was socializing with his clientele. He stated that this withdrawal was due to what he described as poor bathroom facilities at work, in particular the inability to dispose of his pouches discreetly.

At this time, Shane was using a classic closed one piece pouch. Usual management and disposal of these pouches is to empty the bulk of the contents into the toilet then wrap the soiled pouch in paper, secure in a plastic bag and dispose of this into a rubbish bin. Shane felt he was unable to do this, especially emptying the contents into the toilet, and disposing of the pouch in a public place. On several occasions this resulted in him carrying around a soiled pouch, either in a pocket or brief case, or even in the boot of his car.

## Clinical Stories *...continued*

MARIE BUCHANAN

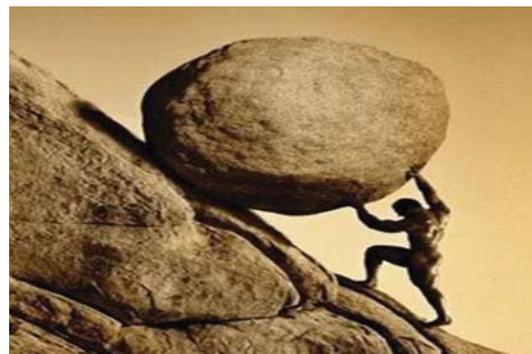
*Clinical Nurse Specialist - Ostomy, Waitemata DHB, North Auckland*

Shane required significant psychological support and reassurance that he would / could continue a “normal life,” including his usual activities and lifestyle, in particular work and fishing. He slowly accepted his stoma and the physical management was not an issue apart from emptying or disposing of the actual pouch. He had gone on the occasional fishing trip with mates, but returned home with a rubbish bag full of soiled pouches in the boot of the car. He also stated that at this time he was very uncomfortable staying away from home, as “storing” his soiled bags for a weekend in someone’s bathroom or bedroom was embarrassing for him. He was back working part time but with limited socialising. Again the soiled pouches were stowed in the boot of his car or pocket and occasionally in his briefcase. He couldn’t bring himself to put them into a public rubbish bin.

Unfortunately, in June 2009 Shane had a recurrence of his bowel cancer. This resulted in a pelvic clearance sacrectomy with the insertion of ureteric stents. This procedure was not able to be completed in Auckland and occurred in Christchurch. He was transferred back to Auckland for rehabilitation 14 days after the procedure. This was surgery marred by a very complicated recovery. His sacral wound broke down, resulting in the need for a flap repair at Middlemore Hospital. He suffered urinary incontinence and was intermittently self-catheterising. He suffered frequent UTI’s, probably due to poor catheterizing technique. The incontinence was the result of nerve damage during surgery and it was hoped it would not be permanent. Shane was in chronic pain and very reliant on pain relief medications. His mobility was dramatically reduced, the use of crutches enabled him to “shuffle” around. The only positive Shane could find was that he lost 33 kgs of weight,

During my initial contact with Shane I had offered him an introduction to another ostomate for support re living with a stoma. He accepted this offer and I put him in touch with another gentleman 50 years of age who had similar social circumstances. He was also self-employed and loved fishing. Both gentlemen shared a similar bowel cancer journey with both experiencing a recurrence and sacrectomy surgery. They became good friends and were a great support to each other. However, while Shane was battling with his complications, his mate succumbed to another cancer recurrence and passed away. This was a very challenging time for Shane, leading to him questioning his own mortality and the outcome of his disease process. It was also a particularly challenging time for me, as I had shared the journey and the loss of

Shane’s friend. Continuing to visit and maintain a positive attitude was difficult. In maintaining a professional relationship with Shane, my feelings regarding the loss of his friend and my patient were mainly kept in check. However, there were some occasions when Shane and I shared our common loss. I believe this was appropriate to the situation and our relationship. It demonstrated the privileged relationships that many stoma therapists develop with their patients and the humanistic framework that many practise from. I believe that I was able to support Shane with true empathy and compassion.



Between July 2009 and September 2010, Shane had twelve admissions to Northshore Hospital, one to Auckland City Hospital and two to Middlemore Hospital, as well as attending over 20 outpatient clinic appointments. At this stage, his colostomy was the least of his concerns but the issue of pouch disposal was always a major concern.

This was a very down time in Shane’s journey. His mood was very low and he stated he often wondered what it was all about and if it was going to be worth it all. He was having regular counselling through the cancer society and during this time required significant support from our service.

Towards the end of this complicated recovery period, Shane was considering returning to work part time. Again, the issues of pouch disposal became the biggest obstacle. We spent a lot of time talking and discussing different options for pouch disposal. Shane still hated disposing of pouches into the public rubbish. He hated the fact of not being “normal”. He hated walking around with a “bag of ‘S@#’”, as he referred to it. But most of all, he hated the fact he hadn’t been out fishing for over 12 months and he was really missing it.

## Clinical Stories *...continued*

MARIE BUCHANAN

*Clinical Nurse Specialist - Ostomy, Waitemata DHB, North Auckland*

Around this time I had become more aware of the Welland biodegradable pouch. My clinical judgement led me to believe that the features of the Flair Active©, which was available from Omnigon may suit Shane's need for disposal of his pouch. I discussed the pouch with Shane and explained the principles of use. Shane was very keen to trial them and I arranged a trial pack to be sent directly to him. The biggest advantage of the biodegradable pouch is that the inner liner with the waste inside is easily detached from the outer cover and can be directly flushed down the toilet. This enables easy and discrete disposal of the waste directly into the toilet. Shane trialled the pouch for only one day. He phoned me and was ecstatic. He couldn't believe that he could flush the waste down the toilet. He stated he felt almost "normal," as he was now flushing his s@#\$ down the loo like everyone else. Since changing to the biodegradable pouch, the management of his colostomy is no longer the overwhelming, defining feature of his life.

Currently, Shane's wounds have healed, he has full bladder sensation and is continent. A recent MRI showed no areas of concern and, finally after a long challenging journey he feels life is on a fairly normal path. He has a positive outlook for the future.



Last year Shane contacted me after having had a fantastic weekend out fishing. He sent me a wonderful photograph of himself holding a large snapper with the caption "Thanks, I made it". The smile on his face was one of the best moments of "job satisfaction" that I have ever experienced. Shane has returned to work, and has resumed a fairly full "normal" life. In his words, he isn't back to "normal whatever that is.... but very close to it".

2012: Shane and his wife have recently moved into an apartment block. He is enjoying the rather simple life of not having to maintain the family home. He said that pouch disposal was a consideration in purchasing the apartment. He felt that if he had been still using traditional non disposable pouches they wouldn't have made the move to the apartment due to the communal rubbish collection.

For both Shane and his family the journey has been an emotional and physical roller coaster. I feel privileged to have shared the journey with them. I am proud that my skills and in-depth knowledge as a stoma therapist has enabled me to make a significant positive contribution to their lives. I believe that the relationship which I developed with Shane made a significant contribution to his recovery. Shane's story demonstrates that having an extensive knowledge of the ostomy appliances that are available in New Zealand can be critical to a patient's recovery and rehabilitation as a new ostomate. I wish to acknowledge the commitment and support of our industry partners, who assist us in the search for knowledge, products and innovative practice.

I am passionately committed to ensuring all ostomy clients continue to have choice and access to product that best suits their needs and life style. I believe that this case study highlights the importance of partnerships which include consumer choice. It can certainly be the difference between "normality" or not.

### ACKNOWLEDGEMENT

Thank you Shane for agreeing to sharing your journey.

# Around the World

**BARRY MAUGHAN**

*Chair, International Ostomy Association Coordination Committee President ASPOA*



## CHANGES, CHALLENGES AND SUCCESSES

In November 2010 the International Ostomy Association (IOA) was re-structured to better meet the needs of national and regional ostomy groups, to stream line the administration, and to better utilize resources.

The existing five regions were amalgamated into three, and rather than an elected Executive Committee there is now an appointed smaller Coordination Committee comprised of two members from each region, one of whom will be appointed chairperson.

The Asia and South Pacific regions amalgamated to form the Asia and South Pacific Ostomy Association (ASPOA).

The North, Central, South American and Caribbean regions amalgamated to form the Ostomy Association of the America (OAA).

The European region remained unchanged.

Implementing the new structure has been a challenge which IOA believes has been successfully met.

Other challenges facing IOA include planning to get new projects started, sourcing and dedicating funding to these, communicating within the Coordination Committee, and successfully utilizing existing IOA tools such as the Visitor Training Program, and the International Stoma Care Advocacy Program (ISCAP).

An ongoing challenge is how to make the welfare of all ostomates globally better, through strengthening existing associations, creating new associations, attracting younger ostomates, and ensuring the availability of appropriate and affordable appliances.

The celebration of World Ostomy Day (WOD) in 2012 was the first major worldwide event that has been organised under the new structure.

Countries and regions worldwide were urged to become involved by planning for and carrying out activities on or about October 6th 2012. The theme was 'Let's be Heard'. The aim of WOD is to improve the rehabilitation of ostomates worldwide by bringing their needs and aspirations to the attention of the general public and the global community, while acknowledging the contributions of ostomy associations and ostomy professionals.

Manufacturers of ostomy products have assisted associations and individuals in a variety of ways to support World Ostomy Day. The Coloplast Merit Award was open to any IOA member association. Each region's winner received a cash prize of \$3000 US. Individuals were also able to enter to become part to the Coloplast model database. More information is available at [www.themeritaward.com](http://www.themeritaward.com).

ConvaTec sponsored a contest which could be entered by individuals submitting short original videos. Each regional winner received an iPad.

Hollister sponsored a WOD photo contest. Individuals submitted photos and the 12 winning photos will be used to create a 2013 calendar. Each winner will receive \$250 for their IOA member association local support group. .

Details of the 3 competitions were on the IOA website [www.ostomyinternational.org](http://www.ostomyinternational.org)

IOA had had a number of successes since 2010. In China, stoma clubs have been strengthened or established in Beijing, Shanghai, Hangzhou, Nanjing and Guangzhou. Amazing work has been done by the Health professionals (ET's and Surgeons) in expanding help for ostomates and the 6 ET training schools have allowed a spread of nurses across China Their challenge earlier in the year was to have a Beijing TV station commission a video about ostomates for World Ostomy Day. This was filmed at a symposium in Zhuhai attended by 180 ostomates and the health professionals. This event was sponsored by Coloplast.

In Iran in October 2011 "Lions for Stoma Care" (Dr Buch and Prof Carlos Pezcoller) trained nurses in Tehran, and now a local nurse training program is being established.

Nurse training will soon take place in the Dominican Republic.

In India, it was planned to train up to 1100 nurses via e-learning. A hundred nurses were trained however the project was recently cancelled due to difficulty getting on-site practical training.

Nurse training funded by the Ostomy Association of America has taken place in Bolivia, Argentina and Chile.

## Around the World ...continued

**BARRY MAUGHAN**

*Chair, International Ostomy Association Coordination Committee President ASPOA*

Several countries are in the process of establishing or planning to establish ostomy associations. Saudi Arabia has the support of its colorectal society and will launch its association on WOD. Members from Sweden have made two visits to Zimbabwe establishing a new association and will return in January. In Kenya, where a new organisation "Stoma World Kenya" has been formed, the Dansac Foundation led by Di Bracken will undertake nurse and visitor training in December. Tunisia's new association has been assisted by members from Lebanon. In Ghana there is a website established and the association offers visits and support to ostomates.

A planning visit to Ethiopia is set for 2013 in conjunction with Lions for Stoma Care and a new association will be formed. In Tanzania and elsewhere IOA is exploring closer cooperation with the World Council of Enterostomal therapy (WCET) to provide help to ostomates.

Several organizations have become stronger. Jorge Vargas Morales from Mexico visited health boards, ostomates and their families and presented the International Stoma Care Advocacy Program (SCAP) in El Salvador, Guatemala, Honduras, Nicaragua and Costa Rica. Two additional groups in Mexico, from Guadalajara and Leon, have joined NCACOA. A preliminary visit has been made to Thailand and a project is planned to take place in the near future to strengthen their association.

With help from Dr. Harikesh Buch (ASPOA Vice president) visitor training programs took place in Malaysia, Singapore and The Philippines in June 2012. Dr Buch will return to Singapore to help form a national association with the Singapore Cancer Society, nurses and ostomates. Dr Buch has just completed further visits to Singapore Malaysia and 3 areas of Taiwan for celebration of World Ostomy day and facilitate visitor training.

In the Philippines a national association has been established and smaller support groups based in different hospitals and on different islands are being started.

In the developing countries many ostomates have no access to any appliances or have to pay for there total cost. The collection of surplus and donated appliances by Friends of Ostomates Worldwide (FOW) and various associations goes some way to assisting these ostomates.

In a small way, the appliances sent by FNZOS help and we are anxious to secure these surplus appliances for donating. We have assisted individuals in Fiji, Tonga and the Philippines and shortly a shipment is being sent to Bangalore.

This year I was privileged to attend the WCET Congress in Adelaide and it was gratifying to meet many nurses from NZ there.

We strongly believe that we can accomplish much by working together.

As we work together in our local associations, in our regions and around the world, we can improve the lives of ostomates. There is still much to be accomplished, but I am confident that each year we will reach out to more ostomates around the world, and help them to be heard.

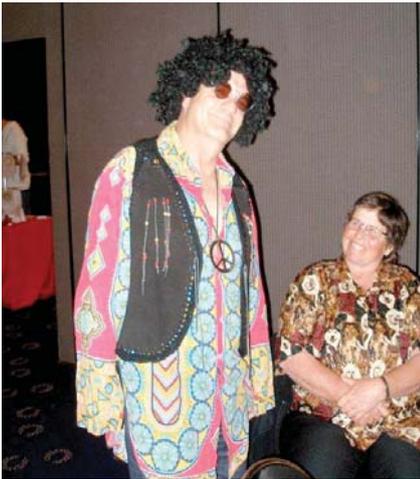
**Barry Maughan,**

**Chair, International Ostomy Association Coordination Committee**

**President ASPOA**

# Conference Name

DATE AND PLACE



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