The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

JULY 2017

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The Outlet

New Zealand Stomal Therapy Nurses

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ENCOURAGING MEMBERSHIP

EASY MEMBERSHIP SUBSCRIPTION CAN NOW BE GAINED ON THE WEB SITE
www.nzno.org.nz

IF YOUR ADDRESS HAS CHANGED PLEASE CONTACT
Jackie Hutchings
Email: jacquelynh@nursemaude.org.nz

Your Executive Committee Members

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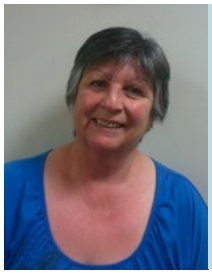

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Chairperson's Report

BRONNEY LAURIE

The year is flying past and winter is well and truly here. South Canterbury is waking to crisp sparkling frosty mornings followed by fresh sunny days. The surrounding mountains are now covered in snow and the shortest day is now behind us.

It was with the deepest regret that the committee accepted Sharon Elson's resignation from the committee and as secretary. Sharon's contribution to the College over the last few years has been invaluable and we will sincerely miss her. I am sure you all join us by wishing her well. Leeann Thom has stepped into the role as secretary and will be a wonderful asset to the committee.

The committee continues to focus on the accessibility of training and education for Stomal Therapy Nurses in New Zealand. Each one of us is aware that it is imperative that throughout our career we continue to remain up to date and best practice is essential. It is unfortunate and frustrating that there is not a more accessible and affordable option available in New Zealand. Nurses struggle to receive funding for the available qualification via New South Wales.

I personally am passionate about Stomal Therapy and it is so important that we work together as a College to ensure that our positions are kept 'precious'. We all have seen many changes over the years within the Health sector; often roles are disestablished as they are considered unnecessary. I believe we continue to be an extremely valuable asset to other health professionals and our patients; we must be proactive in ensuring that there is a future in Stomal Therapy. We are an ageing population and need to continue to encourage successors into these roles.

Kat and I will be attending the NZNO College and Section day and Annual General Meeting in September. Any remits received will be posted on our website and an email will be sent to ask that you have a look at them and contact the committee if any specific concerns arise before we vote.

I can confirm that the next NZNOCSTN conference will be held in Auckland 11th and 12th October 2018. We are looking forward to presenting an informative and exciting programme, please don't hesitate to contact us with any ideas.

A reminder that the Ostomy Federation has its conference in New Plymouth 5th and 6th August, details of this can be found in the Federation journal "N.Z. Ostomate" or through your local ostomy society.

Well that's all for now, keep warm and spring will be here before you know it.

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Editor's Report

JACKIE HUTCHINGS

Winter has really hit us as I write this report – Snow forecast for the South Island Passes and ferry sailings cancelled overnight as 6 metre swells hit Cook Strait and I have no idea what's happening off the Mainland!

LETTERS TO THE EDITOR

I have still not received any Letters to The Editor or News from the Regions unfortunately. Please think about supporting these.

LIBERTY AWARDS

I do thank those who have sent in articles and reports for this edition of our Journal and would encourage others to consider putting pen to paper or rather digits to the keyboard for the November edition. Submissions would need to be with me by 10 October.

Remember that if you have an article published you can also enter the Liberty Publishing Excellence Award with a prize of $2000 which will be awarded at the 2018 National Conference.

UPDATING NATIONAL STOMAL THERAPY CONTACT DETAILSR

Unfortunately I have had a very poor response from Stomal Therapists around the country with updated contact information. The form can once again be found in this edition and even if you think nothing has changed in your DHB can you please send in a response for each practising Stomal therapist in your area. Thank you to those who have completed these.

Once I have received responses from each DHB they will be collated and a new list will be published in The Outlet. This list is extremely helpful when you are transferring patients in or out or even for patients on holiday who require assistance.

AASTN CONFERENCE – BRISBANE 2017

I was very fortunate to attend the AASTN conference and I wish to thank Nurse Maude and NZNOCSTN for assisting with the funding to attend this valuable event.

The venue was excellent and the programme covered a wide variety of topics with stoma, continence and wound covered over the three days. Concurrent sessions were held for quite a bit of the day and it was hard choosing which to attend in many instances.

One of the best sessions I attended was run by Nic Marcon, a psychologist speaking about taking care of ourselves – something we often neglect to do. Nic is an inspirational speaker as he has a different perspective on things from many other psychologists, probably because he has quite a lot of life experience working in a variety of other jobs before he turned to psychology. It would be great to have him come over here to speak to us.

Some other interesting sessions I attended were on ACE care. For those who don't know what an ACE (or MACE in the North Island) is, it stands for antegrade continence enema. Malone is the "M" part of MACE and this is the name of the surgeon who popularised the operation about 20+ years ago even though the operation has been performed for over a century. Usually the appendix is used and brought up to the abdominal wall. A catheter, either fixed or in – out is used to irrigate the bowel. This is usually done for chronic constipation.

It was interesting to hear the different types of irrigation fluid used for ACE patients in different States in Australia and is perhaps something we could look at nationally in New Zealand to see what gets the best results.

Looking forward to receiving articles from you all – everything gratefully received!!

New Zealand Contingent at AASTN conference

Updating National Contact Information

The National Contacts list on the NZNO College of Stomal Therapy Nursing website is very outdated.

There have been many changes around the country since it was written. Can you please assist us with updating this by completing the form below and ensuring each person at your DHB covering stomal patients also completes a copy.

This is a very valuable resource when you have a patient transferring or holidaying in another area or if you just want to contact another stomal therapist for assistance with a query or to discuss an issue especially for those working in isolation.

Name: _____

Title/Role: _____

DHB: _____

Postal Address: _____

_____

Telephone (and extn): _____

Cellphone (optional): _____

Pager: _____

Fax: _____

Email: _____

Hours: _____

Geograhical area covered: _____

Please indicate: Hospital Community Both

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The Liberty NZ Stomal Therapy 'Publishing Excellence' Award

THE AIM

The aim of the Liberty New Zealand Publishing Excellence Award is to recognise the endeavors of nurses working in the field of stomal therapy, encouraging them to achieve excellence by publishing in the NZNOCSTN Journal "The Outlet".

All NZNOCSTN members, who meet the award criteria, can submit their article to be assessed for the award. The award is to the value of $2000. In the event that there is more than one worthy recipient the amount may be shared.

THE PURPOSE OF THE AWARD

The Liberty Publishing Award is to be used towards the cost of:

- Travel / accommodation / registration to attend a national or international conference related to stomal therapy

  or

- To facilitate participation in an accredited post graduate study program leading to qualification as a Stomal Therapist or appropriate study in the associated area intended to advance the knowledge and understanding of the discipline of stomal therapy

ENTRY CRITERIA

- Be a member of NZNOCSTN, both at the time of publishing and at the time the award is made
- Have submitted an article, which has been published in The Outlet and which complies with the Award Criteria
- Have completed the entry form and submitted to The Outlet editors by September in the year of the award. The Liberty Publishing Excellence Award will be made in the same year as the NZNOCSTN biennial conference.
- Only one article per author can be submitted for assessment
- The journals from which articles can be submitted for assessment will be published in the two years prior to the biennial conference as follows;
  - Novembe 2016
  - March, July and November 2017
  - March and July 2018
- By submitting and applying for the Liberty publishing award, the publisher agrees that their name and /or article can be used by Liberty Medical for Education and Marketing.

The assessment panel will critique submitted articles for value to Stomal Therapy practice, contribution to understanding the patient experience, innovation in practice and contribution to the body of Stomal Therapy knowledge.

The successful award recipient will be announced at the NZNOCSTN biennial conference and the award will be made by a Liberty representative.

Best Published Article Entry Form

Please complete and return to The Outlet Editor by the last day of September in the year of the Award submission.

Name: _____

Address: _____

_____

_____

Telephone _____

Email: _____

Qualifications _____

Employment position _____

NZNO Number _____

Article Title and Date of Publication

_____

_____

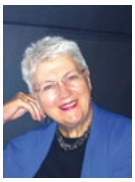
Note: If there are constraints as to when you can and cannot publish your paper, please bring this to the attention of the Executive Committee or The Outlet Editors.

The Elizabeth English Coloplast WCET Educational Scholarship 2018

(in association with the AASTN)

Coloplast would like to offer a maximum of 3 x $2,000 Educational Scholarships to attend the WCET conference in Kuala Lumpur, Malaysia (April 14-18, 2018)

Coloplast have decided to provide scholarships for ongoing WCET conferences. To encourage STNs to strive for the highest in the profession of Stomal Therapy Nursing, Coloplast recognises Liz is a leader in the field of STN in Australia by adding her name to the scholarship, and this will change on a WCET conference naming rotation. The 2018 Coloplast scholarship acknowledges Elizabeth English for her contribution to Stomal Therapy Nursing.



Elizabeth English has worked as Stomal Therapy Nurse at the Royal Adelaide Hospital since 1983. She has spent 14 years on WCET Executive Board, 6 years as Education Committee Chairperson, and 8 years as both President / Vice President of WCET. Liz is a Life member of the AASTN and has held several Executive AASTN positions. Presently she is a current AASTN SPAP representative with the Department of Health and has been a major force behind the Kenya Australia Twinning project. In June 2012 Liz was awarded an AM - a Member of the Order of Australia for service to nursing, particularly in the field of Stomal Therapy clinical practice and education, and through executive roles with national and international associations.

Objective:

Coloplast recognises the need to create innovative educational experiences for all nurses. Coloplast has 3 scholarships on offer to be awarded to financially assist a registered STN in Australia or New Zealand to attend the 2018 WCET conference in Malaysia (Scholarship is not transferable and must be used to attend this conference).

Scholarship Application Guidelines:

Applications must be sent to aucare@coloplast.com by 5pm on November 18th 2017.
All applications will then be sent together to the AASTN Executive for impartial judging.
A decision will be made before Christmas 2017. Incomplete applications will not be considered.

What must you do?

- A completed Educational Scholarship application form available from Coloplast.
- Complete a case study using SenSura Mio Convex. This may include, but is not limited to, how Sensura Mio Convex has helped improve the life of an Ostomy patient, how Sensura Mio convex has helped deal with a difficult stoma, how has Sensura Mio Convex changed your nursing practice etc.
- Write a one-page letter of motivation (How will you benefit from participating in WCET).
- Obtain written verification from your employer that you are able to be released to attend the conference and abide by your "Health Care Professional Code of Ethics" .

The winners will be invited to present their case study at a Coloplast Educational Evening in 2018.

Upon returning to Australia/New Zealand the winners of the Educational scholarships will also be required to:

- Complete a reflective review on the key learnings and experience gained from the WCET conference. This must be complete by August 2018. It will then be published in the Journal of Stomal Therapy Australia.

Scholarship applications open from March 8th 2017 until November 18th 2017. Completed Application Form along with SenSura Mio Convex Case Study must be received by Coloplast by 5pm on November 18, 2017. All applications will then be sent together to the AASTN Executive for impartial judging.

WCET KUALA LUMPUR 2018 22nd Biennial Congress 15 - 18 April

Coloplast

Listening with my heart: Poems by Aotearoa New Zealand nurses

NZNO celebrated International Nurses Day in Wellington with the launch of "Listening with my heart: Poems by Aotearoa New Zealand nurses". Edited by Professional Nurse Advisor Lorraine Ritchie, this fabulous new book features the work of 35 nurses.

Moving and poignant, the poems offer deep observation and insight into the diversity and lived experiences of our nurses. This is an inaugural collection of poems from a very creative group of nurses.

Production of this poetry book is part of NZNO's Visibility of Nursing Project.

'Listening with my heart': Poems by Aotearoa New Zealand nurses
A beautiful book to delight your soul

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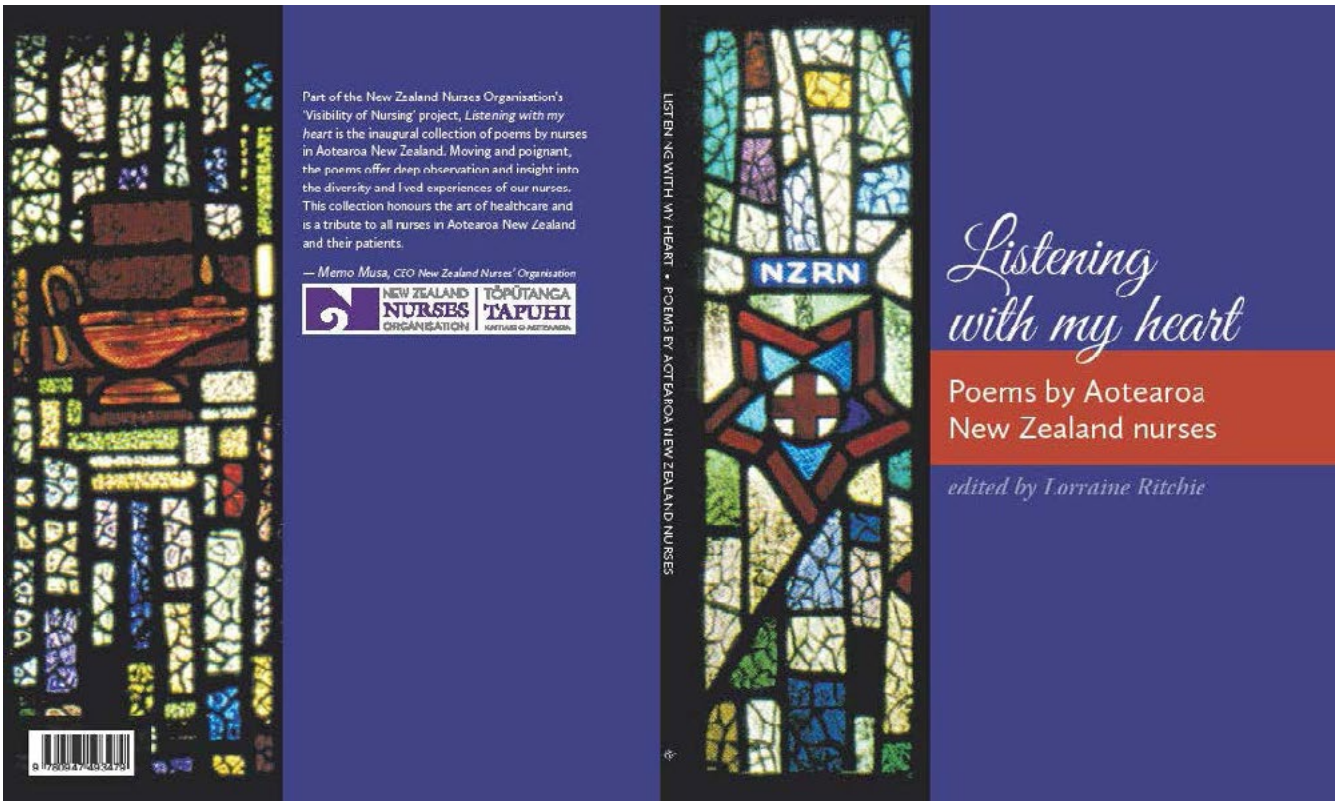

Listening with my heart.

Policy for Bernadette Hart Award

PROCESS

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

CRITERIA

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

FEEDBACK

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

and/or

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

Application for Bernadette Hart Award

CRITERIA FOR APPLICANTS

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

APPLICATIONS CLOSE 30TH NOVEMBER (Annually)

SEND APPLICATION TO:

Jackie Hutchings
Email: jacquelynh@nursemaude.org.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

_____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS

Practice hours Full Time: _____ Part Time: _____

Type of Membership ◯ FULL ◯ LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

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

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

_____

_____

EXPECTED COSTS TO BE INCURRED

Fees: (Course/Conference registration) $ _____

Transport: $ _____

Accommodation: $ _____

Other: $ _____

Funding granted/Sourced from other Organisations

Organisation:

_____ $ _____

_____ $ _____

_____ $ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNOSTS

_____

_____

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

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

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

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

Signed: _____ Date: _____

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Into the Sunshine : Storytelling in Stomal Therapy

REPORT FROM THE 41ST NATIONAL AUSTRALIAN ASSOCIATION OF STOMAL THERAPY NURSES CONFERENCE

12-15 MARCH 2017, BRISBANE, AUSTRALIA

Sue Rossiter
Specialty Clinical Nurse
Stomal Therapy

Nelson Marlborough
DHB

First, thank you to the NZNOCSTN, Nelson Marlborough District Health Board and the Nelson Ostomy Society for funding to enable attendance at the conference. It was great to see fellow colleagues and Stomal Therapists from New Zealand at the conference.

The conference was held over three days at the Royal International Convention Centre and consisted of days focused on Stomal, Continence and Wound Care. The programme was extensive with International and National speakers, including Surgeons, Dermatologist, Psychologist, Clinical Nurse Consultants and Registered Nurses. Each day began and ended with plenary sessions. Concurrent sessions then ran throughout the day and offered various topics and learning opportunities.

Day One focused on Stomal Therapy and began with the welcome and acknowledgment to country. The first speaker, Doctor John Lumley presented the Outcomes of the A La CaRt study completed by Australian and New Zealand Colorectal Surgeons comparing the outcomes of open to laparoscopic pelvic dissections for rectal cancer. The research evidence suggests that surgery is at least equivalent to open surgery with regard to long-term clinical outcomes.

Doctor Beth Campbell presented an overview of pelvic exenteration surgery – technical aspects and stoma considerations. Although this surgery has emerged over the last 20 years it continues to evolve. Exenteration is an option for patients with locally advanced colorectal tumours, and her presentation discussed what was involved and the challenges faced by both the Surgeons and the patients.

A presentation on Faecal mircrobiota transplant was presented by Doctor John Edwards and he discussed collection and delivery of faecal donation and the use in patients with Inflammatory Bowel Disease, Clostridium Difficle and Irritable Bowel Syndrome.

I attended concurrent sessions that related to staff and patient education relating to the care of the person living with a stoma.

- **Look, Learn, Learned – Development of a stoma observation and education care plan,** focused on the development of a Stoma Observation and Education Care Plan to standardize documentation and improve nurses' knowledge, understanding and skills.
- **Stomal Therapist…What Stomal Therapist? Development of a community based model of care for stomal therapy services in Metro North (Australia).** A survey of consumers was completed and 20% of those surveyed indicated they were unable to access stoma support on more than one occasion. Following analysis of the data an evidence based model of care for community stomal therapists was developed and was to be available from the end of 2016.
- **The importance of the ward nurses' role in patient education following stoma surgery.** This presentation explored the nursing staff's role when caring for patients with a new stoma and focused on the benefits for the patient and the nurse. The importance of education and empowering the patient towards independence with their stoma care were identified.
- **Inside out: Beyond the practicalities of stoma care:** This presentation was about research conducted in Ireland which looked at the impact of having stoma on individuals' quality of life. A questionnaire was sent out and over 90% were completed and returned. Some respondents reported surgery as positive, but a vast majority of respondents reported negative feeling. 77% had issues or problems both physical and psychological. A common theme from the questionnaire was that patients did not know where to go for help.

Day Two was devoted to continence and the first speaker, Jill Campbell spoke about Incontinence associated dermatitis: state of the evidence. 42% of the 24% of patients with incontinence in Australia have had Incontinence associated dermatitis caused by faecal and urinary incontinence and this can lead to pressure injury development. Those at risk are individuals with poor skin condition, reduced mobility or diminished cognition. Managing incontinence and implementing a structured skin care regime is important in the prevention of incontinence associated dermatitis. The speaker referenced the following web site for further information: www.woundsinternational.com - Incontinence – associated dermatitis, moving prevention forward.

Nic Marcon is a Psychologist and he spoke about Taking care of the carer: A practical approach to patient care as well as personal self-care. He was a very dynamic and inspirational speaker and spoke about Vicarious Trauma, coping mechanisms, how we connect to others and ourselves and how we can assist patients more effectively. His talk encouraged me to reflect on my own stress and stressors and how I manage these and the strategies I could use.

The concurrent session I attended related to my practice both in ostomy and wound care.

- **Skin Safety Model: A new way of conceptualizing Skin integrity care.** Jill Campbell spoke about the challenges of health care in the 21st century relating to the risk factors, prevention and management of skin injuries especially in the elderly patient. Skin safety is concerned with keeping the skin safe from injury. The speaker presented a model focusing on potential contributing factors of skin integrity, exacerbating elements, potential skin injury and potential outcomes of skin injury. Fundamental care underpins the way forward in the health care system and that fundamental care (base care) is a human right. Out of interest I researched The Skin Safety Model and found the following journal article by Jill Campbell and Fiona Coyer, (2015). The Skin Safety Model: Reconceptulizing Skin Vulnerability in Older Patients, Journal of Nursing Scholarship, Vol 28: Issue: 1 January 2016.

Day Three focused on Wound Care and the first presenters of the day were Doctor Kerry Reid-Searle and Professor Keryln Carville, Are you hearing or listening to the patient's story? This was presented as a simulation experience using Mask Ed (KRS Simulation) and Pup Ed and focused on listening to the person's story and communication.

Professor Fiona Coyer presented a paper titled, Translating evidence into intensive care nursing practice to reduce pressure injuries: The SUSTAIN Study. In Australia, Intensive Care Units have the highest rate of Pressure Injuries and the aim of the study was to reduce barriers to pressure injury prevention practice. Strategies included weekly prevalence audit with feedback, skin integrity checks and turning rounds. The results demonstrated a raised awareness for prioritizing skin care.

Choosing compression for your patients with venous disease: Using the WOCN Venous Leg Ulcer Algorithm, presented by Laurie McNichol, provides a quick reference guide for lower extremity wounds, venous, arterial and neuropathic management.

Doctor Paul Griffith's presentation was on antimicrobial stewardship and the responsibilities of the clinicians. He discussed antibiotic resistance and the impact of resistance within health care. Everyone from doctors, to ward staff, administration and patients have a responsibility in preventing cross infection through hand hygiene.

After morning tea, we broke into the concurrent sessions offered and I attended sessions relating to conditions and treatment of the skin:

- **Pyoderma Gangrenosum and other dermatological challenges:** Pyoderma is a painful ulcerating condition which develops quickly with a strong association with Inflammatory Bowel Disease, Connective Tissue disorders and Haematological Malignancies. Doctor Peters discussed the presentation, causes and management of Pyoderma Gangrenosum, which involves a multidisciplinary approach of care.
- **Complex congenital abdominal wall defects, strategies for wound management,** presented by Professor Roy Kimble discussed the management of Gastroschisis, a birth defect of the abdominal wall causing the bowel to protrude through the abdominal wall and can involve other abdominal organs. Treatment and care depends on the size and involvement of other organs. Simple defects can be surgically repaired at birth, where large defects may be treated with negative pressure or a "silo" is constructed around the bowel until it has reduced in size and can be surgically repaired.
- **Pyoderma Gangrenosum: Challenging peristomal care:** diagnosis is difficult and is generally based on patient history and clinical examination. Biopsy is not conclusive except to rule out differential diagnosis or infection. For patients, the impact on their psychological, social and physical wellbeing can be devastating. For clinical staff, management can be a challenge with maintaining dressings and a sealed appliance. The speaker directed the audience to the following article by De Marty, L. E, Faller, N.A, and Miller, A. (2014): Treating Pyoderma Gangrenosum with Topical Crushed Prednisone – A Report on 3 Cases: Ostomy Wound Management: 60 (6), 50-54.
- **Hidradenitis suppurativa: The Hidden disease:** or Acne Invera is an inflammatory skin disease of unknown cause that affects the apocrine gland-bearing skin in the axilla, groins or under the breasts. It appears as boils or abscesses and can develop sinus tracking. Contributing factors include, adolescence, familial, metabolic syndrome, obesity/smoking and follicular occlusion disease. Treatment is difficult and may include antibiotics for bacterial infection or cellulitis, corticosteroids or surgical intervention.

Professor Keryln Carville's presentation on Innovations in wound theranostics discussed global ageing and associated increase in chronic wounds. As the demand is for improved patient care outcomes and reduced costs, innovations in wound technology such as biochemical and molecular wound markers are becoming increasingly available: the use of Smart Bandages that monitor wounds with sensors in bandages and data collected to be sent to smartphones and tools to detect proteins and protease in wounds. Also discussed were biofilms and their affect on wound healing. Genetic technology and DNA sequencing to identify antibiotic resistant genes and pathological versus non pathological organisms were also discussed. For further information, the following reference was provided: www.woundsinternational.com International Wound Infection Institute, 2016.

The posters were of high quality and included case studies and research on a wide range of topics covering stoma, continence and wound care. The Exhibitor and Trade Stands included those we know in New Zealand involving Stoma products, as well as trade stands displaying products on wound and continence products. Panda Pearls also had a trade stand where you could purchase the most beautiful pearls.

The social events were well attended and the theme for the conference Gala Dinner was "The Country meets the City". This was a great evening and an opportunity to socialize with our Australian colleagues, with fun, laughter and dancing.

Sue's Boots

Conference Centre

Use of MaskEd for role play (old gentleman in photo is actually a woman dressed up)

On reflection following the conference, for the person living with a stoma in New Zealand, the ongoing care after surgery is holistic and patient focused. Patients have access to the Stomal Therapy Services and products across their life span, compared to those patients in Australia, who are often discharged from hospital without follow up. Several speakers spoke about lack of follow up care and it was encouraging to see that the Stomal Therapists in Australia were working towards making changes in practice to follow the person with a stoma into the community after discharge from hospital.

The next 42nd National Australian Association of Stomal Therapy Nurses Conference is to be held in Sydney, Australia, in March 2019.

Trade Displays

Conference Gala Dinner – The Country Meets The City

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Managing a Wet Colostomy

JENNY COULSON & LILY MURRAY

Jenny Coulson
SCN Stomal therapy

Lily Murray
STN

Taranaki Base Hospital,
New Plymouth

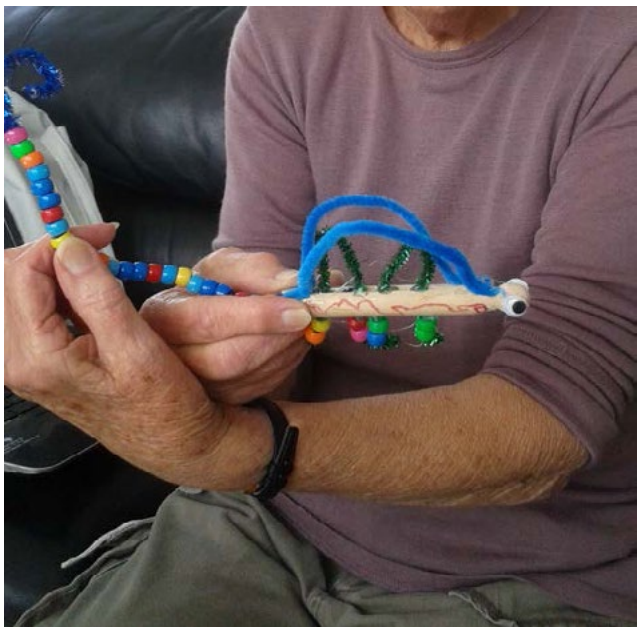
This case study was presented as part of the Liberty Medical best presenters award at the NZNO Stomal Therapy Section bi annual conference 2016, New Beginnings.

A wet colostomy is an uncommon surgical outcome, one our stomal therapy service had not previously encountered. This surgical procedure created problems that required specific management options. Identifying and discussing successfully employed management options may be beneficial to other nurses in their practices. It also highlights the importance of keeping up-to-date with product knowledge as part of a stomal therapist's role. Providing provision of the most appropriate product enables the ostomate to achieve optimal quality of life.

INTRODUCTION

Firstly, may we sincerely thank Ms B for allowing us to share this case study. The knowledge gained has been invaluable and the pleasure in providing stomal therapy nursing care to Ms B has been very gratifying.

Ms B's Mokopuna proudly presented her with a Mokoweri that he made so when she passes her Wairua (spirit) will be carried away on its wings.



Ms B holding a MOKOWERI (dragon)

Ms B describes herself as the daughter of an engine driver, wife of British army man, mother of four, a registered general and obstetric nurse, a social activist, an educator dedicated to community service and woman's refuge, and still actively studying in her 80s, whew!

Ms B was scheduled for surgery at a specialised hospital for a Pelvic Exenteration including Cystectomy and formation of an ileal conduit (if possible). However, what was described in the surgical notes as a 'wet colostomy' was formed due to previous radiotherapy damage rendering half of the ileum too friable to use. As previously stated we had not encountered a wet colostomy before and therefore endeavoured to learn as much as possible about the surgical techniques, outcomes and product options in order to deliver the best care in terms of physical and psychological safety whilst encompassing our patient's cultural uniqueness.

On researching, more literature was found on Double Barreled Wet Colostomy (DBWC), a commonly used technique, hence, it was essential to explore and describe both DBWC and Uretero-Colostomy or Wet Colostomy (WC) to gain more knowledge and understanding of these procedures for optimal patient care.

RELEVANT HISTORY OF DBWC AND WC

1947 - Brunschwig was one of the early surgeons who performed an Uretero-colostomy (WC) in association with pelvic exenteration; however, urosepsis and metabolic changes discouraged other surgeons' use of the technique. The unavailability of stoma appliances at that time to provide adequate peristomal skin protection and contain both urine and faeces in a single pouch was also a contributing factor in outcomes (Brunschwig 1948, Salgado-Cruz 2014).

1989 – Carter revised the surgery and developed a new procedure called DBWC and it is now carried out world wide, with the Royal Marsden in South West London described as being a leading facility. The technological advancement in stoma appliance skin barriers and pouches greatly aided the success of the surgery as the efflux volumes could be adequately contained allowing the patient some quality of life (Salgado-Cruz 2014).

Literature indicates DBWC can be safely performed at the time of pelvic exenteration. The technique is described as relatively easy to learn, reduces operating times, length of stay and the risk of bowel anastomotic leaks. It is also a favourable option over more technically challenging single urinary diversions (SUD) with ileal conduit formation in this heavily irradiated population that has limited overall survival rates (Backes et al 2012, Chokshi et al 2011). Most recent literature states DBWC is associated with good late outcomes as the functional results are similar to ileal

conduit and there is no statistically significant difference in the rate of stenosis of the uretero – intestinal anastomosis, obstructive neuropathy or formation of calculi in the conduit (Salgado-Cruz et al 2014, Pavlov et al 2013,).

Double Barreled Wet Colostomy (DBWC) – implantation of both ureters into a segment of the large bowel enabling separate flow of urine and faecal matter.

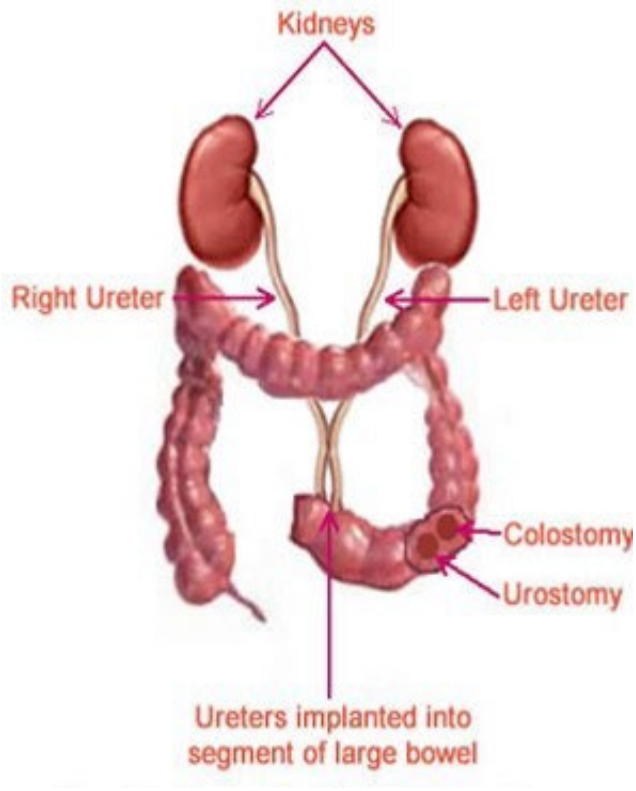
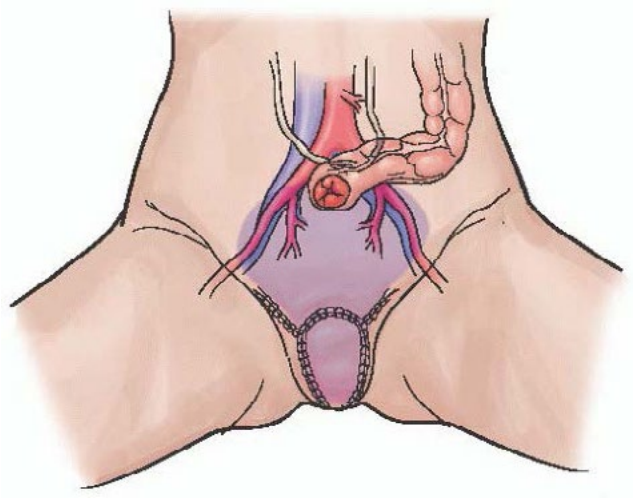


Figure 2. Double Barelled Wet Colostomy (DBWC) and Total Pelvic Exenteration. Retrieved May 8, 2017, from www.stomawise.co.uk

Wet Colostomy (WC) - both ureters anastomosed directly into colon and a single stoma formed.



End result of an exenteration. (Brunschwig, 1948, p. 179)

PURPOSE OF DBWC AND WC

A simultaneous urinary and faecal surgical diversion via one stoma allowing continuous flow of urine and intermittent flow of faeces that may be psychologically beneficial for the patient. It is performed after pelvic exenteration as a palliative procedure or after radiotherapy damage (Pavlov et al 2013).

POSSIBLE COMPLICATIONS (SHORT AND LONG TERM) ARE LISTED AS:

- Urosepsis
- Uretero colonic anastomotic stenosis
- Hydronephrosis
- Metabolic changes
- Stomal changes
- Lithiasis

MS B'S MEDICAL HISTORY

2004 - Ms B was diagnosed with a mobile squamous cell carcinoma (SCC) of the anus extending 2cm in the left aspect of the anal canal. Local dissection was followed by a 5 week course of adjuvant chemoradiation therapy. Regular outpatient follow-up continued until 2009. During this time Ms B described herself as having a good level of continence despite urgency and toileting up to 6 times daily. She remained cancer free for 5 years and was formally discharged.

2013 –Complaining of altered bowel habits, a GP referral was sent requesting a further surgical review. However, no appointment was received and in April 2014 a further GP referral resulted in an immediate appointment.

2014 – Confirmation of recurrence of SCC of anus, Ms B had an abdominoperineal resection (APR) which proved to be a complicated dissection due to previous radiotherapy tissue damage. Biological mesh was used in perineal closure and reinforcing surgipro mesh used around the sigmoid colostomy. In view of Ms B's COPD this proved to be very effective in prevention of parastomal herniation. Ms B had an uncomplicated recovery and found formation of a colostomy gave her bowel control thus reducing the anxiety she had been previously experiencing.

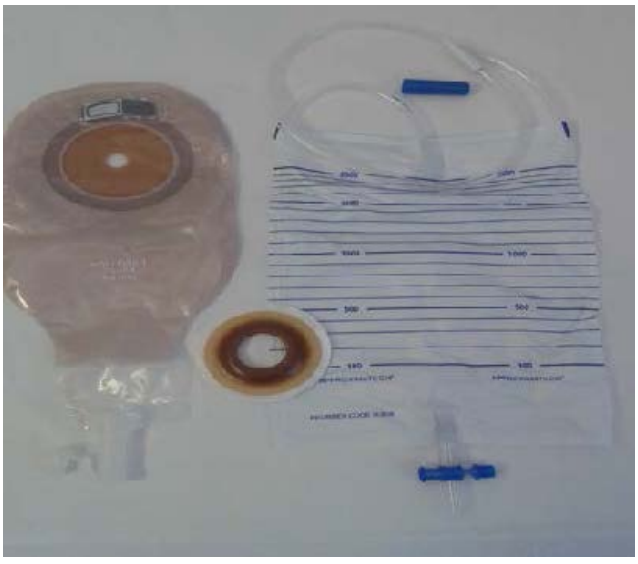
2016 – SCC recurrence diagnosed in the APR scar, vagina and tissue adjacent to the urethra therefore she underwent pelvic exenteration, total hysterectomy, salpingo-oophorectomy, total vaginectomy, cystectomy, excision of omentum, groin node dissection, vertical rectus abdominis myocutaneous (VRAM) flap and two ureteric implants into the descending colon above the existing colostomy. Ms B has the less favoured option described by Brunschwig in 1947 as a WC. Ms B had what was described as a reasonably uncomplicated post-operative recovery considering the size of the operation and being in her 80s. She was discharged home with instructions to complete her course of antibiotics and no further anti coagulant therapies were required.

INITIAL HOME VISIT

On assessment, she was found to be mildly dehydrated, the VRAM flap painful and oedematous, generalised swelling of her right leg secondary to node dissection, inflammation of her left leg varicose vein and reduced appetite. Her stoma and peristomal skin appeared healthy and she had

'normal' stoma function. Ms B felt confident in managing her wet colostomy attaching a 2 litre night bag to contain overnight volumes. We discussed her medications and it was surprising to hear that her antibiotic cover for post-op urinary tract infections would be completed the following day. Ms B had queried this herself but was advised against further cover due to possible long term side effects. However, as Ms B had been advised the histology indicated nodal involvement and progressive disease, after some discussion we both agreed that this rationale did not seem applicable to her situation. She was confused about presenting to our local emergency department (ED) because she had her surgery elsewhere. Reassurance was given that it was appropriate for her to do so but she chose to contact her GP the following morning. Her GP referred her to ED and she was admitted with suspected right leg deep vein thrombosis (DVT), urosepsis and VRAM flap abscess.

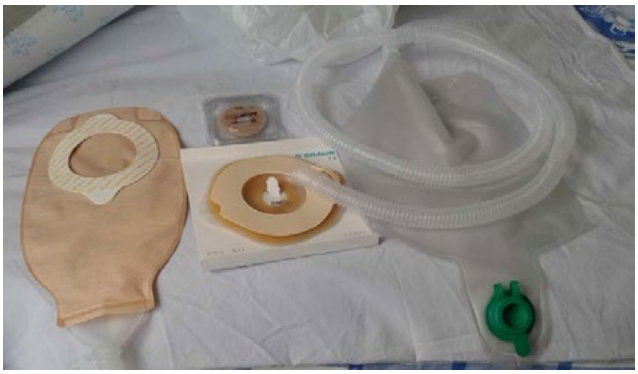
During this hospitalisation period, Ms B experienced pouch leakages. She was very reluctant to change from the system she had become familiar with being Hollister (26064) high output pouch. On examination, her abdomen was softer and a Hollister adapt convex seal- H79530 was added to create some convexity. Despite her bowel motions becoming more firm causing outlet blocking, Ms B felt she would like to continue with the current system. She was advised to increase her fluid intake enabling a watery consistency output to pass through the pouch outlet. A review was offered in 4 days and Ms B was happy with this decision. A discussion was held with the surgical team regarding using prophylactic antibiotics indefinitely. It was agreed appropriate under the circumstances. A urology review was arranged and Ms B was delighted to be going home again.



- *H26064 – high output pouch*
- *2 litre catheter bag*
- *H79530 – adapt convex seal*

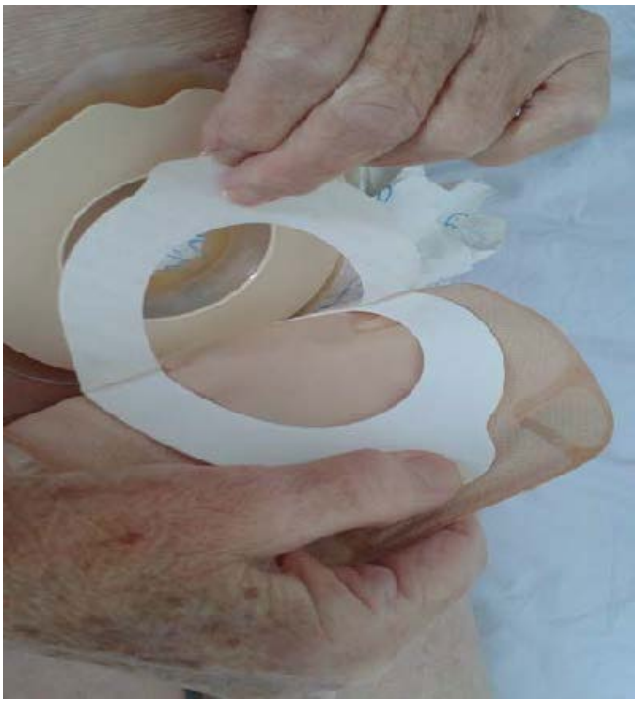
In anticipation of potential pouch leakages post discharge, we researched product catalogues to prepare ourselves for management problems. When Ms B contacted us two days later with leakage issues we were prepared with options.

Her stoma requirements were reassessed as needing the following: - convexity, easy placement, and a larger capacity pouch to contain both urine and faeces allowing both to pass through the pouch outlet into an overnight bag without blocking. The night bag needed to have a wide tube diameter to allow faecal matter to travel freely through into the overnight bag.

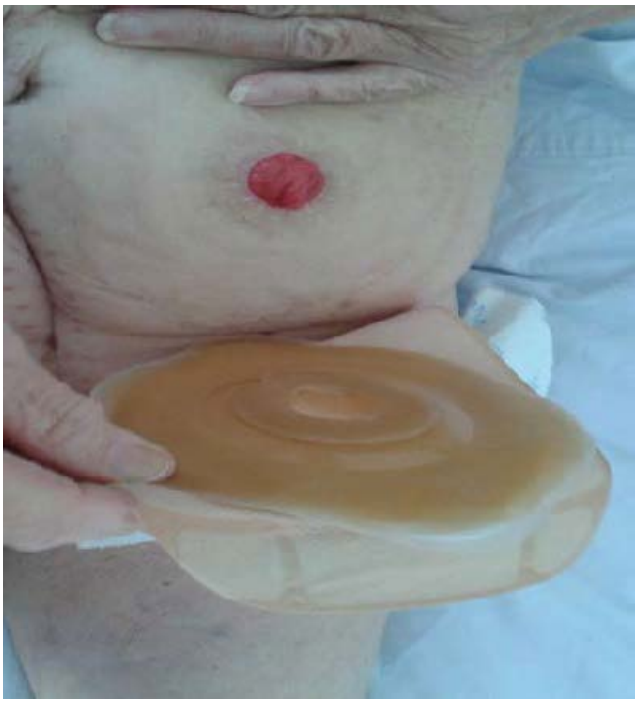


- *Omniwell B Braun 62065 - Flexima Key 60mm maxi tan pouch*
- *Omniwell B Braun 62064 - Flexima Key 60 mm convex flange 25mm precut*
- *Omniwell B Braun 039901 - Flow collector*
- *Hollister 7815 - Adapt slim seal*

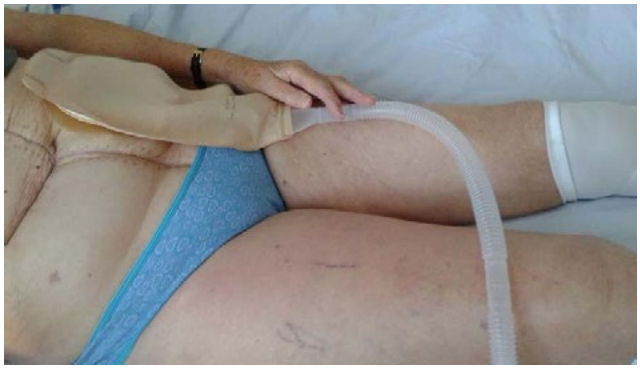
Through trial and error Ms B has worked out the best system for applying the pouch. The flange, seal and pouch is placed as one unit while lying down as this minimises risk of leakage.



Ms B applying pouch to flange



Ms B applying two-piece system laying on bed



Ms B used a strap to stabilise the night flow tubing

The Omniwell B Braun pouch system has met Ms B's needs giving her optimal quality of life. Whether her faecal matter is soft or firm she is able to cope as the system provides a wide bore outlet and the ability to hold larger volumes. Ms B has chosen to no longer use an overnight collector instead she is getting up out of bed 2-3 times a night to empty her pouch. This is not ideal but it is Ms B's choice. Of note, the updated Braun flow collector is no longer transparent and this is certainly more aesthetically pleasing for users of the system. Ms B has had 2 further admissions for pyelonephritis and remains on Cefaclor long term. Recent CT scan indicates bilateral hydroureteronephrosis and partial obstruction due to anastomotic stenosis requiring further intervention. Ms B struggles to maintain her weight and energy levels fluctuate despite the use of prescribed supplements. In spite of this, she continues to lead a busy purposeful life, living independently, driving her mokopuna to school daily, supporting Maori language studies in a teaching advisory role and continues her studies of early customs and issues relating to Maori women. Her enthusiasm for life is inspirational and probably from a stoma nurse perspective, contributes to her health outcomes.

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Living with Pseudomyxoma Peritonei: 10 years on, what next?

Jenny Roberts
Stomal Therapist,
Nurse Maude

Jackie had asked me to write this article for the March edition of "The Outlet" but those who know me will know I am often late. As the saying goes "better late than never".

I work as one of the 3 full time Stomal Therapists at Nurse Maude in Christchurch.

Fig1: Sibylla Maude 1862-1935 founded the district nursing service (fig 2) in Canterbury. It continues to provide a range of community based nursing services, including stomal therapy.

I was thrilled to win the Liberty Medical New Zealand Speaker's Excellence award at the New Zealand Stomal Therapy conference, in October 2016. I thank Liberty Medical for their very generous award. I am excited and looking forward to attending the WOCN conference 2018, in Philadelphia, USA.

This is a short summary of my talk. I did have more photographs, but have chosen not to include them all.

Pseudomyxoma Peritonei (often referred to as Jelly Belly) is a rare disease of unknown cause. The incidence is approx. 2 per million population per year.

Fig 3: You may not know that Audrey Hepburn had Pseudomyxoma Peritonei

It begins after a small growth in the appendix perforates through the wall and spreads mucus secreting cells within the abdomen and pelvis. The symptoms are vague and slow to develop and very often missed. They can include pelvic pain, loss of appetite and fatigue.

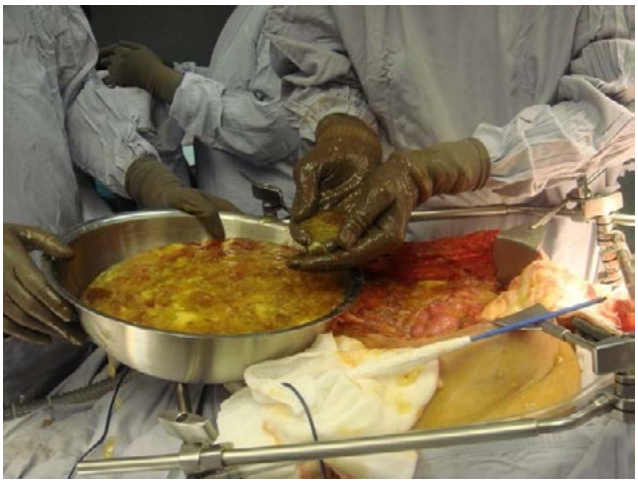


Fig 4: Removal of the jelly-like mucin, during surgery

The surgery is major and can take anything from 6-15 hours and involves removal of multiple organs. It is often followed immediately by intraperitoneal chemotherapy, heated to 42 degrees. The surgery is now performed in Waikato, previously patients went to Australia.

MY CASE STUDY - A 10 YEAR JOURNEY

Mrs S, aged 71 was married with one son who was living in Australia.

In 2006 she presented with abdominal bloating and discomfort, a CT showed ascites.

2007 brought surgery with a laparotomy, bilateral oophorectomy, appendicectomy, and hysterectomy. Pathology showed a low grade mucinous neoplasm

Things deteriorated in 2010. Further surgery was required, this time at St George Hospital, Sydney. This involved peritonectomy, total colectomy, small bowel resection, ileo-rectal anastomosis, loop ileostomy, splenectomy, and diaphragm stripping.

Ten weeks later Mrs S. returned home, I nearly cried when I saw her ileostomy! Her stoma was retracted, tiny and the bag often leaked, despite us trying every available bag and accessory.

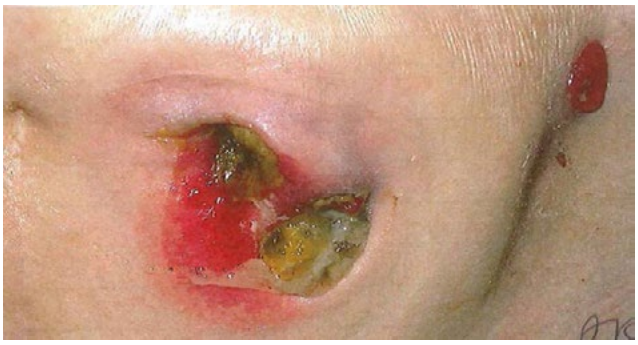


Fig 5: Mrs S's stoma and the abscess beside it secreting mucin

The following five years were a struggle. Mrs S. was devastated when planned stoma revision surgery had to be aborted; there was too much mucin at the incision site. A further CT scan revealed multiple areas of mucin. Mrs S. went on to have frequent sub-acute bowel obstructions resulting in extended hospital stays.

Parastomal abscesses developed around her stoma. She had frequent urinary tract infections and developed a large vesical fistula. Her weight dropped below 50kgs. Mrs S. struggled to eat, her ileostomy output increased and was liquid. She was tired and short of breath but Mrs S. never ceased to amaze me as she continued to play tennis twice weekly, how she managed I am not sure - must have been sheer determination.

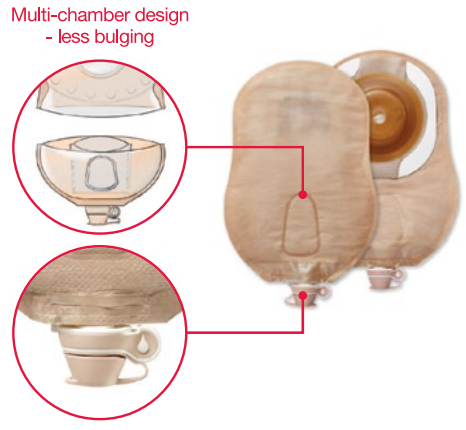
As if living with Pseudomyxoma Peritonei and a leaking ileostomy is not enough to cope with, her house and hill section suffered severe damage in the 2011 Canterbury earthquake. I can only admire her courage and strength to carry on. Mrs S. was such an elegant, immaculate lady who never gave up. A true inspiration.

Mrs S. generously allowed me to share her story and photographs.

The week following the conference, I tried unsuccessfully to telephone her. Later that week I took a call from the oncology ward, requesting review of a lady with a leaking ileostomy bag. That lady was Mrs S. She was extremely frail, weak and deteriorating. I was able to share my success with her. She reached out for my hand, squeezed it and said "that's wonderful, thank you to you, Beth and Jackie for everything you have done for me".

Sadly, overnight Mrs S. died.

What a journey and what a privilege to have been part of it.



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The Woman Who Had Tried Everything

LIPOSUCTION TO ASSIST IN IMPROVEMENT OF ILEAL CONDUIT FORM AND FUNCTION - A CASE STUDY.

Maree O'Connor
CNS Stomal Therapy,
Otago DHB

This was initially presented at the Melbourne combined colorectal and stomal therapy Meeting October 2015.

Gini is a 50yr old woman with spina bifida, and in a wheel chair. She had her urostomy formed when she was 2 years old to assist with continence issues as was the norm at that time (1960's).

Gini has always been a motivated woman and from a young age recognised her potential to live a full and active life. At the age of 15 she was asked by a family with a new born spina bifida baby girl if she would come and talk to them about living as a person with this condition. A big ask of a young girl doing her utmost to live normally, and as is the way with Gini, she agreed. This family found her to be such an inspiration and gave them hope and understanding. Gini is honoured to be this girl's Godmother. Gini has watched this girl grow and avoid the need for a urostomy as she does Intermittent Self Catheterisation (ISC) but in no way regrets her own decision not to have this done when it was offered to her. She says "why would I, I was independent and didn't want to have an operation that may or may not work for me".

In 1984 Gini's urostomy developed a stenosis and required refashioning, and from her notes it appears that all was well for the next 10 years. At the age of 27 the trouble really began, however Gini successfully held down a job and married in 1990.

From 1993 Gini began her frustrating journey of leakage, being wet and numerous product trials and product combinations. These brought both hope and despair. It seemed that things would work well for a while and then fail again.

Ten years ticked by and I first met Gini in 2003 when she phoned us as she had used 3 months of supplies in 6 weeks. At this stage the leakage was just a bit of a nuisance for her as there were more exciting things going on in her life… Gini and her husband had been travelling and had adopted a wee 18 month old baby boy! She was finding her increased activity of bending and lifting to manage her new son was decreasing pouch wear time.

This began another round of product trials, all a variation on a theme: convexity, seals, and so on with little gain overall.

Stomal therapy assessment demonstrated that Gini had gained weight and this may have contributed to some of the issues, we offered surgical referral for review but Gini declined. More types of stoma equipment were trialled. When she started to experience 4 leaks a day she agreed to see the surgeon.

I suspect there were times Gini did not wish to follow through on suggestions, for example using a belt and a leg bag, However, would many young busy women want to be trussed up with belts and straps and leg bags, I can see her point of view.

Finally a surgical revision of the urostomy was performed in July 2006 with only a small gain in length, the pouch leaked that day even with a catheter in situ. However as she recovered and using stomahesive paste into skin creases, leaks were less frequent.

Gini had great faith in a product called "skin bond" and much to her anguish it was removed from the market in 2007, and she felt nothing else seemed to work as well for product adhesion as it did.

In 2008 Gini again experienced multiple leaks and once again was trialling stoma pouches and combinations of stoma products. There is a degree of tension for the stoma nurses with the balance of Quality Of Life issues and quantity of product, budgetary considerations and patient compliance. At the end of the day, a Stoma nurse's goal is to assist people to live successfully with their stoma, so it is frustrating for us all but most of all for Gini.

In New Zealand there are funding constraints and Ministry of Health Specifications around the use of stomal products, there is after all considerable cost to the health care system for the provision of stomal products and it is necessary for product to be used in a cost effective manner. Two to three Urostomy pouches per week is the guideline. By 2013 Gini was using two to three pouches per day, a significant deviation to the specifications.

Gini saw the surgeon again in April 2013. She was still keen to avoid surgery as she had a busy young family of 3 children by now and it would be difficult to be "out of action" for any length of time. She worked hard with the dietician and went to the gym to decrease her BMI and was successful with this and saw some improvement with pouch wear time. Gini told the surgeon she did not want surgery.

The usual pattern recurred and the wear time improvement was not maintained. Gini admitted she had begun to lose her self-confidence and her self-esteem. By now Gini was tired. She was tired of being wet, she told me she was tired of producing more washing than her children and she was tired of changing her pouch just to have it leak again. It was really getting her down. She told me at this point she just didn't bother. If it leaked she thought "what's the point..it is just going to do it again in a short time" so, she just didn't bother, and went about her day wet. However one day her daughter said, as children do in their brutally honest way.."oh Mum you are smelly mummy again!" This made her sit up and think, I can't get around like this, it is affecting how the children see me and Gini was very aware they already coped with having a Mum different to other mums. Enough is enough it was time to get something done.

So when she saw the surgeon, Mr Potter, in May 2014 he broached the possibility of liposuction and by August it was decided liposuction really could be useful to pursue and she was referred to the plastic surgeon.

Mr Potter, the Colorectal surgeon, approached me regarding this option and while I had no first-hand knowledge of it I had read some American articles that appeared favourable and we thought it worth a try.

The literature is reasonably limited with mostly case reports done in the 1990's. Samdal published a paper in 1995 "Troublesome Colostomies & Urinary Stomas treated with Suction-Assisted Lipectomy" discussing outcomes of 8 patients who underwent this technique, 5 of them for leakage issues. Post treatment 4 patients had no leaks or less than 1 leak per month compared to a range of 1-4 leaks pre procedure. No complications occurred and patients reported being "very satisfied with the outcome". The same author published another paper of a single case with similar outcome. Marguiles published a paper "Suction-Assisted Lipectomy or the correction of Stomal Dysfunction" in 1998 discussing 5 patients who had this undertaken for leakage, again there was a marked improvement in appliance wear time and no significant complications. Sharma published a paper in 1996 "Liposuction for retracted urostomy" regarding a single urostomate with appliance leakage who had positive results. Please see references attached. Overall, these studies demonstrated positive results with no complications and while small in numbers did suggest the procedure could be worthwhile for Gini.

I met with the plastic surgeon, Mr Will McMillan, and discussed the size of the area that would benefit from being "plateaued" and also the possibility of leaving some fatty tissue at the 9 & 3 o'clock aspects of parastomal skin where there is creasing. Mr McMillan was willing to do so if technically possible.

Gini was aware this surgery had not been done here before and she was keen to try it, she was keen to avoid the risks and extensive nature of a stoma revision and the time it would take to recover as her young family kept her busy. She felt the liposuction was a good option.

SURGERY WAS PERFORMED ON THE 18TH MARCH 2015

This involved pre-op gentamycin and Kefzol antibiotic prophylaxis along with DVT prophylaxis of compression stockings and Clexane.

A General Anaesthetic was given. Infiltrate solution was prepared, this being 1L N/S, 40mls of 0.5% Marcain and 1mg adrenaline, and 200mls of this solution was infiltrated into the parastomal area. A Hegar dilator was used to intubate the stoma and hold it in a position to help decrease the risk of damage to the stoma itself.

5mm and 4mm liposuction cannulas were used to then aspirate 200mls of fat.

The 3 port sites used were closed with 4/0 Monocryl and steri-stripped.

POST-OPERATIVE CARE/MANAGEMENT

Gini was then required to wear a pressure bandage as able for at least 2 weeks.

One overnight stay was required and then she was discharged home.

(Information supplied by Consultant Plastic Surgeon Mr W McMillan).

PROGRESS

Gini found the pressure bandage rather difficult to try and keep on and still manage emptying and changing her pouch.

Two days later I spoke with Gini, she was feeling reasonable, using panadol for pain and could see the bruising "coming out".

25/3 (1 week later) Gini was very excited with 6 day wear time. Bruising remained but doing well.

31/3 (2 weeks later) Gini reports, bruising gone, 6 day wear time, the area feels "tingly" she is very pleased so far.

26/5 Gini experienced a leak, she thinks pouch was overfull, generally doing well with 4 day wear time. Using adapt seal and convex pouch.

20/7 Gini says she had a period over 2 weeks where she did get leaks which she attributes to cold weather… however Gini is experiencing 4 day wear time and she says at this stage she is delighted.

Currently Gini appears to be doing well. Her product usage appears to be within the prescribed amounts and she is not contacting the stoma nurses for assistance.

So now it is watch and see. We do not know at this stage whether the benefit will be sustained and if so for how long however the results are looking promising so far.

This has been a very interesting process working with Gini through it all and seeing the successful outcome so far. We hope she continues to do well and is no longer suffering the consequences of urinary leakage via her Ileal Conduit and enjoying an improved Quality of Life.

Thank you to Gini for her willingness to share her story and to Mr W McMillan (Plastic Surgeon) and Mr J Potter (Colorectal Surgeon) for their input and support.

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