The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

OCTOBER 2014

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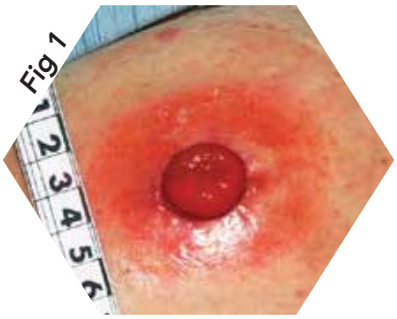
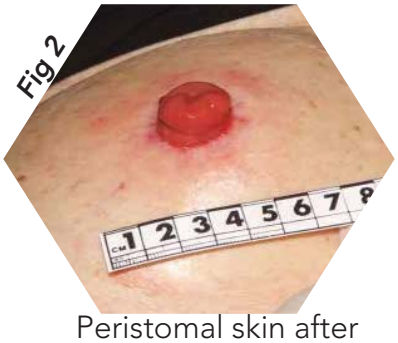


Peristomal skin, red and macerated



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The Outlet

New Zealand Stomal Therapy Nurses

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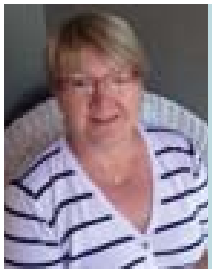

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NZNOSTS Section: Chairperson's Report

MAREE O'CONNOR

The committee have worked hard over the last two years to strengthen the NZNOSTS.

There is quite a process for committee members to come to know what the work of the committee is, the requirements set by NZNO, the goals of the section, the strengths and weaknesses of the committee, what has already been achieved and what still needs to be progressed.

By mid term the committee had developed a clearer understanding, and confidence in the work there is to do. This enabled the committee to move forward on key issues. The main goal as determined by section members being; to achieve College status independently by 2016.

Throughout our term of office we have moved steadily towards this goal. We have made significant progress on developing a strategic plan, we have been updating the Standards of Practice, developing role descriptions, updating the section rules; working on an Education Policy along side the day to day business of the section (for example, growing membership, producing The Outlet, advocating for patients regarding medical devices with PHARMAC, and providing our national conference.

Needless to say it has been busy!

We hope the membership is in concordance with the work achieved so far.

Being a committee member is always interesting, and worthwhile and we encourage section members to participate whether this be by submission of articles for the journal, being prepared to be nominated onto committee, taking part in section surveys or contributing in other ways. Your input is both welcomed and appreciated.

This report will serve as, the report for this latest addition of our journal and as the report for the BGM.

I would like to take this opportunity to thank the committee for all their hard work and commitment during this term of office.

Best wishes

Maree O'Connor
NZNOSTS Chairperson

Learn from Yesterday, Live for Today, Hope for Tomorrow

MAREE O'CONNOR
NZNOSTS Chairperson

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ON THE MOVE

6th - 7th November
RYDGES HOTEL AUCKLAND
Registrations Open

NZNOSTS Conference Programme On The Move

NOVEMBER 6TH & 7TH 2014

Day 1 November 6th 2014

0730-0800	**Registration desk open**
0800-0815	Welcome Powhiri, *Whitiora Cooper, Kaumatua*
0815-0845	Opening Guest Speaker *Margareth Broodkorn, Director of Nursing and Midwifery, Northland DHB*
0845-0900	The Kenya Experience, *Richard Ward, Sales and Marketing Manager (Omnigon)*
0900-1000	The Impact of Liver Surgery on Survival for Colorectal Cancer, *Adam Bartlett, Liver Surgeon, Auckland DHB*
1000-1030	**Morning Tea**
1030-1100	Re-poopulate (Clostridium diff.and faecal Transplant), *Jacky Watkins, Nurse Educator, Counties Manukau DHB*
1100-1200	NZNOSTS Biennial General Meeting
1200-1300	**Lunch**
1300-1500	Understanding Stress, Disgust and Avoidance in a Bowel Health Context, *Nathan Consedine, Liberty Guest Speaker*
1500-1530	**Afternoon Tea**
1530-1600	Challenging Practice, *Wendy Sansom, Clinical Nurse Consultant, Box Hill Aust (Salts presenter)*
1600-1630	Marie's Story-the whole journey with FAP, *Carol Lee, Clinical Nurse Specialist, Stomal Therapy, Waikato. Liberty Presenters Awards*
1830	*Conference Social Event: Racing at Rydges*

Day 2 November 7th 2014

0800-0830	**Registration desk open**
0830-0900	Finding My Way: On the Road Towards a Specialised Role, *Clayton Hopewell. Liberty Presenters Award*
0900-0930	Ehlers Danlos Syndrome Type 4 What is it? *Rachel Pasley, Liberty Presenters Award*
0930-1030	A Colorectal Cancer Screening Program in NZ, *Paul Frankish, Gastroenterologist, Waitamata Health*
1030-1100	**Morning Tea**
1100- 1200	Colorectal Surgery, *John Groom, Colorectal Surgeon, Wellington*
1200-1230	Changing the problem: A simple approach to a Complex Problem, *Vicky Beban, CNS Stomal Hutt Valley. Liberty Presenters Award*
1230-1300	**Lunch**
1300-1330	Because Not all Patients want to be Guinea Pigs & Not all Nurses Learn the Same Way, *Jennifer Rowlands. Liberty Presenters Award*
1330-1430	Moving On: Nursing through the Decades in NZ, *Judy Kilpatrick. Associate Profession, Head of AUT School of Nursing*
1430-1500	Conference Awards
1530	Conference closing Poroporoaki, *Whitiora Cooper Kaumatua*

NZNOSTS Conference Programme On The Move

NOVEMBER 6TH & 7TH 2014

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Please print clearly

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Address: _____

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Telephone: _____ **Email:** _____

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Full fee	**$300**	Includes morning and afternoon teas, lunches and social event - Thursday night
Early bird before 01/09/2014	**$270**	Includes morning and afternoon teas, lunches and social event - Thursday night
One day only	**$150**	Includes morning and afternoon tea and lunch
Social Event	**$65**	Partners or single day registrants

NB All registration fees (above) are inclusive of GST
All registrations are entered into a Lucky Draw - one registration fee reimbursed

Please tick ◯ I will be attending the Thursday evening social event

Theme: Glamorous Rooftop Races - dress-up encouraged

◯ Do you have any special dietary requirements?

◯ Vegetarian ◯ Gluten Free ◯ Other (please specify) _____

Accommodation:
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The National Executive Committee would like to thank the following sponsors for their support in assisting us to facilitate conference 2014, Omnigon, Liberty, Coloplast, ConvaTec, AinsCorp and NZMS

NZNOSTS Conference
An Evening at Rydges Rooftop Races

NOVEMBER 6TH - 6.30-11.00PM

Venue Rydges Rooftop Terrace, Federal St, Auckland. Rydges Rooftop Terrace is located on the tenth floor of the conference venue. With the WOW factor to impress this amasing venue offers spectacular views of Auckland's beautiful city scape and the fabulous Waitemata Harbour.

Time 6.30-11.00pm

Date Thursday 6th 2014

Cost the cost of the social event is included in the price of full conference registration. Additional tickets, for guests of delegates may be purchased for this event at $65 each

Social Program: Racing, Fashion and Dancing

On arrival at the event, guests will be supplied with a packet containing;

- $10,000 (sadly not real money)
- Betting slips
- A voting form for the Fashion in the Field Parade

Racing: there will be two horse races during the evening and guests can use their supplied money to bet on the outcome. Our sponsor, Omnigon have supplied an I pad which will be awarded to the most successful racing better at the conclusion of day two of the conference.

Fashion in The Field Parade: during the evening officials will offer selected guests the opportunity to participate in a fashion in the field parade. Selected contestants will be those who have entered into the spirit of this event and made a fashion statement with their outfit. Guests will select the winner of the parade by voting on the form provided in their pack. Our sponsor, Coloplast has donated a kindle reader for the winner of this event. The prize will be awarded at the conclusion of day two of the conference.

Food and Beverages: substantial finger, wines, beers, OJ and soft drinks will be served for the first two hours of the event after which a cash bar will be available. The food and beverage service has been supported by Omnigon, Liberty, ConvaTec and Coloplast.

Dancing: Coloplast have supported Limelight Music Company to DJ us through the evening until 11pm

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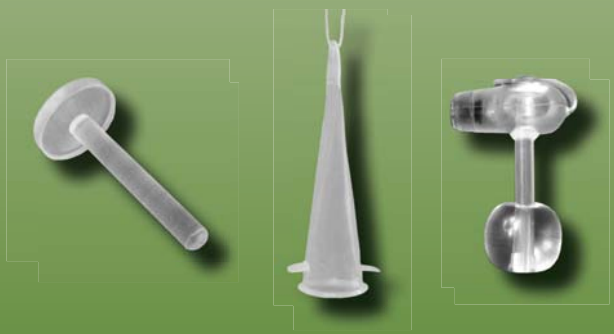

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Policy for Bernadette Hart Award Selection

PROCESS

- The Bernadette Hart Award will be advertised in the NZNOSTS Journal 'The Outlet'.
- The closing date for the BHA applications is the 30th November each year.
- The NZNOSTS National Executive committee will consult and award the BHA within 1 month of the closing date
- All applicants will receive e mail acknowledgement of their applicant
- All applicants will be notified of the outcome, in writing, within one month of the closing date.
- The monetary amount of the award will be decided by the NZNOSTS National Executive committee. The amount will be dependent on the number of successful applicants each year and the financial status of the BHA fund.
- The name of the successful applicant(s) will be published in the NZNOSTS Journal 'The Outlet'.
- The BHA Policy will be reviewed annually in May by the NZNOSTS Executive Committee.

CRITERIA

- The applicant(s) must be a current member of the NZNOSTS and have been a member for a minimum of one year.
- Successful applicant(s) must indicate how they will use the award. The award must be used in relation to Stomal therapy nursing practise.
- The applicant(s) previous receipt of money (within the last 5 years) from the NZNOSTS and/or the BHA will be taken into consideration by the NZNOSTS executive committee when making their decision. This does not exclude a member from re- applying. Previous receipt of the BHA will be taken into account if there are multiple applicants in any one year.
- The funds are to be used within 12 months following the receipt of the BHA.

FEEDBACK

- The successful applicant(s) agrees to either:
  a) submit an article to 'The Outlet' within six months of receiving the BHA. The article will demonstrate the knowledge gained through use of the BHA or
  b) to present at the next NZNOSTS Conference. The presentation will encompass the knowledge/nursing practice gained through the use of the BHA.

Implemented September 1998
Reviewed June 2014

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

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

APPLICATIONS CLOSE 30TH NOVEMBER (Annually)

SEND APPLICATION TO:

Ginnie Kevey-Melville
Email: ginnie.kevey-melville@northlanddhb.org.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

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Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership ◯ FULL ◯ LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

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

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

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EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ _____

Transport: $ _____

Accommodation: $ _____

Other: $ _____

Funding granted/Sourced from other Organisations

Organisation:

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PREVIOUS COMMITMENT/MEMBERSHIP TO NZNO STS

_____

_____

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

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

◯ Yes I 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: _____

Classification of colorectal cancer to aid the stomal therapy nurse in practice

TRACEY BEATTIE
STN (Cred), BCN, RN, Grad Dip Nursing, Master of Clinical Nursing, Clinical Nurse Consultant Stomal Therapy Breast Care, North West Regional Hospital Burnie TAS

Colorectal cancer (CRC) contributes significantly to the morbidity and mortality of Australians. The importance of staging cannot be overemphasised in the management of patients due to the major influence it has on treatment and survival rates. A thorough understanding of classification systems is essential for members of the multidisciplinary team who are providing care for patients diagnosed with colorectal cancers and will be outlined in this paper.

The presence of a stoma following surgical resection often serves to enhance problems associated with a diagnosis of cancer, including delays in physical and psychological recovery. The provision and reiteration of information, along with tailored care provided by the stomal therapy nurse can significantly assist patients diagnosed with CRC. Valuable psychological support can be an added benefit when the stomal therapy nurse is available to help navigate the treatment pathway.

INTRODUCTION

In Australia, 80 people die of colorectal or bowel cancer every week[1,2]. If this figure was an indication of road traffic deaths, society would be truly outraged. Colorectal cancer (CRC) is the second most diagnosed cancer for both sexes in Australia behind breast cancer for women and prostrate cancer for men[3]. It is a significant health problem, not only for Australia but throughout the western world. Incidence rates have been rising for two decades and whilst ageing populations and dietary choices are contributing to the development of this rise, it is difficult to assign any one reason for the increase.

The aetiology is complex and involves both interaction between inherited susceptibility and environment factors. The risk of developing bowel cancer increases at the age of 40 years and then rises sharply and progressively from the age of 50[2]. Early detection and treatment are the key factors to improve survival rates[3]. This is made difficult by the nature of the disease. However, population screening has commenced in Australia with free faecal occult blood testing kits sent to people aged 50 and 65 years, with recall and necessary follow-up for positive samples[3].

A malignant tumour that begins in the bowel wall can be confined locally for long periods before spreading or 'metastasising' to lymph nodes and other organs of the body. Polyps or adenomas are tiny growths inside the colon or rectum that resemble cherries on stalks which can become malignant over time.

Evidence suggests that adenomas account for a significant proportion of CRC, acting as precursors for a cancel type known as adenocarcinoma[2]. Rarer histological types of CRC include signet-ring cell (also adenocarcinoma), small-cell carcinoma and medullary carcinoma[4].

Treatment options for CRC usually begin with surgical resection, which is performed with the intention of cure[4]. The need for adjuvant therapies such as chemotherapy or radiation therapy will be assessed based on the pathology assessment of local disease and tissue-based and tissue-based prognostic factors in the resected specimen[4]. This pathology testing at the time of surgery is the most reliable system that relates accurately to patient survival[2]. This is known as 'staging' the cancer. Staging provides uniform and valuable information which can be shared among the multidisciplinary team to base treatment recommendations and considerations for the patient involved[5]. It is important that the stomal therapy nurse (STN) is educated in the staging of CRC and has access to individual patient pathology to base stomal therapy care appropriately and accordingly.

STAGING CRC

The first consideration will be to determine if the tumour is benign or malignant. Benign tumours will demonstrate cells that closely resemble normal healthy cells. Malignant cells, on the other hand, will be vastly different to healthy cells[6]. The abnormal growth will also be graded as either a well, moderately or poorly differentiated lesion. The more differentiated (or different from the normal cell) the more malignant the neoplasm is classified, indicating a poorer prognosis.

The process of staging cancer began over a hundred years ago5 and it was first described by Dukes, known as Dukes' Staging System[2,7]. The Dukes' System consisted of stages A, B and C and correlated well with patient survival and was, therefore, easily adopted. It

Classification of colorectal cancer to aid the stomal therapy nurse in practice *...continued*

TRACEY BEATTIE

was later extended by Turnball, who added stage D to reflect the existence of residual tumour or known metastases to other areas[2]. This system is superseded in Australia where two main systems are utilised, although they are, in essence, extensions of the original Dukes' staging method. The two systems are The Australian ClinicoPathological Staging (ACPS) system (Table 1) and the pathological staging system according to the American Joint Committee on Cancer (AJCC) (Table 2), the TNM system.

Definitions of the AJCC TNN system are: T relates to the size and invasiveness of the primary tumour, N for regional lymphatic node involvement and M for the presence of distant metastases8. Accuracy of staging is vital as treatment is generally determined by the assigned stage.

Table 1 Australian ClinicoPathological Staging (ACPS) system[9].

Maximal Spread of Cancer	ACPS
Mucosa	AO
Submucosa muscularis propia	A
Beyond muscularis propia	B
Free seosal surface	
Local nodes involved	C
Apical nodes involved	
Tumour transacted (histological)	D
Distant metastases (clinical or histogical)	
Pathological TNM Staging nomenclature[10]	

LAYERS OF LARGE BOWEL[11]

Mucosa: Innermost layer - directly responsible for absorption and secretion (mucous). Consists of three layers: epithelium (cells), lamina propria (connective tissue) and muscularis mucosae (smooth muscle fibres).

Submucosa: Not separate from mucosa; however, contains blood vessels, lymophatics and nerves - absorption of nutrients through the blood stream occurs here.

Muscular layer: Responsible for gastrointestinal movements - waves of contractions (peristalisis). Two distinct layers of smooth muscle include the inner 'circular' and outer 'longitudinal' layers.

Serosa: Outer smooth muscle membrane that gives strength to the digestive tract.

Source[10]

ASSESSMENT

After initially greeting John and introducing myself, he asked me if there was anything I could do that would improve his quality of life. The implication was that, if I couldn't then visiting him was wasting his time. What a challenge! I soon came to realise, that John was very direct and appreciated open, honest communication about his situation. I asked him, if there was one thing that he could change about his situation what would it be? He said that, what he wanted was to go to bed at night smelling sweet and clean so that he could cuddle his wife without wet pads.. Seventy per cent of MS patients feel that urinary incontinence is the worst aspect of their condition (Fowler, Panicker, Drake, Harris, Harrison, Kirby & Wells;2009). John definitely agreed with this.

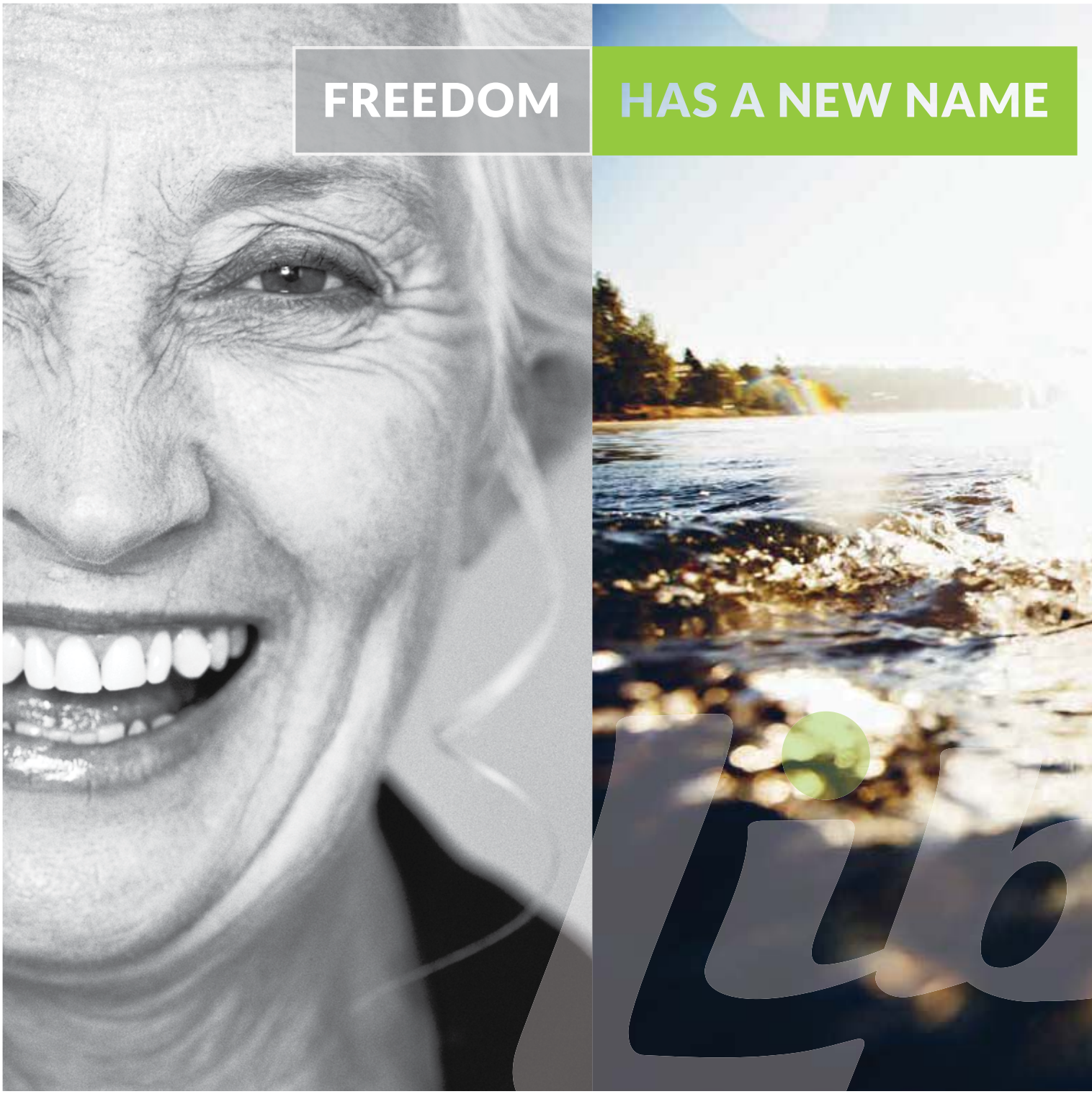
From about 2004, when he started to wear pads, John's main urinary complaint has been his need to go to the toilet frequently, especially at night. This is very disruptive as he needs assistance getting out of bed. As a consequence, Carol also has very disputed sleep If John delays toileting by more than a couple of minutes he starts to leak urine, which he can not control. He has a slow stream of urine and sometimes has to push and strain to start the flow. He has had urinary tract infections (UTI) requiring antibiotics however these have not been recent events. Otherwise John's general health is good. He avoids contact with doctors unless there is no other option.

STAGE 0

This is the earliest stage of CRC. At this stage the lesion has not extended beyond the mucosal lining into the lamina propria. Often treatment and cure involves removal of the polyp (via colonoscopy) and no further intervention is required.

STAGE I

At this stage the 'polyp' has progressed to cancerous but remains localised with the submucosal layer. Treatment will involve surgical resection with end-to-end anastomosis with optimal 2 cm clear margins[2]. The five-year survival rate following this procedure is between 88 and 95%[2].



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Classification of colorectal cancer to aid the stomal therapy nurse in practice ...continued

TRACEY BEATTIE

STAGE II

This stage can be compared with Dukes' stage B and indicates spread or metastases into the muscular mucosa but does not involve any lymphatic spread. Surgical resection is also the required treatment and the result is an estimated survival of between 60 and 70%[2]. The use of adjuvant therapy in stage II remains debated. Despite resection of the tumour tissue, the use of therapies is controversial because of conflicting data8. Further treatment may be considered and recommended if the tumour grade is poor, if positive surgical margins exist, if there is bowel obstruction at presentation or if inadequate nodes were obtained for sampling (less than 12)[8].

STAGE III

Describes cancer that has spread outside the colon to neighbouring lymph nodes, previously classified as Dukes' stage C. Treatment recommended will include resection of tumour and adjuvant therapies such as chemotherapy and radiotherapy. The number of lymph nodes involved will influence survival rates. For patients with four or more lymph nodes involved, the five-year survival rate is reduced to 43%.

STAGE IV

Or Dukes' stage D, indicates that cancer has metastasised to other organs of the body. This stage carries a much poorer prognosis with patients usually succumbing to the disease5. Most common areas of spread include the liver and lungs which may also undergo surgical resection. Australian five-year survival rate for this stage is currently 7%2.

Table 2 Anatomic stage/prognostic groups[10]

T - spread of primary tumour		Stage	T	N	M	Dukes
Tis	Carcinoma in situ	0	Tis	N0	M0	-
T1	Submucosa	1	T1	N0	M0	A
T2	Muscularis propria	T2	N0	M0	A	
T3	Subserosa, nonperitonealised pericolic/perirectal tissues	IIA	T3	N0	M0	B
T4	Other organsa or structures/visceral periotoneum	IIB	T4a	N0	M0	B
N - regional lymph nodes		IIC	T4b	N0	M0	B
NO	No regional lymph nodes metastases	IIIA	T1-T2	N1/N1c	M0	C
N1	1-3 positive regional nodes	T1	N2a	M0	C	
N2	4 or more positive regional nodes	IIIB	T3-T4a	N1/N1c	M0	C
M - distant nodes		T2-T3	N2a	M0	C	
MO	No distant metastasis	T1-T2	N2b	M0	C	
M1	Distant metastasis	IIIC	T4a	N1/N1c	M0	C
		T3-T4a	N2b	M0	C	
		T4b	N1-N2	M0	C	
		IVA	Any T	Any N	M1a	
		IVB	Any T	Any N	M1b	

Classification of colorectal cancer to aid the stomal therapy nurse in practice *...continued*

TRACEY BEATTIE

CURRENT SUBSETS

The cancer staging system described by the AJCC[10] is continually updated and adjustments made according to incidence reporting and trial data; the latest adjustments are shown in Table 2. This provides an international, uniform systems on which health professionals can base treatment decisions and discuss options with patients and other specialists. Due to such professional input and scrutiny, stages have been further broken down into subsets according to, for example, extent or grade of the disease.

A T4 lession is now divided into T4a if it penetrates the surface of the visceral peritoneum or T4b if the lesion invades other organs or structures. The N classification has also been broken down and classed more specifically. N1a relates to metastases in one regional node, N1b means two to three nodes are affected. N2 is subdivided into N2a, which corresponds to between four and six nodes involved and N2b meaning that metastases is present in seven or more nodes. M1 has also been further subdivided, with M1a representing spread to one site and M1b indicating multiple metastic sites[10].

IMPLICATIONS FOR STOMAL THERAPY CARE

Surgical resection of the CRC can result in formation of a stoma at any surgical stage of treatment. This may be in the form of a permanent colostomy as a result of an abdominal perineal resection for a low rectal cancer, for example, or a temporary ileostomy to aid anastomotic healing time.

Colorectal cancer patients who require a stoma experience more problems with body image adjustment, sexuality and lower overall quality of life compared to those CRC patients who do not need a stoma[12]. The subsequent effect of living with cancer and a stoma can, therefore, present a significant challenge for both the patient and the family[13].

INFORMATION PROVISION

Patients who have planned, versus emergency surgery, and who are 'marked' for the possibility of stoma formation can often be better prepared. STNs can use this opportunity to gauge the patients' understanding of the diagnosis and subsequent care and clarify where needed.

In the author's experience, patients often feel that stoma formation is the "worst case scenario" and have vocalised "it's good news, no bag!" during postoperative review where end-to-end anastomosis has been successful. The concern has been at times that patients don't comprehend or fully understand the implications of a stage III or stage IV cancer. The fear and anxiety have been more related to the 'bag' rather than the cancer itself. Additionally, postoperative information is, at times, provided on quick ward rounds by busy specialists during recovery time where patients are tired and/or medicated with pain relief. These issues can contribute to gaps in knowledge and information for CRC patients, especially in the early phase[14].

Although the STN's services will no longer be required in such situations, there may exist an opportunity to provide links to further information or referral to cancer care coordinators if available. Providing a simple resource such as 'questions to ask your doctor' can be helpful for follow-up outpatient consultations.

STOMA CARE EDUCATION

Formation of a stoma following colorectal surgery can challenge and individual's life enormously[13]. When combining a devastating diagnosis of cancer with an incontinent faecal diversion that has the ability to make sounds and odour, it is understandable that adjustment takes time and support. Interestingly, however, is that, "ostomy self care is the most important variable predicting positive adjustment"[13]. It is, therefore, vital that the STN makes every effort, where possible, to educate with the aim of facilitating independence.

Loved ones will often also be suffering from psychological distress from the diagnosis and may want to resume responsibility for care to lighten the burden or show support[12]. It is important to communicate that simply a family's understanding and acceptance may help improve any anxiety and depression felt by the patient and can be the key to an improved quality of life.

The STN's ability to successfully coach and be respectful and positive by providing unconditional support to the patient and their family will influence adaption[13]. It also enables the development of a professional rapport. The patient and family may then feel comfortable to discuss other concerns with the STN, such as sexuality and progression of disease[15].

ADJUVANT TREATMENT ADVICE

The STN who understands the staging system will often be able to predict which patients will be recommended further treatments and should prepare to give the patient relevant advice. It is important to discuss the potential need for chemotherapy or radiation treatment to dispel fears where possible and discuss common side effects. Patients should be encouraged to ask questions about treatments and report side effects to their

Classification of colorectal cancer to aid the stomal therapy nurse in practice *...continued*

TRACEY BEATTIE

oncology nurse or specialist. Some patients will 'suffer in silence', believing side effects to be expected or fear treatment may be stopped[11]. Explanations that are given regarding adjustments to dose and treatments for side effects can reassure the patient and possibly reduce more serious treatment complications.

Practical advice needed for stomal therapy patients includes management of gastrointestinal disturbances from chemotherapy such as diarrhoea, nausea, vomiting, mouth ulcers or constipation[11]. Patients with closed-ended pouches may require product changes to drainable appliances may cause skin irritation. Ileostomy patients may be particularly vulnerable, if experiencing very fluid stools or vomiting, due to the risk of dehydration. Advising of the signs of symptoms of dehydration, such as headache, lethargy and dry mouth is important so that patients know when to seek assistance and prevent medical emergencies.

The nutritional status of cancer patients who have recently had major bowel surgery is often poor. The administration of chemotherapy agents can cause further depletion. Recommending small, frequent meals and an adequate fluid intake is necessary. In the author's experience, support is also needed for the care giver, who is often concerned about the change in appetite and low intake of the loved one. Enticing patients to eat and offer an ever-changing menu can prove exhausting for care givers. Referral to a dietician should be considered for more specific advice and management.

Radiation therapy may be used post-surgery or as a means to reduce the tumour size prior to surgery or for symptom relief during palliation[16]. Common side effects of treatment can include fatigue, skin damage and sexual dysfunction. Radiation to the pelvis can cause erectile dysfunction in men and vaginal fibrosis in women[11]. Patients who have needed to have a stomal created have already experienced major body image change; problems with sexuality are an added distress.

Patients of all ages and disease stages need opportunities to discuss intimacy with openness and sensitivity guaranteed. Health care professionals such as the STN can open the lines of communication on sexuality, give stoma-related advice and refer to the patient's general practitioner or sexual counsellors if problems exist.

CONCLUSION

Caring for patients diagnosed with CRC involves a multi-disciplinary approach for best patient outcomes. Developing successful, professional relationships with surgeons, oncologists, oncology nurses, dieticians and social workers ensures open avenues for patient discussion and referral.

The STN is encouraged to promote the role so that other health professionals respect and understand the value and importance of the care that can be provided by the STN. This can be achieved through attendance and active communication at multi-disciplinary meetings and by educating all staff on the STN role. Medical specialists will more likely share valuable patient information, such as the disease stage, with the STN if there is an understanding that this information will directly improve patient care and provide patients with an optimal health care experience.

Not all STNs will have opportunities to provide outpatient consultations following discharge from hospital. It is even more imperative then that appropriate referrals and resources are provided to patients prior to discharge so they are no lost to follow-up and quality care.

As specialist nurses, STNs have an obligation to provide knowledgeably professional and specialised care. This is achieved and evident through professional development and adherence to the Australian Association of Stomal Therapy Nurses (AASTN)17 standards for the advanced practice nurse. Commitment to these standards not only enhances self-care and rehabilitation of the individual but also professional confidence in the role. Additionally, the STN's knowledge of CRC staging ensures high-quality stomal therapy care, including providing much needed psychological support and empowerment to the patient at a very stressful time of their life.

Classification of colorectal cancer to aid the stomal therapy nurse in practice *...continued*

TRACEY BEATTIE

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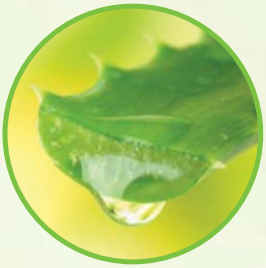

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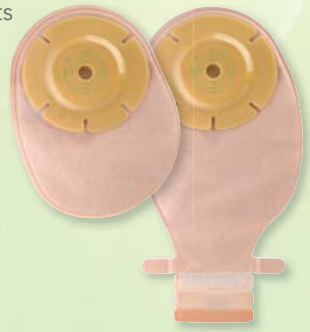

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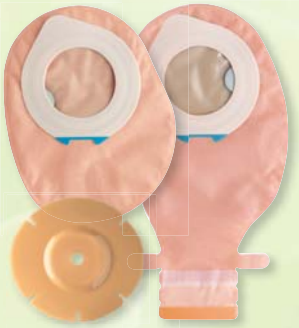

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Case Study: "Mr T"

MARIE BUCHANAN

Marie Buchanan,
Clinical Nurse Specialist,
Ostomy

INTRODUCTION

So; what does the "T' stand for? Most people who cared for Mr T would be likely to say; terrible, troublesome, trying, tactless, time consuming, testing and probably a total pain. These descriptions were probably warranted and true at that time.

His behavior on the ward, I understand, was nothing short of appalling. This was outlined in his last discharge letter and confirmed by his family.

I was privileged to see another side to Mr T. I see the "T" as representing traumatized, terminal, terrified, tearful, ticked off, tired and much thwarted.

I believe it would be an understatement to say Mr T wasn't the easiest or nicest of men to work with and try to care for. In the 30 odd years that I have been practicing I have never come across a more challenging patient, personality and behavior wise. He treated the majority of staff with an offensive arrogance and rudeness often with inappropriate raciest, personal belittling statements laced with sexual over tones and pure nastiness. I am sure his behavior challenged every single professional standard of every staff member involved in his care.

In this case study I would like to share MY experience with Mr T. I want to acknowledge the people who tried to help him and ended up most likely being personally abused for their trouble. I hope this case study may not only offer some explanation for MrT's behavior but also the opportunity to learn from it. I am definitely not making excuses for Mr T's behavior but offer some closure to what was a very traumatic episode of care for this man.

CASE STUDY

Mr T was a 67 year old gentleman. In May 2012 he was diagnosed with bladder cancer. He underwent a total cystectomy and formation of a permanent urostomy in June 2012. A total cystectomy removes the complete bladder and requires the formation of a permanent urostomy to allow urine to pass out into an artificial pouch placed on the abdomen. This is the preferred treatment for bladder cancer. It offers a high success rate and no risk of reoccurrence because the bladder has been completely removed, (Choueiri & Raghaven[1]). This surgery does not come without risk; bowel perforation being one of these. Unfortunately, there was an intraoperative complication that resulted in Mr T having to have an ileostomy formed. When he awoke from the planned surgery he was informed he now had 2 stomas, the planned urostomy and an unplanned ileostomy. He was devastated and reacted in a very aggressive and negative manner. He did not accept the ileostomy and refused to manage it. He remained in hospital for a total of 101 days. This was due to several complications including a dehiscence of his wound. However, his refusal to managing his ileostomy was also a significant contributing factor in his prolonged admission. (He was independently managed his urostomy throughout this time).

During the period of discharge from September 2012 to February 2013 I had minimal input with Mr T. Following the initial routine urostomy assessment, support and education he did not require ongoing visits. He was independent with his urostomy management, changing his pouch once a week on a Sunday. I had assessed his supply needs and these were placed on a regular order delivered directly to his home. Ongoing contact was maintained through phone contact, each phone call he stated he was doing well. As his ileostomy was a treatment injury this was managed by a private ACC provider. He declined review or input in regards to his ileostomy from our service.

In 2013 his health took a turn for the worse. He was admitted to hospital because of seizures caused by an electrolyte imbalance. His cancer had metastasized and he was in the terminal phase of his illness. I had not been aware of his admission, deterioration in health status or his pending discharge. His behavior as an inpatient had been documented as "extremely challenging, non-compliant, disruptive and difficult to manage". He refused/challenged all care offered to him including stoma assessment/care.

Thursday: I received a phone call from an inpatient nurse concerned that Mr T had severe excoriation around his stoma and was probably going to discharge himself that evening against medical advice. She stated he had not been happy on the ward and that his pouch was leaking everywhere but he had refused any offer of help. I suggested she contact the inpatient Ostomy service to arrange an assessment as soon as possible prior to discharge. I stressed that if he did self-discharge to ensure a referral to the community ostomy service was made to ensure follow up at home could be arranged ASAP.

Friday: On checking in the morning I noted that no referral had been received for community follow up. I checked the on line inpatient system, concerto, but noted he was still showing as still being an inpatient on the ward.

Mid-afternoon I received a phone call from a colleague to say that Mr T's daughter had just phoned her saying no one had visited Mr T at home yet. She stated that his ileostomy bag was leaking and he was in a terrible mess. He had indeed self-discharged the evening

Case Study: "Mr T" *...continued*

MARIE BUCHANAN

before against medical advice but no referral to community for follow up had been made. She had reviewed him on the ward and was very concerned about his skin integrity; she sent me a photo of the excoriation of Mr T's skin. I was shocked at the extent of the excoriation of Mr T's skin. I agreed to contact him immediately to arrange a home visit as soon as I could get there. I phoned and spoke with Mr T who agreed to my visit.

When I arrived at Mr Ts home his daughter, was there in tears and obviously extremely concerned re Mr T's well-being. Mr T was lying on his couch in shorts and an open shirt. I could see that he had excrement from his waist to his thighs. I was shocked at his appearance and condition. I introduced myself and gained Mr T's consent for the visit. My initial impression of Mr T was that he was extremely rude, used offensive explicates with derogatory comments with one specific comment being "at least you are white". Mr T's daughter become very upset and was telling her Dad to be quiet. He yelled at her to just leave, which she did. Her parting comment to me was "good luck".

Once we were alone I acknowledged that he must be in a lot of discomfort and that I was there to offer him assistance and to try to make him more comfortable. I began by asking how I could help him to which I received a raft of profanities and personal abuse. Through these I ascertained that I had permission to do what was required to address his needs. I explained to him that I had to remove the ileostomy pouch that was "floating" in the excrement and then remove the majority of the waste before applying saline soaks to settle his skin. I chose saline soaks as in my previous experience these have provided excellent relief to excoriated skin. Mr T was agreeable to this but I was very aware of his apprehension and dis-trust of me. I removed the pouch easily and with minimal discomfort but when I was attempting to carefully remove the excrement off his excoriated skin with saline and gauze I noticed I was also removing peeling, burnt skin from his torso. This was causing extreme discomfort and I stopped immediately. I placed several large saline soaked combines over the area to try and offer some relief for Mr T from the pain.

As I do when I am nervous I was chatting throughout the "ordeal" to which Mr T finally said to me "would you just shut up"! I also have a habit of saying sorry and obviously I was continuously saying this as I was sure I was causing a lot of his discomfort, again he said "If you say sorry one more time you can just P*** off". I sat back and thought "sod you".

I sat on the floor beside Mr T who was on the couch and noticed it was now 2 hours since I had arrived. I thought to myself, "Why am I bothering to try and help this rude man when he is abusing me like this". I looked at him and I could see his skin under the saline soaks was red and bleeding in places. There was excrement all over his body and clothing. He was wincing in pain and he actually appeared to be quite pathetic. At that moment I thought I want to help this man. I don't believe this rude man is the real Mr T. How can I leave anyone like this without trying to help? This is what it is all about, making a difference. I decided at that moment to not let his rudeness or inappropriateness push me away. Riddle [2], discussed issues around managing "challenging patients". He suggests that the clinician makes a conscious decision to "not be offended by the patient" which defuses confrontation and can offer an opportunity for a therapeutic relationship to emerge. I believe this is the choice I made at the time and that choice allowed a more positive interaction to occur.

I sat very quietly beside Mr T while I left the saline soaks on for over 1/2 an hour quietly pouring more saline onto the combines. I could see Mr T beginning to relax. His skin reacted very well to the saline soaks and this provided a great deal of relief to Mr T. I assessed his skin carefully. It was extremely excoriated and there were several areas of burnt peeling skin, specifically directly around his stoma, with extreme excoriation down his side and across his lower back. The whole area was moist and weeping. I dried it with gauze as carefully and well as possible without causing any further trauma. I dusted it lightly with stomaheisve powder aiming for a dry surface to allow the pouch to adhere. I reapplied a shallow convexity pouch adding a belt to provide extra security and to hold the pouch in place. Although Mr T was not keen on the belt initially he reluctantly stated it actually felt more comfortable and secure. I must admit I had a very sly smile when he admitted this! I applied a thick layer of aqueous cream to the excoriation around his side and back and secured combines under the belt to ensure no further trauma occurred to the skin. This provided excellent relief for Mr T and I could see him physically relax somewhat.

As I went to leave Mr T grabbed my hand and looked straight at me and said "Thank you". I can say that this is the most meaningful, honest "thank you's" I have ever received.

This visit took over three and half hours at the end of the day at the end of the week. Hull [3], discusses how our own sense of running late can trigger an angry response or attitude and suggests that by taking a deep breath and calming yourself will be more constructive and allow for a positive interaction to occur. I believe I took several deep breaths over this visit with a positive result. I allowed Mr T to direct the whole process and went at his pace. I was often stopped with the raise of a finger or a loud "stop", or "slow down" punctuated with profanities and contempt. It was suggested to me later that I had allowed Mr T to manipulate me into bowing to his needs but I do not see it as this. I believe that I managed to gain his trust and respect by not challenging, reacting negatively or showing offence to his behavior.

I agree with Rutecki[4], who stresses that it is the clinician's responsibility to determine why a person is being identified as a "difficult patient". The patient must remain the center of care, not the clinician. We need to be much more concerned about why the

Case Study: "Mr T" *...continued*

MARIE BUCHANAN

patient does what he/she does and much less about how it affects us. My experience with Mr T is an excellent example of this and once I heard his "story," which was extremely sad and traumatic I believe I understood some of his behaviors.

Monday: The pouch I applied on the Friday had remained intact and Mr T had managed well over the weekend. I felt that our relationship had changed, in the fact Mr T had developed some trust in me and was not as defensive as he had previously been.

I visited Mr T several times over the next few weeks. His skin took several weeks to return to a healthy intact condition. Through careful management, education and assessment Mr T was able to manage his ileostomy independently at home with minimal input from our service. (ACC providers had been discontinued). Over this time our relationship slowly changed. We developed a healthy therapeutic relationship. This was achieved through an enormous amount of time and patience on both sides. I believe I got to know Mr T very well and understood his needs and personality well.

Over the time I spent with Mr T I was privileged to learn small insights which suggest reason why he behaved the way he did. I believe that his racism, especially towards people of Asian descent, could have been attributed to the fact that 20 years ago his wife had been mis-diagnosis by a locum who happened to be of Asian descent. Sadly, his wife had a very aggressive cancer and passed away within 6 weeks of that diagnosis. This lead to another snippet of why Mr T may have been the way he was. He never grieved for his wife and to the day he passed away I believe he still hadn't come to terms with her death. The passing of his wife plummeted him into the role of a solo parent for which he was totally ill prepared. As was consistent with the social roles of that time Mr T has been the "workaholic" provider and his wife was the home maker, child minder. Prior to his wife's death Mr T had had very little to do with the children's care. At the time of his wife's death the children were 6, 8 and 10. He continued to work very hard as well as taking on the parental duties. Later in life he felt that he had failed as a parent stating to me that he "didn't get it right."

One significant conversation I had with Mr T was when he confided to me that he was terrified of leaving his children without any parents. He felt he had let them down tremendously and his extreme guilt around this was depicted as aggressive, rude and offensive behavior. Ironically, this was often directed towards his children. This conversation allowed me to offer the input of the hospice service, not for Mr T as he flatly refused to have hospice input, but for his children who may require ongoing support and bereavement counseling. This suggestion initially received a very aggressive response but a week later he came back to me and said it would probably be very good for his children to be introduced to the hospice and asked for an introduction, which I arranged.

Through hours of patience I got to know that a raised eye brow or finger meant to stop and give him space. Knowing these traits allowed me to provide the care he desperately needed and deserved the same as any other client/patient. Some may say that I bowed to his demands but I do not see it as this as to me it allowed a mutual platform to develop. My reward was the minutes of him freely talking and opening up to me. Of all the hours that I spent with Mr T, I only witnessed the very calm, polite gentleman a few times, but these times were extremely rewarding. He had a very cheeky smile which I often saw as I walked into his home. We had a commonality of having lived in the South Island and talked about common places we both knew allowing him to reminisce and remember good times.

REFLECTION

I believe that the decision to not let Mr T's behavior affect me personally and making the commitment to know "why" was fundamental to us developing the therapeutic relationship that he so desperately needed. Caring for Mr T was one of the most exhausting and challenging experiences of my career, but more than that it was also the most rewarding. I firmly believe that I made a significant difference in Mr T's care through empathy, professionalism and knowledge.

I acknowledge and thank Mr T as it was a privilege to have been allowed into his life and to make a difference when he desperately needed it. I am very aware this was not easy for him. I attended Mr T's funeral and was humbled at the number of people who attended and the positive acknowledgements they gave. Mr T's funeral was an opportunity for closure for me as it confirmed the importance of knowing the other side to this man and of not judging by what you see or think that you believe. He was a good man, a father; grandfather, brother, uncle and friend. He defiantly was not just a "challenging patient".

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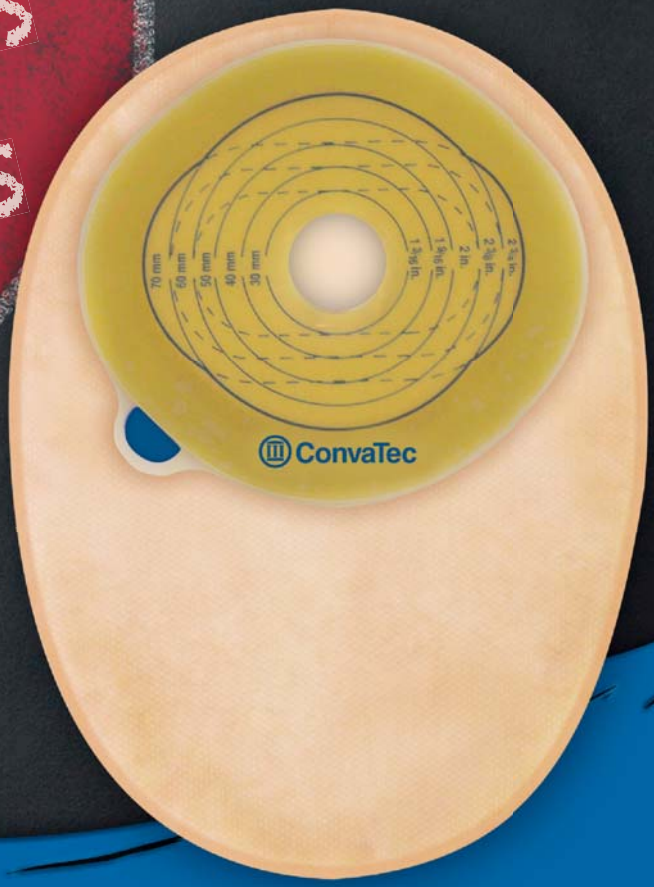

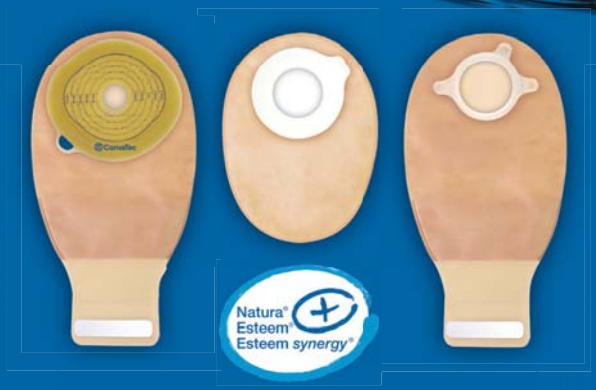

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WCET Conference 2014

GOTHENBURG, SWEDEN - FRANCESCA MARTIN

The conference was held at The Swedish Exhibition and Congress Centre in Gothenburg, a city on the west coast of Sweden, from 15-19th June. It was attended by 1700 people from all around the world but mainly from Europe with a good sized contingent from Australia and four of us from New Zealand. There were very few Americans as apparently their own national conference was scheduled at around the same time.

The programme was divided into three streams: ostomy; wound; and continence. There was only one session of one and a half hours for paediatric presentations. Some of the ostomy sessions involved: Peristomal Skin Disorders by Calum Lyons, who spoke of cryotherapy and botox treatment in stoma care; Innovations in Practice by Pat Black, who spoke about the use of a health care assistant who had done a diploma in stoma care and was able to do inpatient stoma nursing work – much of what is done normally by a Stomal Therapy Specialist Nurse. Pat was using the case of a particular HCA as a model of what could be achieved to free up a specialist nurse's time and be more affordable for the health budget. Two presentations on intestinal transplantation by Dr Gustav Herlenius and Advanced Nurse Practitioner Simon Turley were very interesting. The first bowel transplant in Sweden was in 1990 and there have been twenty six transplants all together, seven children and nineteen adults. There was a very high mortality rate in the first few years as the use of cyclosporin alone for immunosuppression was not enough to prevent rejection. Since the introduction of Tacrolimus, which achieves immunomodulation, rejection has reduced to forty to fifty percent. All bowel transplant patients have an ileostomy in order to monitor the bowel through endoscopy and biopsy.

There were poster presentations, most of which dealt with ostomy, wounds and fistulas. The standard of these was generally high even though for many of the presenters English is a second language.

The social programme included a midsummer party at a restaurant about fifteen minutes' walk away from the congress venue. Swedish culture was on show with servings of traditional Swedish food of herrings and potatoes, and dancing around a special flower covered pole. The Frog dance is a charming and funny dance performed by Swedes with flower wreaths on their heads accompanied by folk musicians and songs (some of which are rather rude) and the imbibing of schnapps. There was daylight until about 11 pm and the streets and parks were full of people staying out late at night to enjoy the light evenings.

The conference was well organised, everyone was friendly and most people spoke English. It was a busy five days with presentations throughout the day, breakfast symposiums, social functions in the evening as there were industry functions to attend as well as the Congress Welcome Reception, Midsummer evening function and the Congress dinner. It was great to get to know the other Kiwi nurses better at the conference. Thanks to Jenny Roberts, Annet Nichols and Ginnie Kevey- Melville for the comradeship and the opportunity of getting to know each other better.

Swedish Exhibition & Congress & Hotel Gothic Tower

(from left) Jenny Roberts, Annet Nichols, Francesca Martin, Ginnie Kevey-Melville

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Omnigon Educational Development Trip

15-24 JUNE 2014 - GINNIE KEVEY-MELVILLE

Following the WCET Congress a group of Australian and New Zealand Stomal Therapy Nurses travelled to the United Kingdom to visit and participate in Welland Medical and Eakin Innovation Workshops. The purpose of the educational event was to give us a greater appreciation of the work that goes into the development of stoma appliances and accessories.

The Innovation Workshops included a tour of Welland Medical factory in Crawley in southern England, and the Eakin factory in Belfast. This was to view the step by step process of how the products are manufactured and the quality control process. The quality control process is very hands-on, and the staff are extremely efficient in detecting any imperfections. The staff were very receptive and happy to answer any of our questions. It was obvious that everyone involved with the manufacturing of the products are dedicated and enjoyed their work.

The Welland and Eakin Research and Development Teams are focused on the development of new products. The emphasis is on innovation, creativity and continual improvement in stomal appliances and accessories. The staff were very interested in the feedback from us on their products, and how they work for the people who use them. Pouch design including size, shape, filter efficiency, adhesiveness, and biodegradability were discussed.

The trip was not all work, and included lots of fun, socialising, networking with colleagues and making new friends. There were great sightseeing experiences and social events around West Sussex, England, the north coast of Northern Ireland and Belfast. The United Kingdom has a fascinating history, and beautiful scenery.

This experience has given me a greater insight into the production of some of the Welland and Eakin stomal appliances, and the accessories we use in caring for people with a stoma. I am in awe of the people who research, develop and manufacture these products, and their dedication to perfection and quality.

Thank you to Omnigon for making this educational event possible.

Giant Causeway, Coast Ireland

(left) Jeremy Eakin

Welland Factory, Crawley England

Guidelines for writing in The Outlet

The editors of the Outlet are appreciative of the opportunity to assist and mentor first time publishers or to receive articles from more experienced writers. The guidelines below are to assist you in producing a clear, easy to read, interesting article which is relevant to nurses.

The main goal of writing for the Outlet is to share research findings and clinical experiences that will add value and knowledge to the clinical practice of others. The essence of writing for the Outlet is a story / or research study, told well and presented in a logical, straight forward way.

GUIDELINES

- Readers of the Outlet are both generalist nurses and specialist Stomal Therapists. Articles should be focused on what a nurse / patient does, how a nurse / patient behaves or feels, events that have led to the situation or on presenting your research methodology and findings. Linking findings to practice examples often increases comprehension and readability. Addressing questions related to the Who, What, Why When, Where, How of a situation will help pull the article together.
- Writing Style. Excessive use of complicated technical jargon, acronyms and abbreviations does not add to the readability of an article and should therefore be avoided if possible. Short sentences rather than long running ones are more readable and generally promote better understanding. The Outlet has a proofing service to assist with spelling, grammar etc.
- Construction of the Article. It may help in planning your article if you bullet point the key concepts or points, format a logical paragraph order and then write the article from that plan.
- Article Length. There are no word limits for publishing in the Outlet. First time writers may like to limit themselves to 2500-3000 words which is approximately three published pages
- Photographs, Illustrations, Diagrams, Cartoons; these are all welcome additions to any article. Please e mail these with your article providing a number sequence to indicate the order in which you wish them to appear and a caption for each.

CONSENT

- Please remember the need to preserve any patient's privacy rights and the confidentiality of their information. The author is responsible for ensuring that they have gained appropriate consent to a patient's information.

COPYRIGHT

- The NZNOSTS retains copyright for material published in the Outlet. Authors wanting to republish material elsewhere are free to do so provided prior permission is sought, the material is used in context and The Outlet is acknowledged as the first publisher. Manuscripts must not be submitted simultaneously to any other journal.
- Referencing. The preferred referencing method for material is to be numbered in the body of the work and then to appear in the reference list as follows,

  1) North,N.& Cledon,M. (2012) A multi-center study in Adaption to Life with a Stoma. Nursing Research 3:1, p4-10

- Most submitted articles will have some editorial suggestions made to the author before publishing.

EXAMPLE ARTICLE FORMAT

Title: as catchy and attention grabbing as possible. Be creative.

Authors: a photo and a short 2-3 sentence biography are required to identify the author/s of the article.

Abstract: usually a few sentences out lining the aim of the article, the method or style used (eg narrative, interview, report, grounded theory etc) and the key message of the article.

Introduction; attract the reader's attention with the opening sentence.

Literature Review if publishing a research paper.

Tell Your Story: Who was involved? / history of situation. What happened? / your assessment findings. Why you took the actions you did? the rationale for your decisions / actions. Your goals- / plan. The outcome? Your reflection / Conclusions? What did you learn, what would you do differently next time? Remember there is valuable learning in sharing plans that didn't achieve the goal you hoped for.

Patient stories are a good place to start your publishing career and nurses tell great stories. As editors we encourage you to experience the buzz of seeing your work in print and we undertake to assist in every way that we can to make the publishing experience a good one.

Thanks to Teresa O'Connor and Anne Manchester, editors of NZNO Kai Tiaki for allowing us access to that journals publishing guidelines.

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The Outlet

New Zealand Stomal Therapy Nurses