



The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

- Stomal Therapy Section
Transition to College -
'Have Your Say'
- Crohn's Disease and Wound
Healing
- Journey from the Dark Side

AUGUST 2013

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The Outlet

New Zealand Stomal Therapy Nurses

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www.nzno.org.nz

IF YOUR ADDRESS HAS CHANGED PLEASE CONTACT
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Welcome to the August Edition of the Outlet

The new NZNOSTS committee attended a two day committee meeting in Wellington on 9th and 10th of May. Committee members have now established relationships with each other and have developed a working knowledge of their portfolios within the executive.

The Section to College sub-committee reported back on their endeavours to date. They have completed the process of canvassing potential section partners who we could merge with. Please find a full report from the sub-committee in this edition of the Outlet. With the report is a survey / ballot form and the monkey survey website to complete the same survey electronically. It is VITAL that the membership take the time to assess the issues of our section either joining with the Gastroenterology section or continuing as a stand alone Stomal Therapy Section. The section to college issue is the single biggest change of direction we have ever faced. The process to either remain a stand alone entity or merge with gastroenterology must be completed by 2016. The survey is the membership's last opportunity to influence the future direction of their section. If you would like any further information re this issue or regarding the survey please contact one of the executive committee.

The terms of reference for the Bernadette Hart Awards have been reviewed and the application form has been updated. Further information and the application form are in this journal. The closing date for applications is November 30th 2013. Successful applicants will be notified in January 2014.

Announcement: The NZNOSTS conference will be in late 2014 in Auckland. Planning is well underway for a dynamic, educational, fun event so plan to be there.

Lorraine Andrews (Co-editor)



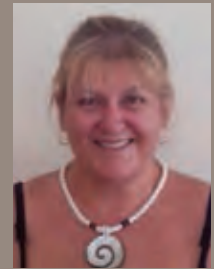
LORRAINE ANDREWS

Co-editor - The Outlet

Executive Update

MAREE MCKEE

Committee Member and Co-editor of the Outlet



As a section, we now only meet every two years at our general meeting. One of our aims, as your executive committee is to make sure the membership is well informed and aware of the issues and decisions that are being made on your behalf.

This information will be a regular part of our journal the 'Outlet'.

Since being elected, we have had a teleconference and now two face to face meetings in Wellington at the NZNO offices. A small segment of time at the first meeting was set aside to introduce ourselves and get to know one another, and our new portfolios. Then it was straight on to business.

In an effort to save on cost, NZNO are in the process of looking at purchasing computer technology called Webinar. This is a programme that will allow on line conferencing. This will save the section significant capital expenditure by eliminating the need for face to face meetings.

In our earlier meeting we discussed ways to encourage our delegates to publish articles in the 'Outlet'. We have in the past celebrated and recognised those who were first time presenters at our national conference but have not given the same recognition and acknowledgement of the effort that is required to publish. To encourage interest in the Outlet, it was put to the committee that we do the same for those willing to publish. As a result, it can now be confirmed that we will give a small recognition to first time writers who publish in the Outlet.

Maria Stapleton attended the Committee meeting to update us on the progress the steering committee is making in regard to the Section to College status. This stimulated a lot of discussion which concluded in a mandate for the steering committee to develop a survey to be included in this 'Outlet' Journal and an online survey. It's hoped, that section members will take the time to complete either the paper survey or the on line survey so the executive committee will have a clear understanding of the memberships wishes on this important issue. Please read the information and be part of the decision making. This is very important to our future.

Other items on the agenda were the review and up date of the Operational Plan for the section committee, Stomal Therapy rules, standards of practise, Bernadette Hart application form/ criteria and the Stomal therapy web site.

The new membership forms were reviewed. These are now to be sent to Tessa Cate clerical support at the NZNO offices. Terra Wilson our secretary will send a letter of acceptance to the new member. Over the next year we are encouraging an intensive drive to promote our section and get new members involved.

As it is the end of the 2013 financial year we received feed back from the section accountant regarding our financial status. Presently, the section is working well within its limits. A full account of the incomings and outgoings will be presented at the General meeting at the 2014 conference.

Lastly, we have started our planning for the 2014 National Stomal Therapy Conference. After a lot of discussion we voted to hold our next conference in Auckland. Preparations for the conference are now underway and we will be looking for abstracts to be submitted later in the year.

Introduction Profile and Roles of New Committee

Nicky Bates

Executive Committee Treasurer



I have been a stomal therapist for about 13 years. I am based in community health at Wanganui Hospital, covering both inpatient and community patients. Like all of you, I find Stomal Therapy a rewarding and challenging profession.

I have stayed on the committee as treasurer. I am also on the steering group to transition our section to college status by 2016. I have enjoyed being on the committee for a variety of reasons. It has been great to gain awareness and knowledge of the workings of NZNO as an organisation and the many different arms it has. I went on the committee to gain a broader overview of the National issues within Stomal Therapy and to further develop my professional knowledge - I have certainly done this. The best thing about the committee is that I have got to know some great STNs who were only a name to me previously.

Terra Wilson

Executive Committee Secretary



Hello, my name is Terra Wilson. I am originally from Canada, but came to Invercargill when I was 20 years old and started my nursing career.

My previous nursing experience includes surgical, medical and district nursing. I currently work as a stomal therapist and part time in day theatre. I have been a stomal therapy nurse since 2004. In 2005 I completed my Stomal Therapy Post Grad Certificate through the New South Wales College of Nursing. This was the

beginning of my most interesting, challenging and rewarding nursing role. I quickly developed a passion for this specialty and strive to keep our practice in Southland current and innovative. I provide stoma care and education for patients in the hospital setting, clinics and the community. We have approximately 380 patients.

As the new secretary for the NZNOSTS I have had to learn very quickly and undertake to do my absolute best for the committee and its membership. I have never undertaken such a position in the past but it is my nature to confront and welcome new challenges. I would like to thank those who voted me onto the committee; you have taken me out of my comfort zone! Thank you.

'Time to Have Your Say' New Zealand Nurses Organisation Stomal Therapy Section Transition to College

LORRAINE ANDREWS & MAREE MCKEE

(co-editors)

Since 2010 there have been numerous reports and articles in the Kai Tiaki and The Outlet concerning New Zealand Nurses Organisation (NZNO) plans to transition sections to colleges.

A presentation regarding the progress was delivered at the 2012 biennial meeting in Wellington (this is available on the New Zealand Nurses Organisation Stomal Therapy Section (NZNOSTS) website). We now need input and direction from you, the members.

History of Process to Date

The process began when a paper prepared by Susanne Trim 'NZNO National Sections, Colleges and Virtual networks: a framework for future development' was released in February 2011. NZNO executive passed a directive "all its national sections relating to clinical specialty would work towards meeting the criteria for becoming a clinical college of NZNO and that this process should be completed by 2016." (C & S Handbook, 2011, p.75). It also directed sections to identify where there may be a natural alliance with other sections and to look at ways forward to amalgamate into a single college. This plan is intended to future proof NZNO from uncontrolled development of national sections and colleges.

New Zealand Nurses Organisation Stomal Therapy Section (NZNOSTS) committee brought 'the transition from section to college' to the attention of members prior to the 2010 NZNOSTS conference in Hamilton and those attending were involved in discussion at the biennial general meeting. As a result of this meeting a directive was passed to begin the process of transition from section to college by exploring the option of alignment with continence and wound groups.

Following the formation of a relatively new NZNOSTS executive committee in 2010 letters requesting initial discussion were sent to both the Wound Society and to the Continence Group with no responses received. With other issues requiring significant executive committee time including the National Procurement project, review of Standards and conference planning; it became apparent the work involved in transitioning from section to college would be more than the executive committee could commit to at that time. An application for special funding to create a subcommittee to lead the progression to college status was applied for from NZNO. In May 2012 the NZNOSTS committee were advised this had been

successful and \$3000.00 was allocated to support this process. Subsequently in July 2012 the subcommittee of the New Zealand Nurses Organisation Stomal Therapy Section Transition to College (NZNOSTSTC) was established. Members of the subcommittee are Maria Stapleton from MidCentral District Health Board as Chairperson; Nicki Bates from Wanganui District Health Board as Secretary; Lorraine Ritchie the Professional Nurse Advisor and Judy Warren from Waikato District Health Board.

The NZNOSTSTC held an initial face to face meeting in Wellington where the Terms of Reference were confirmed. Subsequently five teleconferences were held between 22nd August 2012 and 25th March 2013. During this period contact was made and dialogue completed with representatives from NZ Wound Society; NZNO Perioperative Nurses College; NZNO Cancer Nurses Section and NZNO Gastroenterology Section. Attempts to initiate dialogue with the NZ Nurses Continence Society proved unsuccessful.

Plans for dialogue with group representatives were made. The agenda for discussion included demographics of a potent amalgamated College i.e. member numbers, journal, awards; where the group was already in process of section to college transition; what other common interest groups are they aligned with and whether they had been approached by other NZNO sections. Finally a S.W.O. T. Analysis (strengths, weaknesses, options, threats) was used. From this it was hoped the three most likely options would be identified, with supporting evidence to then seek a mandate from the NZNO section members as to what option/s to pursue. A video conferences allowed the opportunity to explore all the options and assess the compatibility of the respective groups.

Assessment of Potential College Partners

Discussions with [NZNO Cancer Nurses](#) revealed they have a membership of 618 and are advanced with the all documents collated; education; policy; rules etc. They have in fact been accepted by the NZNO BOD as achieving College status this month. They have secured Ministry of Health (MOH) funding and are presently developing the knowledge and skills framework that is required. It is felt that this group is very large and that NZNOSTS members would be at risk of becoming a very small voice if we amalgamated with them

Another of the potential partners [New Zealand Wound Care Society Incorporated](#) is a registered charity, with 350+ members and is not presently affiliated to NZNO. The New Zealand Wound Care Society Incorporated committee have discussed our transition group approach and have declined further discussion. The Society

'Time to Have Your Say'

New Zealand Nurses Organisation Stomal Therapy Section Transition to College

LORRAINE ANDREWS & MAREE MCKEE

(co-editors)

wants to maintain their independence and could not see any advantages/benefits for them in belonging to NZNO as a college.

The NZNO Gastroenterology Nurses Section responded via Lorraine Ritchie their PNA, they have 300 + members and via Raewyn Paviour NZNO Gastroenterology Nurses Section Treasurer have since indicated they would be keen to pursue the option of developing an alliance. They have been able to secure the help of Jackie Watkins and the endoscopy knowledge and skills framework is now completed.

As discussed earlier attempts to dialogue with NZ Nurses Continence Society, which is also an independent society and not presently affiliated to NZNO initially looked promising, however gaining contact and dialogue proved unsuccessful. This is now not considered a viable option.

What has become apparent is the volume of work required in the development of the knowledge and skills framework. This was well demonstrated by Marina Lambert presentation delivered at the 2012 biennial meeting in Wellington and the fact that two of the sections contacted have employed someone to do this.

Discussion was also held with Fiona Unac on how the Medical Imaging Nurses of New Zealand went through the process of joining NZNO Perioperative Nurses College. This was very useful in identifying the process of incorporating an independent society into a NZNO college.

The NZNOSTSTC have over the last few months explored several options on your behalf without committing to any future partner or plan. If the option to develop an alliance is pursued we cannot at this point say what the structure of the new organisation would look like. What is clear is that a period of negotiation would be required with the preferred group to ensure appropriate representation and allocation of resources was secured for each specialty group. Initial enquires reveal that amalgamated groups would have one executive committee with representatives from each speciality. The numbers of each specialities representation on any combined executive committee is as yet undetermined. Any scholarship funding would remain separate and be allocated on the specific speciality terms. Topics for negotiation would include running a joint or separate journals and conferences, amalgamation of existing funds etc.

Marie Stapleton Chairperson NZNOSTSTC

If the memberships preferred option is to continue as a stand alone entity and not join with the gastroenterology/venterology section, the new stomal therapy college would remain focused on issues relevant to the practice of stomal therapy alone. Amalgamation with the

much larger gastroenterology section is likely to dilute the groups focus.

The membership of an amalgamated executive committee is as yet unknown; however as the smaller group we would potentially not have equal representation. Continuing to college status alone allows greater opportunity for the membership to experience, learn and develop by contributing at executive level.

With an amalgamated national executive committee there is a significant risk that stomal therapy issues i.e. product contracting may not be articulated at the level required to be influential. It is possible that the amalgamated executive committee could lack the credibility to promote stomal issues on a national platform.

If the membership's preferred option is to proceed to college status as a stand alone stomal therapy entity, the executive committee would remain responsible for publication of a stomal therapy focused journal and for facilitating a biannual stomal therapy conference. There is always a fiscal risk to the section in undertaking these activities. This risk is likely to be diminished within a larger college with greater financial resources and the potential to run combined conferences.

If the option to progress to college status alone is the preferred choice the amount of work involved will need to be recognised. The NZNOSTS has both an executive committee and a steering committee to facilitate and manage the workload. Some of the requirements for college status are already in place. There are templates available to guide us through the process and we are fortunate that sections who are well advanced through the process have generously shared their work to assist us.

NOW we need **YOU** the NZNOSTS members to direct the next phase of development in progressing NZNOSTS from section to college status.

You can have your say by

Completing the monkey survey online
(the link has been sent to all members e-mail addresses)
www.surveymonkey.com/S/WZVRKEJ

OR by completing the voting form included.

*On behalf of the NZNOSTS Executive Committee
and the NZNOSTSTC Committee*

Medical Devices Contract PHARMAC

LORRAINE ANDREWS

Co-editor - The Outlet

To capitalise on the savings achieved in the purchasing of pharmaceuticals and implement the recommendations of the Horne Report (2009) the New Zealand government has mandated PHARMAC to standardise, prioritise and procure medical devices. This will include ostomy products. PHARMAC's time line is to have contracts negotiated by 2015 and for the process for national procurement of medical devices to be implemented by 2017.

PHARMAC has begun an extensive consultation process which will include seeking input from clinicians.

A response template requesting information has been circulated by PHARMAC to clarify the following;

- credible sources of information that they should engage with
- types of relevant information to be considered
- what from a clinical perspective is considered essential in developing a national medical devices management system
- what current system is in place for assessing and procuring medical devices including the introduction of new products and enhancements
- what role does clinical input have in the existing procurement system
- what are the key groups, meetings, publications that PHARMAC should utilise

In response to PHARMAC's request for information and on behalf of the membership the NZNOSTS committee has submitted comments.

On 4th March Maree O'Connor (NZNOSTS chair person),

Maree McKee, and Lorraine Andrews were joined by Rachel Pasley from Northland in attending a video conference with PHARMAC representatives. Keys points made by the group included;

- one size definitely doesn't fit all in ostomy devices
- locking into a narrow number of suppliers is detrimental to patient care, access and choice
- the importance of a reliable supply chain
- the fiscal and social cost of any attempt to change existing patients from a familiar and proven product
- the need for suppliers to have a commitment and presence in the New Zealand market
- the need for equitable access and consistency in application across the country
- distribution requirements

The general feeling after the teleconference was positive with PHARMAC representatives being responsive to and appearing to value input from clinicians.

The opportunity exists for strategic nursing input into a future key area of health economics which will impact on our practice and on our patients. With the goal of achieving a sustainable medical devices contract which is based on patient and clinician need and on behalf of the NZNOSTS membership, the Executive Committee intend to take every opportunity in engaging with PHARMAC over the next few years.

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS:

- Must be a current member of the NZNO Stomal Therapy Section for a minimum of one year.
- Demonstrate the relevance of the proposed use of the monetary award in relation to Stomal therapy practice.
- Present appropriate written information to support application
- Use award within twelve months of receipt
- Be committed to presenting a written report on the study/conference program or write an article for publication in 'The Outlet' (journal of the Stomal Therapy section) which may be published or presented at the national conference. (This may be negotiable in certain circumstances).

APPLICATIONS CLOSE 30TH NOVEMBER (annually)

SEND APPLICATION TO:

Terra Wilson

Email: secretarystnznzno@outlook.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 NZNO STS

HAVE YOU BEEN A PREVIOUS RECIPIENT OF THE BERNADETTE HART AWARD? O NO O YES-DATE

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

☐ Presenting at the next National Stomal Therapy Section Conference.

Signed: _____ Date: _____

In Memory

MAREE MCKEE



Sadly, in February 2013 the ostomy community lost one of its foundation personalities with the unexpected passing of Meg Wood.

Meg had been challenged by many episodes of poor health since her retirement as Community Stomal Therapist for Central Auckland.

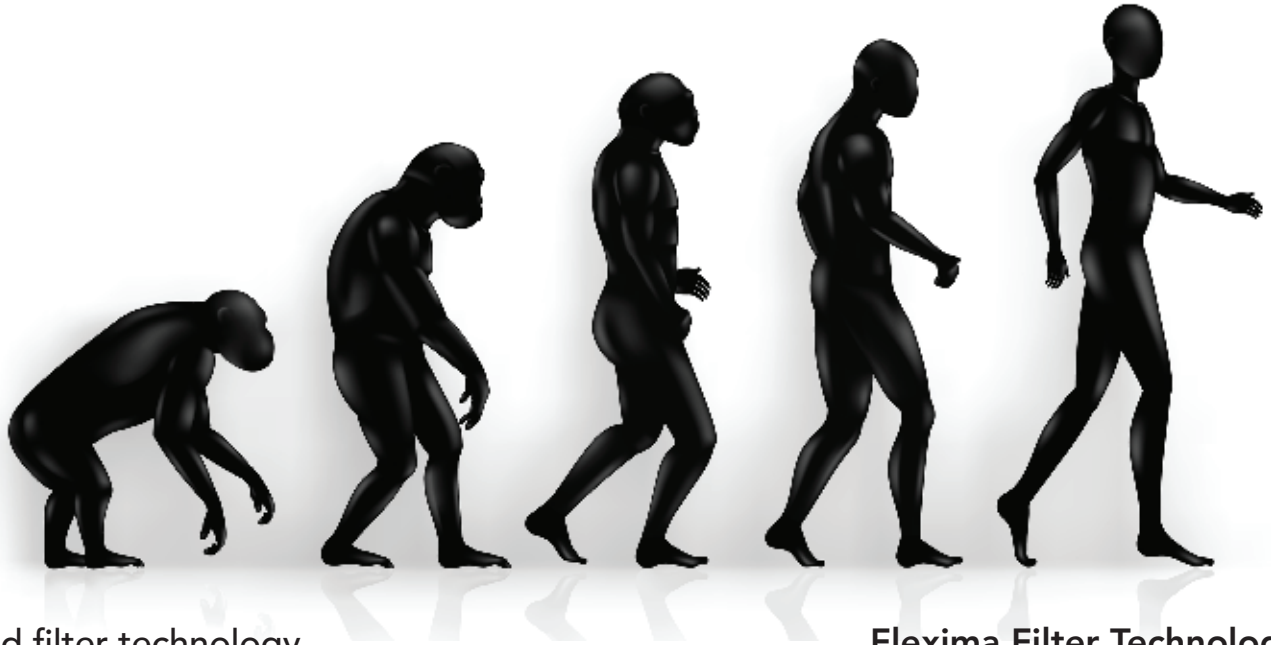
Meg was very proud of her contribution to Stoma care, and was well respected by her colleagues and patients. During her long career, Meg had significant involvement as a member of the Ostomy Society Committee. She was passionate about the service and always willing to support the right of ostomates to receive the best support and service that could be provided. Not only was she an avid supporter of the Ostomate but also of her Stomal Therapy colleagues as a member of the executive committee. Meg was a role model and mentor for many new Stomal Therapists.

I am sure that the people who knew her well would agree that she was a strong lady, who had high standards, and who, with a warm heart cared whole heartedly for her people. Meg was always willing to stand up and advocate for her colleges, the patients and the service.

Meg will be missed not only by her family, but also her friends, colleagues and patients

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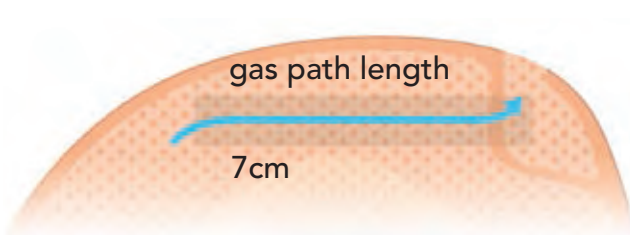
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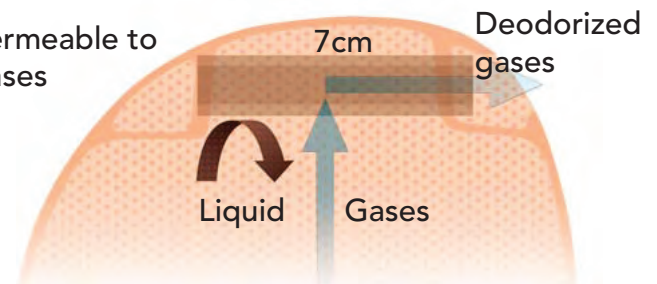


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A Young Woman's Journey through the Ravages of Crohn's Disease and Pregnancy

CARMEN GEORGE

Clinical Practice Consultant STN, Flinders Medical Centre, SA.

PETA LEECH

Clinical Practice Consultant IBD, Flinders Medical Centre, SA

Diagnoses and initial treatment

In early 2006 when she was just 16 years old Sarah (pseudonym) presented to an adult gastroenterologist with lethargy, epigastric pain, significant weight loss, poor appetite, tenderness in the right iliac fossa, joint pain, episcleritis, mouth ulcers and iron deficiency. She had no significant previous medical history or medication use but did have a positive family history of Crohn's disease (her mother). Some of Sarah's symptoms had been present for more than a year. Sarah's presenting signs and symptoms were highly suggestive of Crohn's disease including the extra luminal symptoms of joint pain, mouth ulcers and episcleritis.

Due to her young age Sarah was referred on to a paediatric gastroenterologist at the Children's Hospital. Here she was diagnosed with Crohn's disease after an ultrasound, endoscopy and colonoscopy revealed a thickened terminal ileum, ileitis and a narrowing of the ileal lumen, typical of Crohn's disease. At this time her inflammatory markers (ESR and CRP) were also elevated.

Her presentation at an early age and with significant weight loss predicted for a poor prognosis, it was decided to treat her aggressively and she was commenced on a reducing dose of oral steroids in the short term and the immunosuppressant Azathioprine.

Immunosuppressants were used because of the high levels of tumour necrosis factor a protein produced by the immune system. Steroids, in this context, are used for their rapid anti-inflammatory action to relieve the associated gut and surrounding tissue inflammation and its symptoms.

Azathioprine is an immuno-modulator which is used as a long term treatment to promote a steroid-free remission which avoids the side effects related to long term steroid use. Unfortunately it can take several weeks or months to see any effect of treatment, if any. The exact mode of action of Azathioprine is not clearly understood but its effect is to "inhibit the proliferation of cells, especially the fast-growing lymphocytes. T-cells and B-cells".

It is unclear how Sarah responded to this treatment as she was then lost to all gastroenterology contact for 18 months. One assumes she responded well and then ceased treatment of her own accord.

Second presentation

Sarah presented again to adult care when she was 18 years old. For 3 months she had been experiencing symptoms of abdominal

tenderness and iron deficiency. She was taking no medications at this time.

Her disease activity was reassessed with further endoscopy and colonoscopy where it was observed that the extent of her disease had increased to include the right colon with an inflamed stricture in her terminal ileum. At this point she was recommenced on oral steroids and azathioprine and her iron deficiency was treated with an iron infusion.

Over the next months she was unable to wean off her oral steroids without experiencing a flare of her symptoms and oral Metronidazole was added to the treatment regimen. A CT of her abdomen was performed which excluded the presence of intra-abdominal abscess or bowel perforation.

The journey

Later in 2007 Sarah required a 6-day hospital admission where she was treated with intravenous steroids and metronidazole which was converted to oral steroids and metronidazole prior to discharge and she was continued on azathioprine. At this stage the gastroenterology consultant was considering the next treatment options for her: escalating her treatment to an anti-Tumour Necrosis Factor antibody in the form of Infliximab or surgical intervention as the level of immuno-suppression achieved with Azathioprine was inadequate to control her disease necessitating frequent requirement for further steroid treatment.

The current focus of treatment for Crohn's Disease is to maximise medical therapy and bowel preservation prior to choosing the surgical option. The rationale being that this is a young persons' disease (ie this is a relapsing/remitting disease that patients have for the rest of their lives) and that surgical resection is not curative in Crohn's Disease. Approximately 80% of Crohn's disease patients will need an operation at some time in their life, the disease usually comes back at the site of the anastomosis, and 70% of previously operated patients need another operation.

In early 2008 Sarah was continuing to be steroid dependant, unable to wean off steroids without a flare of her Crohn's disease. A successful application was made to Medicare for PBS subsidised Infliximab treatment. Over the next 12 months Sarah was well with regular two monthly Infliximab as her sole Crohn's treatment. 'For those that respond to this treatment, the benefits can be spectacular and life-changing resulting in return to a near-normal life. The main side effects of this class of drugs are infusion or injection reactions, increased risk of infection and some cancers and drug-induced lupus.'

A Young Woman's Journey through the Ravages of Crohn's Disease and Pregnancy ...continued

CARMEN GEORGE

Clinical Practice Consultant STN, Flinders Medical Centre, SA.

PETA LEECH

Clinical Practice Consultant IBD, Flinders Medical Centre, SA

In mid 2009 Sarah's disease flared again and she again required a hospital admission. It was suspected at this stage that Sarah may have developed antibodies to the Infliximab treatment thereby negating some of its effect and her treatment was changed to an alternative anti-TNF antibody, Adalimumab. Infliximab and Adalimumab are the only anti-TNF drugs currently available in Australia for the treatment of Crohn's Disease. Infliximab is a mouse-derived product given intravenously 8-weekly and Adalimumab is a fully human product administered subcutaneously 2-weekly. Allergy or loss of response to one agent does not preclude successful treatment with the other agent as they are "seen" differently by the human immune system.

In November 2009 Sarah presented with further symptoms. At this stage her disease was reassessed by way of colonoscopy and post inflammatory irritable bowel syndrome was excluded as a possible cause.

Pregnancy

At around this time Sarah became pregnant the activity of inflammatory bowel disease at the time of conception often predicts disease activity over the duration of the pregnancy with 1/3rd of patients improving, 1/3rd staying the same and 1/3rd deteriorating. This predicted fairly accurately the torrid time Sarah was about to endure during her pregnancy:

In the first 6 months of 2010 Sarah required 7 hospital admissions spending a total of 64 days in hospital.

Surgery

During this time it was decided to re-try the Infliximab treatment. Unfortunately it seems that this may have been too late as she was readmitted in July 2010, now 28 weeks pregnant, with a large phlegmon i.e. a spreading, diffuse inflammatory reaction to an infection with a micro perforation. This required surgical intervention with an ileo caecal resection and ileostomy formation.

It was planned to place the Infliximab treatment on hold at this stage and re-start treatment at 1 week post partum.

The decision to take her to theatre for a bowel resection was made when she was at 28 week gestation.

Preoperatively she was seen by the stomal therapy nurse (STN) for information about the surgery, counselling and stoma marking. At this time Sarah was very unwell and willing to accept any surgery that would make her feel better. The position for the stoma

was marked above the level of the navel to accommodate the increasing size of her abdomen during pregnancy. Sarah's attentive mother was with her during this consultation.

Post surgery the pathology report revealed that 'the appearance of the ileo-caecal specimen conformed to that of Crohn's disease mostly affecting the ileum where there was a transmural granulomatous mass corresponding with the clinically diagnosed ileo-caecal fistula.'

Post Surgery

Post operatively Sarah was initially in the high dependency ward before transferring to the obstetric and gynaecology ward. At the first STN visit post operatively Sarah was very quite and passive not wanting to look at her stoma. At that time the stoma was well perfused, protruding, but sitting in a moat. On the second post operative visit, before any eye contact had even been made with Sarah her mother who was sitting in a corner of the room demanded to know if her daughter was going to get any counselling about her stoma.

It was explained to Sarah and her mother that it was part of the STN role to provide counselling and to refer Sarah on to someone else if thought necessary. Sarah started to respond to the verbal interventions. Prior to this conversation she had displayed very negative body language (ie turning her head away, closing her eyes).

During her post operative recovery the acute pain team was involved as Sarah's pain was difficult to manage with usual pharmacological interventions. This had also been the case with previous admissions for exacerbation of Crohn's disease.

Over the next couple of days Sarah responded well to the coaching towards self care for her stoma. She chose a one piece appliance with a soft mouldable convexity and quickly became adept at emptying this.

Prior to discharge she demonstrated competence in changing her appliance. She was discharged home to her mother's care at day 5 post op with an outpatient's appointment to see STN in 2 weeks. She was given the STN phone number and asked to phone should she have any problems or concerns.

A Young Woman's Journey through the Ravages of Crohn's Disease and Pregnancy ...continued

CARMEN GEORGE

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PETA LEECH

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Post discharge

At her first outpatients visit Sarah expressed how well she was feeling and that at last she was enjoying her pregnancy. She was managing her stoma extremely well. There was some skin erosion around her stoma from the stoma shrinking in size and the peristomal skin being exposed. She was shown how to manage this and adapt her appliance.

Over the remainder of her pregnancy she had regular OPD appointments with STN. During this time the stoma did stretch slightly at the base as her abdomen enlarged. Her Crohn's disease did not flare and for the last 10 weeks of her pregnancy she was well and coped extremely well with her ileostomy.

The new mother

Sarah went into spontaneous labour at full term but unfortunately required an emergency caesarean section when the baby became distressed during labour.

Baby was delivered without incident but Sarah's progress was complicated with an initially, undiagnosed abdominal wound collection requiring 2 trips to theatre for laparotomy and drainage of the collection.

During this time, after the birth of her baby Sarah felt that she was not being listened to and that the pain she was experiencing was being dismissed as an exacerbation of the Crohns. The medical notes reflect ambiguity with clear documentation by one doctor that the abdominal pain Sarah was experiencing was most likely Crohn's, and by another doctors documentation saying Sarah had the clinical appearance of a septic collection.

It is documented that her mother insisted on an MRI as she said the previous bowel perforation had only been picked up on MRI.

A CT scan was normal but Sarah was febrile, with high inflammatory markers, a pain score of 8/10 and an extremely tender lower abdomen. She had no chest infection, mastitis or urinary tract infection. An MRI was performed which revealed a pelvic collection and Sarah went for a laparotomy and drainage of pelvic collection. Post operatively she was in the high dependency unit where she was on a Ketamine infusion and a Fentanyl PCA. At this time her pain scores were between 6 and 8. She was on triple antibiotic therapy and anticoagulant therapy, she had an abdominal drain and an IDC. The morning after her late night surgery the acute pain service increased the dose of Ketamine and added a background infusion to the Fentanyl PCA, they noted that Sarah was distressed by sleep deprivation and the inability to nurse

her baby. Two hours later a MET (medical emergency team) call was made as Sarah had developed tachycardia. She was assessed as having peritonitis, dehydration, bilateral pleural effusions. She returned to the operating theatre that evening for a further laparotomy and washout. It was documented that there had been 100mls purulent fluid mainly in the pelvis. Post operatively she was transferred to ICCU for mechanical ventilation and haemodynamic monitoring.

As she became progressively well she was transferred back to the ward and then home with her mother, partner and her new baby.

When the baby was 5 weeks old Sarah then still only 21 years old was referred to the peri natal mental health service as she was finding that 'parenting' was not what she had expected' she also felt that the past year with multiple surgeries and a serious illness was catching up with her. She was experiencing, difficulty sleeping, disturbing dreams and feeling depressed. At that time she was commenced on anti depressants in addition to counselling.

Sarah was understandably keen to re-establish the continuity of her GI tract and in October underwent an ileoscopy and flexible sigmoidoscopy which revealed no Crohn's activity.

Closure of Ileostomy

Sarah was re admitted to hospital for reversal of her end ileostomy. At this time her baby was 2 months old.

The surgical reversal was thankfully uneventful; Sarah was discharged home on day 4 post surgery. At that time she was still on 40mg of prednisilone daily which was being tapered down by 5 mg a week. At her 6/52 post operative outpatients visit she was well, enjoying motherhood and on no prednisilone. She was restarted on 8 weekly Infliximab infusions.

Sarah is currently free of any symptoms of Crohn's disease and enjoying motherhood and remains under the gastroenterology service where she continues on Infliximab and regular monitoring.

The Co-editors wish to thanks Carmen, Peta and the AASTN for allowing us to re-publish this article.

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

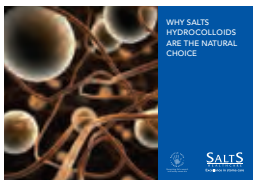


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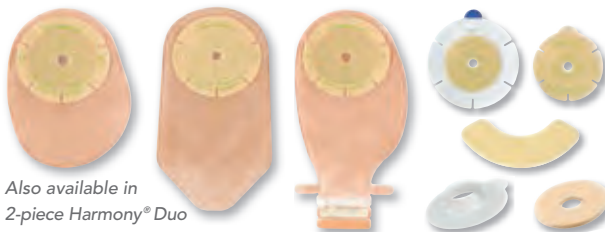


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CASE STUDY

Crohn's Disease and Wound Healing

SOPHIE WALLACE.

Sophie has a background in surgical nursing and an interest in colorectal post operative care. In 2012 Sophie completed the post graduate certificate of Stomal Therapy Nursing through the New South Wales College of Nursing. Sophie currently works as a surgical nurse and stomal therapist in Mercy Ascot Auckland.



The aim of this article is to carry out a systematic assessment of a patient, incorporating a brief summary of their medical history whilst also recognising and exploring the damage source to his skin. The assessment will look at the normal anatomy and physiology of the integument and draw comparisons in the form of a clinical assessment of the patient's wound and factors that may impair wound healing.

For the purpose of this article the pseudonym of Vatu has been given to my patient. He has given his consent for the author to use his information and photographic imaging for this wound assessment case study. Vatu was aware of his right to decline participation. Written and verbal consent was obtained. This is in accordance with the New Zealand Nursing Council Code of Conduct (2009) which states that a registered nurse must enable the patient/ client to make informed choices by providing them with information and act in a professional manner that safeguards confidentiality and privacy of information a written consent was obtained.

Social

Vatu is, a 64 year old married man had 3 grown up children. His parents emigrated from India to New Zealand when Vatu was a child. Vatu and his wife ran a commercial market gardening business on the land originally owned by his grandparents. Vatu's children all lived close by with their spouses and had careers outside of the market gardening business.

Health History

Twelve years ago Vatu was diagnosed with Crohn's disease. Crohn's disease is a transmural granulomatous disorder that can involve any portion of the gastrointestinal (GI) tract. Lesions may be multifocal, with areas of diseased bowel separated by normal sections of bowel tissue. A significant number of patients will have involvement of the small bowel, and 41 % of patient's with Crohn's disease will have involvement of the ileocolic area. The aetiology of Crohn's disease is still unknown. With symptom suppression and remission

the patient's quality of life can be restored, however, medical and surgical treatments are not regarded as curative. (Kiran & Fazio 2004: 82) Crohn's disease is a life long chronic condition.

Vatu underwent a panproctocolectomy with ileorectal anastomosis; surgery involved the removal of both the colon and rectum but preserved the anal sphincters. This procedure is performed in younger patients who have good sphincter tone - it does not necessitate a permanent stoma and the risk of autonomic nerve damage is reduced. The disadvantage of this surgery is the significant risk of disease recurrence (Kiran & Fazio, 2004: 84).

Vatu recovered well after the surgery resuming normal activities, raising his children and working in his business. Vatu attended regular colorectal check-ups which involved an annual colonoscopy and routine bloods.

Vatu was monitored for his low iron levels and occasionally required iron replacement therapy. Crentsil & Hanauer (2004: 74) state that iron deficiency anaemia is a common occurrence in Crohn's patients and it is often necessary to carry out iron replacement therapy to maintain a normal hematocrit level.

Surgery

At Vatu's annual review it was found that he had a left inguinal hernia. After further discussion the decision was made for Vatu to undergo an open mesh hernia repair. Post-operatively Vatu developed acute abdominal pain with gross distension - he showed signs of sepsis; tachycardia and pyrexia. Vatu was taken back to theatre four days after the initial surgery. An exploratory laparotomy and excision of small bowel and anastomosis was performed. A total length of 60 cm of bowel was resected.

The findings were;

- pus and
- small bowel content throughout the abdomen
- multiple adhesions to the abdominal wall and between loops of the bowel
- a large abscess cavity.

Multiple enterotomies were made during this arduous surgery.

Following his extensive surgery Vatu spent some time in the intensive care unit for close observation and monitoring. One week later Vatu was taken back to theatre for a laparotomy, exteriorisation of the anastomosis and drainage of sepsis. These findings changed the course of Vatu's life for the foreseeable future.

CASE STUDY

Crohn's Disease and Wound Healing *...continued*

SOPHIE WALLACE.

His entire transverse ileocolic anastomosis had separated causing an enterocutaneous fistula.

Pontieri-Lewis, V. (2005: 68) believes the occurrence of an enterocutaneous fistula specifies aggressive Crohn's disease that requires aggressive medical management. It is essential the cause of the fistula is determined so that an appropriate treatment regime can be commenced.

Vatu was in intensive care when he first became known to me. It was there that our journey together began.

Vatu appeared vulnerable and scared, unsure of an unknown and frightening future. He was a slight man, weighing 55kgs giving him a Body Mass Index (BMI) of 20.2. A healthy BMI score is between 18.5 and 24.9. Vatu expressed his concern of being hospitalised for a long period of time as his wife would not manage the market gardening business on her own and none of his children were keen to continue the business. This highlighted the need for psychological support and care as part of the nursing care plan. Restoring Vatu's mobility and independence would be imperative to his psychological wellbeing. Cobb and Knagg (2003: 439) recognised the presence of a fistula as being a frightening experience which often results in a patient suffering from altered and poor body image with an associated loss of confidence.

Management of a wound begins with wound assessment. Vatu's general health would determine how well his wound healed. The wound assessment tool used was derived from the Silver Chain framework (Carville, 2007: 63).

It focuses on factors that inhibit healing such as;

- medication
- nutritional status
- weight and height
- mobility
- adjunct therapies (such as chemotherapy/ radiation)
- diagnostic investigations.

The assessment was carried out to incorporate a holistic evaluation of Vatu and the many complexities determining his wound management.

The specific factors that would impair Vatu's wound healing and which the author will focus on are;

- fluid and electrolyte imbalance

- nutritional support
- maintenance of skin integrity
- containment of fistula output and odour
- prevention of infection
- psychological care and support

Vatu had a wound that had been left open to heal by secondary intention - this is when healing takes place by the process of delayed granulation, contraction and epithelialisation. Vatu's wound was at risk of infection because of the lack of epidermal barrier to micro-organisms (Doughty & Sparks-Defriese, 2007: 77). The presence of a high effluent output (exceeding 500ml/24hrs) fistula further compromised wound healing.

Vatu's fistula was not suitable for surgical closure at this time. Slater (2009: 226) believes that by delaying surgery it will allow time for metabolic and nutritional deficiencies to be corrected. Adhesions make the abdomen a hostile environment for future surgery and create a potential risk of future enterotomies.

Wound Assessment

On examination, Vatu's wound was discharging copious amounts of small bowel content - a substance that is enzymatic (alkaline) and corrosive to the skin. The wound measured 15cm from the superior to the inferior edge. It was 2.5cm in depth and 5cm in width from the lateral edges. The base of the wound was a combination of areas of slough (necrotic tissue) and granulating tissue

Figure 1



CASE STUDY

Crohn's Disease and Wound Healing *...continued*

SOPHIE WALLACE.



Figure 2.

There are three stages to the wound healing process:

- inflammatory phase
- proliferation phase
- maturation phase.

A wound is in the proliferation phase when granulation takes place. Granulation tissue is composed of collagen and extracellular matrix. The development of new networks of blood vessels takes place in the angiogenesis process. An adequate oxygen and nutrient supply to the blood vessels is needed in order for healthy granulation tissue to be sustained (Clinimed, 2011). Vatu's wound appeared to be at the proliferative phase of wound healing. The wound base showed evidence of healthy granulation tissue which was granular and uneven in texture. The surface was red in colour, warm and shiny with some evidence of epithelial tissue present. The colour and condition of the granulation tissue is often an indicator of how the wound is healing and therefore an important observation to report.

The opening from the fistula was at the medial aspect of the wound. The transmural nature of Crohn's disease make patients vulnerable to developing a fistula which often results in diminished resistance to infection and reduced cellular energy for tissue growth and repair. Vatu's pre-existing anaemia meant that a reduced supply of red blood cells were being circulated and this affects the amount of oxygen being carried to the wound, thus inhibiting wound healing (Carville, 2007: 40).

The mortality rates for patients with enterocutaneous fistula is estimated as approximately 20% (Kate, 2010:1) due to patients becoming;

- dehydrated
- developing electrolyte imbalances
- malnutrition and
- sepsis

The surrounding skin of Vatu's wound appeared healthy with no evidence of erythema or maceration.

On initial assessment the wound bed had some evidence of slough and stringy, necrotic tissue. It is common to see evidence of necrosis in compromised tissue of chronic non-healing wounds such as Vatu's. The removal of such tissue promotes healthy tissue growth by illuminating non-vascularised tissue, bacteria and cells. Vatu's wound swab culture showed a heavy growth of mixed gram negative bacilli, streptococcus milleri, enterococcus and mixed anaerobes. These anaerobic bacteria prevent wound healing and can spread into the blood. Symptoms of a systemic infection would include fever and rise in white blood cells (WBCs). The normal range for WBC's is $3.5 - 11 \times 10^9/L$, Vatu's WBC was $12.5 \times 10^9/L$. Vatu was commenced on Cefoxitin antibiotic, an intravenous therapy given to treat infection. Vatu also suffered from wound pain, associated with a wound infection. The surgical team prescribed regular analgesia and additional analgesia that was to be given prior to wound appliance changes. Relaxation techniques were encouraged to further relieve anxiety and pain during appliance changes.

Nutritional support is a key factor in managing an enterocutaneous fistula. Adequate nutrition is fundamental to cellular tissue, tissue repair and integrity. Receiving fluid replacement and an intravenous feeding (TPN) regime has been shown to reduce GI secretions by 30-50% which improves the potential of achieving a spontaneous closure (Lloyd et al, 2006). Initially for Vatu it was a priority to stabilise his condition and focus care on correcting fluid losses from the high output fistula. This was carried out by keeping Vatu on a strict fluid balance and recording his weight daily. Fluid and electrolyte imbalance and malnutrition often result in protein, electrolyte and mineral depletion; these are lost through excessive wound exudate (Carville, 2007: 132). For healing to take place protein, fat, carbohydrates, vitamins and minerals are needed in adequate supply.

A challenging aspect of fistula management is that of skin integrity. Loss of skin integrity plays a fundamental role on the patient's

CASE STUDY

Crohn's Disease and Wound Healing *...continued*

SOPHIE WALLACE.

physical and psychological wellbeing. An accurate description and measurement of fistula drainage is essential for wound management as it often determines the plan of wound care. When deciding on the type of system to manage the fistula, the following factors should be considered:

type of wound,

- proximity of wound to a stoma, drains etc,
- quantity of exudates,
- patient individual needs (Hess, 2002: 436)
- durability of containment system.

In an attempt to provide effective and efficient containment of the fistula output, whilst also providing security and comfort for Vatu, several systems were considered.



Figure 3



Figure 4

As illustrated, Fig 4 an Eakin® fistula and wound pouch was

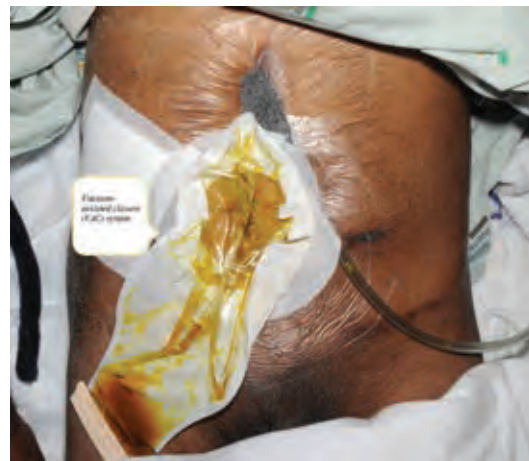
applied. Vatu had an even plane of skin which was free from creases to adhere the pouch to. The pouch drained the small bowel content away from the wound. This allowed measurement of the output and protected the surrounding skin from being contaminated.

Nutrition

Enteral nutrition (the administration of artificial nutrients via a naso-gastric tube) is known to increase fistula secretion rate and as a consequent Vatu's fistula was putting out over 1 litre in 24hrs of small bowel content. If this method were to continue, it could in fact, put Vatu at a greater risk of malnutrition and further delay the healing process. The decision was made to commence intravenous feeding (TPN). Keeping a patient nil by mouth can be distressing. Reassurance and education was paramount to keep the patient informed and emphasising the bowel's need for rest. Specialist debate is ongoing regarding the associated merits of allowing the bowel to rest or whether this period of rest is in fact detrimental to the patient (Lloyd et al, 2006: 227). Small (2003: 737) believes the risks associated with TPN administration, such as infection, are out weighted by the benefits of sustaining nutrition and correcting the effects of malnutrition.

Surgical intervention was required for debridement and removal of the devitalised and infected tissue (slough) on the wound bed. The decision was made for a final planned surgery which involved an abdominal washout, debridement and application of a Negative Pressure Wound device isolating the fistula to drain into a pouch.

Figure 5



Negative Pressure Wound Device (NPWD) entails using an open

CASE STUDY

Crohn's Disease and Wound Healing *...continued*

SOPHIE WALLACE.

pore foam which is cut to fit the size of the wound and covered by a semi-permeable adhesive drape. The microprocessor-controlled unit is attached to deliver the negative pressure therapy. Hunter et al (2007: 257) maintains that NPWD's therapy promotes perfusion and assists in tissue granulation, thus resulting in faster wound healing.

Vatu was transferred to the Surgical ward, he was optimistic and had confidence in the NPWD. The team were achieving accurate fluid balances and correcting electrolyte imbalances with the intravenous fluids and TPN regime. Vatu's weight and condition remained stable and the clinical signs of infection appeared to be improving with a decrease in WBC and normalisation of vital signs.

However, on re-assessment the ward nursing team had reinstated the Eakin® fistula drainage pouch. This was a learning opportunity for all. With an output of over one litre per day the NPWD had been a questionable and optimistic choice of containment system. The wound healing benefits of the NPWD were lost when the output repeatedly overwhelmed and blocked the system causing leaks.

Figure 6



Evidence of wound contraction and epithelial migration at the edges of the wound is evident in Fig 6. This illustrates wound healing in spite of the NPWD not being in use. The wound measured 11cm from superior to inferior edges and was 4.4cm wide. The depth of the wound bed was 0.5cm, showing positive reductions in size.

“Psychological support is important...” (Orr, 2011: 2). Having a secure drainage system that allows medical and nursing teams to accurately measure output and plan care accordingly is just one of the benefits of the Eakin® fistula drainage bag. A secure reliable containment system can change the patient's overall outlook significantly.

Vatu was taught how to attach a night drainage bag prior to settling, this enabled him to sleep all night without being disturbed and without the worry of an over-full bag. It also gave him a small measure of independence, boosted his self esteem and established him as a partner in his care. Vatu was able to sit out of bed and mobilise without the worry of offensive odours. Independence was restored and education commenced to teach Vatu and his wife how to care for the fistula drainage bag. Slater (2009: 68) advocates patients should be as independent as possible physically and psychologically in preparation for discharge. She also emphasises the importance and support of a multi-disciplinary team involvement in discharge planning. Keeping the patient motivated is imperative to achieving optimum physical and psychological wellbeing in wound healing. As illustrated in this case study, for patients with an enterocutaneous fistula the hospitalisation period, healing and rehabilitation process can be prolonged. Vatu's future will include further, high risk surgery to close his fistula.

In conclusion, fistula and wound management continue to be complex and challenging. With a wide range of containment systems available, nursing assessment is vital to the selection of the most appropriate system for any individual patient.

CASE STUDY

Crohn's Disease and Wound Healing ...continued

SOPHIE WALLACE.

REFERENCES

- Carville, K. 2007. Wound Care Manual. 5th edn. Silver Chain Foundation. Australia.
- Clinimed 2011. Phases of wound healing. Clinimed Ltd. UK. Available online: <http://www.clinimed.co.uk/wound-care/education/wound-essentials/phases-of-wound-healing.aspx> <accessed 2011, August 19>
- Cobb, A. & Knagg, E. 2003. Cited in: Thompson, M. J. 2008. An accountable fistula management treatment plan. *British Journal of Nursing*, 17, 7, 434-440
- Crohn's and Colitis Foundation of America (CCFA) 2009. Surgery for Crohn's Disease. Available online: www.ccfa.org <accessed 2011, August 13>
- Crensil, V. & Hanauer, S. B. 2004. Cited in: Cowell, J. C., Goldberg, M. T. & Carmel, J. E. 2004. Fecal and Urinary Diversions Management Principles. Elsevier, Mosby. Missouri.
- Doughty, D. R. & Sparks-Defriese B. 2007. Wound - Healing physiology. Cited in: Bryant, R. & Nix, D. (ed) Acute and Chronic Wounds: Current Management Concepts. 3rd edn. MO, Mosby. St. Louis
- Falanga, V. 2004. Cited in: EWMA 2004. Position report. Wound bed preparation in practice. European Wound Management Association (EWMA). Viking Print Services. London
- Hunter, J. E, Teot, L, Horch, R, Banwell, P. E. 2007. Evidence-based medicine: vacuum-assisted closure in wound care management. *International Wound Journal*, 4, 3, 256-269
- Kate, V. 2011. Cited in: Orr, M. E. & Caple, C. 2011 Enterocutaneous Fistula: Care of the patient. *Nursing practice & skills*. Cinahl Information Systems. California.
- Kiran, R. P. & Fazio, V. W. 2004. Cited in: Cowell, J. C., Goldberg, M. T. & Carmel, J. E. 2004. Fecal and Urinary Diversions Management Principles. Elsevier, Mosby. Missouri.
- Lloyd, D. A, Gabe, S. M. & Windsor, A. C. 2006. Cited in: Slater, R. 2009. Nutritional management of enterocutaneous fistulas. *British Journal of Nursing*, 18, 4, 225-230
- Nursing Council Of New Zealand 2009 'Code of Conduct for Nurses'. Nursing Council of New Zealand. Available online: www.nursingcouncil.org.nz <accessed 2011, August 13>
- Pontieri-Lewis, V. 2005. Management of Gastrointestinal Fistulas: A Case Study. *Medsurg Nursing*, 14, 1, 68-72
- Slater, R. 2009. Nutritional management of enterocutaneous fistulas. *British Journal of Nursing*, 18, 4, 225-230
- Slater, R. 2011. Supporting patients with enterocutaneous fistula: from hospital to home. *British Journal of Community Nursing*, 16, 2, 66-73
- Small, M. 2003. Cited in: Burch, J. 2003. The nursing care of a patient with enterocutaneous faecal fistulae. *British Journal of Nursing*, 12, 12, 736-740

Journey from the Dark Side

ERICA CROSBY

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My initial contact with Les was on night shift during his first surgical admission.

"F*** off" were his first words, followed up with "That f***ing surgeon has f***ed up. If you or anyone else thinks I'm doing this f***ing bag thing you can all get f***ed"

"Hi Les, I'm Erica" began our three year journey.

I reviewed Les's history. Les had presented acutely to hospital following ten days of malena and was admitted to a general medical ward. He had sustained a rapid two kilo weight loss. A colonoscopy revealed a sigmoid tumour 35cm from the anal verge. Despite a considerable medical history which included poorly controlled hypertension, renal impairment, repeated gastro-intestinal bleeds and gout Les had had only one previous admission to hospital. This was for a cerebral vascular accident in 1999. A builder by trade, Les had chosen to retire after his CVA. Les acknowledged he is a man who needs to be in control. He is highly intelligent and insightful; stating that often he acts as he sees fit with little regard or consideration for either the wider picture or the consequences. Perhaps typically of this generation Les also confirms he is a 'doer' not a 'talker'. He finds intimate relationships, other than with his family, uncomfortable.

During this admission, Les discharged himself before being reviewed by the surgeon. In hindsight this reactive response was Les feeling out of control and overwhelmed by the diagnosis. It was not until the following month that Les presented for a consultation in outpatients clinic and a plan was made for elective admission to hospital for an anterior resection.

Two days post his surgery Les became febrile; he experienced flank pain and had an elevated white blood count. It was not until four days after this: on day six post his initial surgery that Les returned to theatre. Les underwent a Hartmann's procedure for an anastomotic leak. The findings included gross faecal contamination throughout his abdomen.

Les's colostomy was healthy, unremarkable in appearance, function or location on the abdomen wall.

Les did not have a straight forward recovery from this event. He continued to have ongoing temperature spikes and a CT scan revealed multiple abdominal and pelvic collections. These necessitated many attempts at ultrasound-guided drainage. In total Les spent six weeks recovering in hospital. The treatment goals

and processes implemented in hospital were designed to meet Les's immediate physical survival needs. Little attention was paid to Les's deteriorating psychosocial state. Les was labelled difficult; rude and time consuming. His relationships with staff members were generally poor.

Les was a frustrated angry man. He perceived a lack of competence on the part of the surgeon had led to the anastomotic breakdown. Equally, he believed a lack of competence on the part of the health professionals caring for him immediately after his initial surgery had directly caused a delay in diagnosis and treatment.

My relationship with Les began in the small hours of the night and continued over the course of many nights. During the night, without the distraction of medical, nursing and physiotherapy treatment to occupy him, Les was able to focus his full attention on his grievances. The diagnosis of bowel cancer had resulted in a heightened sense of uncertainty and foreboding for Les, amplified due to the complications from his surgery. I felt it crucial to acknowledge Les's feelings, and restore his confidence that his roles as father, husband, and man were still valid. We talked over the coping strategies that he had utilised while recovering from his stroke, he shared stories about his grandchildren, and his many escapades on building sites. A therapeutic relationship began to emerge.

Les's family support was extensive and through them a different side of Les appeared. His wife, Mary worked early morning shifts. His eldest daughter Sam, had elected to visit for an extended period of time from Australia to support Les. Les's son, who had also suffered a mild stroke, his wife and their child, also lived in the family home. A younger daughter lived nearby. They were a close family united in their support of Les.

A change in my professional circumstances meant my involvement with Les continued in the role of Stomal Therapist when he was discharged to community care.

Les refused point blank to participate in stoma care. I can report that his extensive vocabulary of profanities was well utilised whenever the subject was discussed. Unwisely, due to the dependence that it fostered, Les's daughter Sam had forged an agreement with her father that she would be the sole provider of his stoma care.

Immediately post discharge Sam experienced difficulties in caring for the colostomy. Appliances which had previously achieved a 3-4 day wear time were at best lasting 36 hours. At times, these were

Journey from the Dark Side ...continued

ERICA CROSBY

Stomal Therapist, Counties Manukau District Health Board

changed 2-3 times a day. Sam disclosed that many changes were at Les's insistence and for no apparent reason.

Our trials of different equipment met with varying degrees of success. Often a period of stability would be followed by episodes of excessive equipment usage without an apparent clinical reason. Close investigation revealed that these periods often coincided with Les receiving information that was contrary to his expectations. For example; receiving the date for his reversal of Hartmann's procedure which was later than he had expected. And being informed at clinic that his reversal surgery may necessitate an ileostomy.

Les's first experience of a significant alteration in his health status was not following the pathway he had expected or to quote him 'consented for'. Although Les's activities were not condoned, I believe he was manipulating his environment in an attempt to regain some control. There is no doubt that supporting Les through this phase of his recovery came at a significant fiscal cost.

One thing Les found very difficult to accept was the need for an ileostomy following his reversal surgery. He perceived it almost an insult that having been subjected to a colostomy; he was then expected to tolerate an ileostomy as well. Part of any health care professional's role is to educate and advocate on behalf of the patient. I felt my relationship with Les was now sufficiently well established for me to provide him and Sam with information even in the face of Les's refusal to hear that information. On multiple occasions Les had refused information, but then freely engaged in the information sharing process. Small, routine but significant pieces of information were given and re-enforced many times. Les expressed an understanding of the surgery and a desire to "just get on with it".

Les's recovery from the reversal procedure was unremarkable and he was discharged nine days later.

On initial assessment Les's ileostomy was sloughy. The peri-stomal skin was excellent, the location on the abdomen was unremarkable.

Les's daughter Sam had returned to Australia and Les himself was doing the majority of stoma cares. Les was in great spirits. He verbalised his belief that his continuing life as an ostomate was now for a finite period of time and he was making plans for a trip overseas with Mary. Les firmly believed that the next few months would conclude with the successful reversal of his ileostomy. He accepted the ileostomy as a 'means to an end'.

Les was using a two piece appliance and achieving a weartime of four days. The main concern was an excessive output. Unfortunately Les did not perceive this as of any concern. Life, according to Les, was full steam ahead and this included drinking whatever he liked in whatever volumes he liked. He was extremely inconsistent in his compliance with medications such as Loperamide. Les selectively filtered all information about diet, fluids and salt intake. If he disliked the information he filtered it away. Les genuinely did not perceive any threat to his health from continued high ileostomy outputs. Accommodating Les's need to feel in control led to many negotiations. Communication to, and a collaborative effort with Les's GP were required to ensure he adhered to his medication regime. Even with this input I am not convinced we managed to make any noteworthy difference on either Les's compliance or the type and volume of his ileostomy output.

Sometime later Les presented for reversal of his ileostomy.

Regrettably, this procedure also failed to follow the expected pathway and did not meet Les's expectations. Three days after his surgery Les developed fresh rectal bleeding and an elevated temperature. Over the next several days Les' condition continued to deteriorate. Les returned to surgery for an exploratory laparotomy. An anastomotic leak and large peritoneal abscesses were found. A double barrelled ileostomy was formed.

Les's abdomen was unable to be closed and a marlex mesh was inserted for temporary closure.

A stormy three months in hospital followed. Les experienced multiple ICU admissions, treatment for nosocomial pneumonia, repeated blood transfusions for gastro-intestinal bleeds and trips to theatre for debridement and reefing of the mesh in his open abdominal wound.

Les experienced several episodes of depression during this admission. Whilst refusing intervention from the psychiatric team he did consent to commencing anti-depressants. A planned 3-4 week period in rehabilitation was abruptly ended when Les again discharged himself from care.

I reviewed Les and his third stoma in the community. The ileostomy was healthy, the peri-stomal skin slightly reddened, with creases in the abdominal contours at 3 and 9 o'clock. Unfortunately, this third stoma was flush to the abdomen, and proved to be the most problematic of them all.

Journey from the Dark Side ...continued

ERICA CROSBY

Stomal Therapist, Counties Manukau District Health Board

This period was possibly the lowest point for Les. Once again there had been a significant deviation from the planned care. This resulted in previously resolved issues resurfacing. Les's anger and need to blame became the focus of his attention. Once again Les's control over his life and activities were threatened. Les's decision making deteriorated further.

Despite multiple interventions from both the district nurses and the stomal therapists Les experienced many leaks. His wife Mary was undertaking his ileostomy cares as Les again declined to participate. Les was alternating between drinking inappropriately to not eating or drinking at all in an attempt to reduce the ileostomy output. He was refusing to take Loperamide. During the next six weeks Les had three admissions to hospital with renal failure caused by dehydration resulting from a high volume ileostomy output. On two of these occasions Les again discharged himself from care. He did not attend scheduled clinic appointments.

It became essential for us to acknowledge that we couldn't assume what the goals of care were for Les. Les's apparent destructive behaviour was his way of expressing his need to be in control in the face of the many losses he had already experienced. Les's perception and fear that his life would be controlled by this stoma needed addressing. Frequently during my first visits I would find him, for example, precariously perched on a ladder hanging wall paper, whilst his appliance was leaking. Stopping his activities of life to deal with 'that thing' was not acceptable to him. A large part of caring for Les during this time focused on allowing him the time to express his anger, his need to blame, his anxiety of the future, whilst also redirecting his destructive behaviour and its consequences, towards a more positive outcome.

Due to the insecurity caused by repeated appliance leaks Les believed that his goal of a trip to Australia with Mary was now beyond his reach. This was a major aim for Les, so we started with that. Les acknowledged that his appliances were only leaking when his output was liquid. He was able to articulate what dietary influences contributed to this. He acknowledged he was

irritable with Mary when she 'mucked around' with applying the accessories to his two piece appliance. Les refused several times to acknowledge hearing the rationale for these interventions. I felt reasonably certain this far into our relationship I could be a bit more direct in responding to this. We discussed the idea that it was his actions holding up the overseas adventure, not his ileostomy. I suggested that he give a trial of adhering to the prescribed regime of stool-thickeners, and the combination of eakan seals and adapt convex ring I had recommended. Again, a routine intervention, but another one that was significant for Les.

Two weeks after this plan commenced, Mary reported appliances were lasting 3-4 days, and the output was consistent with a normal ileostomy. This pattern was established over the forthcoming months, and continued with no major issues.

I was privileged to share Les's experience over a long time frame from his first catastrophic hospital admission through three years of active community care. This continuity of care allowed me to establish a unique relationship with him.

As health professionals, we constantly endeavour to take cognisance of all the factors in a patient's reality that will impact on successful stoma management. For Les, it was only after resolution of adjacent issues that he could re-focus to achieve successful independent stoma care.

Les and Mary enjoyed two separate trips around Australia.

AASTN Conference Report

HOBART 20 - 22 MARCH 2013

JACKIE HUTCHINGS



I was very fortunate to be granted funding from the Bernadette Hart Award to attend the AASTN conference in Hobart. As I enter my thirtieth year since starting stomal therapy it was wonderful to attend my first international conference. It was also special to have been granted this award as Bernadette Hart was my charge nurse in Invercargill and was my mentor as I began my stomal therapy career. As a memorial to Bernadette Hart I was allowed to set up the stomal therapy service in Southland. Previously patients had been seen in the ward or in our own time.

The speakers at this conference were many and varied and it was often difficult to choose what to attend when concurrent sessions were held. The calibre of the speakers was generally very high except one and this is the session I have decided to write this report about as it has stuck in my mind and has in fact been very thought provoking.

The speaker was a stomal therapy nurse who I will not identify. She worked in a hospital setting and felt that the ward nurses were too dependent on her. I think many of us who work in these situations probably feel the same. She decided to have staff complete a simple questionnaire so she could identify gaps in their knowledge but as usual only a small number were completed and most staff felt they were confident with stomal cares. This also seems quite familiar.

What came across clearly to me though was the negative attitude this person had and how much she appeared to downgrade the ward staff. She had set herself up to be superior to them and her presentation seemed to be more about self-validation.

The reason this presentation was so powerful to me was because it made me think about my own practice. It is so easy to go into the wards and take over all the stoma cares while we are there but that is only 4 - 6 hours per day at best and our patients are then cared for by the wonderful ward staff.

Perhaps instead of pouring such a lot into the patient we should involve their nurses at the same time in an informal way. This type of teaching can be quite powerful as it is very non-threatening and the patient, nurse and stomal therapist can all feel part of a team helping the patient come to terms with their stoma both physically and psychologically.

I feel that patients can become too reliant on their stomal therapist and this can lead to ward staff feeling undermined and dissatisfied even though it has been unintentional. We need to remember that we are just part of a team and that each team member is equally important to the outcome for the patient. I would also hate to close the gap so that we appear unapproachable. Education is a two way street and there is much we can learn from each other.

I would encourage all those with an interest in stomal therapy to attend an international conference (and don't wait as long as me). It was interesting to hear things from an Australian perspective particularly regarding supply of product. They are also looking forward to seeing what happens in New Zealand with regards to Pharmac as their concern is that the Australian government will want to go the same way limiting choices available to patients and clinicians which could be very detrimental to our patients' outcomes.

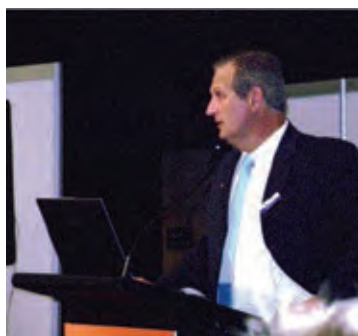
Following the conference my husband and I had the weekend to do a bit of exploring at the markets, looking at the history of Tasmania, exploring the wonderful old buildings and wildlife. I learnt a lot about Tasmanian Devils and the terrible disease that is decimating their population at an alarming rate. Tasmania is an extremely interesting island and I do hope to return sometime soon as there is still a lot I want to see and do there.

Once again, thank you for helping me make it possible to attend this conference.

AASTN Conference Report

HOBART 20 - 22 MARCH 2013

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¹ 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.

² Hoefloek 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

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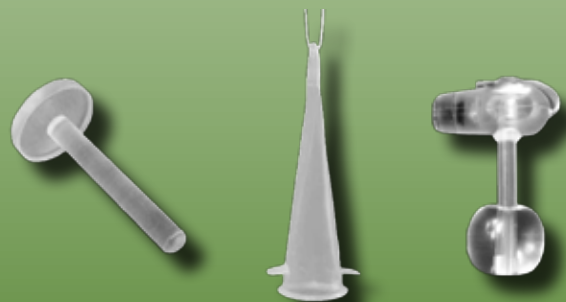
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