



The Outlet

New Zealand Stomal Therapy Nurses

In this issue:

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NOVEMBER 2013

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The Outlet

New Zealand Stomal Therapy Nurses

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SUPPLEMENT

NEW ZEALAND STOMAL THERAPY NURSES CONTACT DETAILS

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ISSN 2324-4968 (Print)

ISSN 2324-4976 (Online)

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Stomal Therapy Section.

www.nzno.org.nz/groups/sections/stomal_therapy

Disclaimer: The Outlet is the official journal of New Zealand Nurses Organization Stomal Therapy Section. The opinions and views expressed in the Outlet are those of the authors and not necessarily those of NZNOSTS, the editor or executive committee.

Published three times a year by Blacksheepdesign
www.blacksheepdesign.co.nz

Chairperson's Report

Welcome to our 3rd edition of The Outlet magazine for the year. I would like to thank our co-editors for their enthusiastic commitment for making our NZ Stomal Therapy Journal so interesting and informative. It is fantastic to see our NZ practicing stomal therapy nurses submitting their experiences of our nursing speciality.

The committee have canvassed you, our membership to see what you wanted to do in regards to becoming an NZNO college. The votes came back very clearly that we want to be a college in our own right. We have a steering group assisting with this task and I am confident that we will achieve this within the timeframe required.

Conference planning is underway and we are excited to announce that it will be held in Auckland in November 2014, so keep this in mind as you plan your year!

I attended the NZNO College and Section day in September and found it quite inspiring. It was very interesting to hear the other sections and colleges speak of both their concerns and their initiatives. It was also helpful to be reminded of what other specialities there are and to have these people in the same room to approach and discuss ideas with was invaluable. It raises awareness of who else we can connect with on various issues and ideas. I look forward to discussing some ideas from the meeting with the rest of the NZNOSTS committee at our face to face meeting on 29th November.

It appears that PHARMAC are pursuing other medical device users at this stage, so there are no new developments in regards to Stomal devices. We continue to monitor the progress of this initiative and will keep you informed of any developments within Stomal therapy.

Don't forget we are always happy to hear from you if you have any ideas or thoughts, just send an email or give us a call.

As Christmas is nearly upon us I hope everyone is able to take some time to have a break, enjoy some summer weather and activities. Enjoy, be safe and Merry Christmas.

Maree O'Connor

NZNOSTS Chairperson.



MAREE O'CONNOR
NZNOSTS Chairperson

Learn from Yesterday, Live for Today, Hope for Tomorrow

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Nicolas, an ostomate since 2010

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NZNO Section to College Survey Results

LORRAINE ANDREWS (Co-editor)
& LORRAINE RITCHIE (NZNO PNA)

Executive Committee Resignation

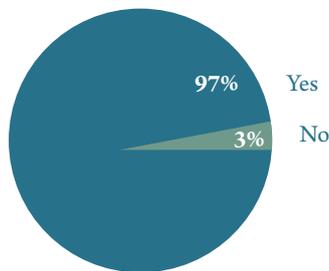
The Executive Committee would like to thank the members who informed themselves and voted in the August survey on the section transiting to college status.

The Executive Committee now has a clear mandate from the membership to proceed to college status as a stand alone Stomal Therapy entity.

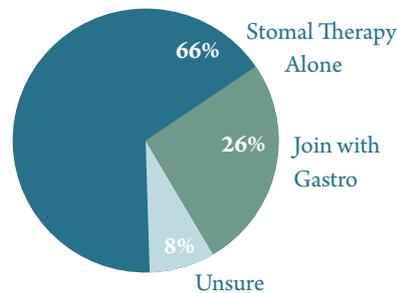
Survey Results

Total Votes 38
31 votes received on monkey survey
8 votes received as hard copy

Have you read and understood the background information?



How do we proceed to college status?



Where to From Here?

Now that the decision has been made to progress to a Stomal Therapy College, there is much work to be done! For several months now, a stomal section 'transitioning to College' sub-group has been working away in the background exploring options for college progression. This group will still exist with the executive committee's approval and support and is tasked with the responsibility of meeting all the goals of the College transitioning template; these include having an Education Policy, a Strategic Plan, Standards of Practice, a new title and logo. The members of this group are: Maria Stapleton (ex stomal committee member), Judy Warren (ex stomal committee chair), Maree O'Connor (current stomal committee chair) and Lorraine Ritchie (NZNO PNA). They will report to the executive committee and second others to help with particular pieces of work. The ultimate goal is to have all documents approved at a stomal conference AGM. Thereafter they will need to be approved by NZNO. This needs to occur by the end of 2016. The template for the College transition is accessible in the College and Section Handbook (hard copy and electronic copy), and if any members are keen to help with any particular projects, please let the editors or committee know. Thank you

It is with genuine regret that the Executive Committee accepted the resignation of Terra Wilson in October. Terra was elected to the committee in November 2012. She embraced the challenges involved in being the executive committee secretary, a role that she has forefilled with great organisation and efficiency. The committee would like to wish Terra the best of luck as she pursues a new career direction and sincerely thank her for her contribution to the section.

The committee will consider the options available to us in filling the vacant position when we next meet in November. As we are still compliant with the requirement for one South Island committee member, have five remaining members and are almost half way through our term of office it may be possible to absorb the secretary role with in the existing committee members.

If the committee consider a sixth member is required due process will be followed to second another member.

Please feel welcome to contact a committee member if you require further information

Lorraine Andrews & Maree McKee (co-editors)

Stomal Therapy Section Recruitment Program

LORRAINE ANDREWS

Co-editor

In line with the Executive Committee's objective to market and grow the stomal therapy section's membership, a staged recruitment campaign is underway.

The Outlet journal will be used to market and promote the section to potential members. With each publication of The Outlet, additional copies will be sent to key sponsors in targeted geographical areas. The aim is for the sponsors to utilise the additional copies of the Outlet to actively recruit.

The NZNOSTS began 2013 with 157 members; with the addition of 29 new members from Counties Manukau and 30 plus from Northland we now have close to 200 members.

The target is for each area to achieve 15-20 new section members. Clearly Northland are the team to beat. The only requirement for membership of the Stomal Therapy section is NZNO membership. Members are permitted to join only two NZNO sections or colleges.

The planned target areas and sponsors are:

Date:	Area:	Sponsors:
March 2013	South Auckland	Maree McKee, Lorraine Andrews
August 2013	Northland	Ginnie Kevey-Melville, Rachal Pasley, Marie Oldridge
November 2013	Southland, Otago	Maree O'Connor, Terra Wilson
March 2014	Waitamata	Maree Buchanan, Sandy Izard, Eileen Austin
August 2014	Palmerston North, Wanganui	Nicky Bates

Bernadette Hart Awards and Application Forms

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

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

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

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

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

Applications for the Bernadette Hart Awards 2014 will close on 30th November 2013. Application forms are to be forwarded to **Terra Wilson** either by e mail at secretarystnznzno@outlook.co.nz or posted to arrive by 4pm on 30th November to **Terra Wilson** at **5 Hamilton Ave, Winton 9720**

POLICY FOR SELECTION OF BERNADETTE HART AWARD RECIPIENT

The National Executive Committee shall meet yearly after the closing date for applications for the Bernadette Hart award to consider applications. The closing date will be 18 January and thereafter 30 November each year. This will be advertised in The Outlet. Awards will be made as per the following criteria:

- The successful applicant(s) will be notified by letter within one month of the closing date. Unsuccessful applicants will be written to, to acknowledge receipt of their application.
- The monetary amount of the award will be decided by the Executive Committee and will be dependant on the number of successful applicants.
- The name of the successful applicant(s) will be published in the NZNO Stomal Therapy Nursing Journal - The Outlet.

Deciding criteria is based upon:

1. The applicant(s) must have been a current member of the NZNO Stomal Therapy Section for a minimum of one year.
2. The relevance of the proposed use of the monetary award in relation to stomal therapy practice.
3. To be used within 12 months following the receipt of the award.
4. The applicant(s)' previous receipt of money from the Stomal Therapy Section and whether or not they have received the Bernadette Hart Award in the past. The latter does not exclude a member from applying more than once, although it may be taken into account if there were multiple applicants in any one year.
5. The applicant(s)' commitment to contributing back to the Stomal Therapy Section after being granted the Bernadette Hart Award by verbal report at the Section Conference and/or a written report in "The Outlet".
6. The recipients ability to foster stomal therapy opportunities to new members.

Implemented September 1998

Reviewed January 2009

Bernadette Hart Awards and Application Forms

CRITERIA FOR APPLICANTS:

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

APPLICATIONS CLOSE 30TH NOVEMBER (annually)

SEND APPLICATION TO:

Terra Wilson

Email: secretarystznzno@outlook.co.nz

BERNADETTE HART AWARD APPLICATION FORM

Name: _____

Address: _____

Telephone Home: _____ Work: _____ Mob: _____

Email: _____

STOMAL THERAPY DETAILS:

Practice hours Full Time: _____ Part Time: _____

Type of Membership FULL LIFE

PURPOSE FOR WHICH AWARD IS TO BE USED

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

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

EXPECTED COSTS TO BE INCURRED

Fees: (Course / Conference registration) \$ _____

Transport: \$ _____

Accommodation: \$ _____

Other: \$ _____

Funding granted/Sourced from other Organisations

Organisation: _____

\$ _____

\$ _____

\$ _____

PREVIOUS COMMITMENT/MEMBERSHIP TO NZNO STS

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

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

Presenting at the next National Stomal Therapy Section Conference.

Signed: _____ Date: _____

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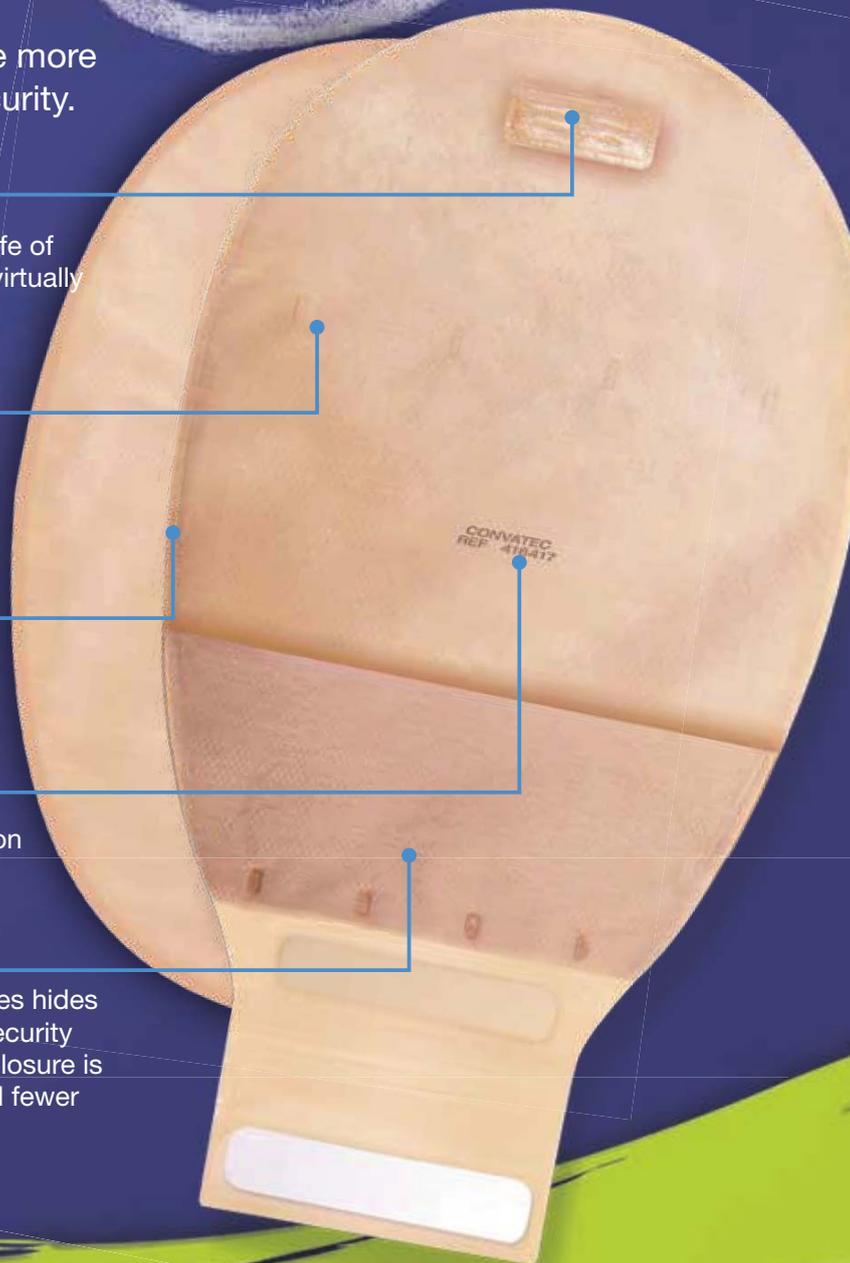
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On Ward Management of an Extensive Laparotomy Wound Breakdown

ALAN SHACKLETON

Alan Shackleton is Counties Manukau DHB's Wound Care Nurse Consultant and Clinical Lead for the Wound Care Service. His role encompasses providing advice and education around the management of complex wounds both within Middlemore Hospital and through the Complex Wound Clinic at Manukau SuperClinic Alan is also responsible for strategic planning in relation to wound care products, policies and procedures DHB wide.



Due to the level of risk involved in returning a patient with multiple co-morbidities to the operating theatre, the management of a complex wound may be required in a ward setting with sharp wound debridement.

Mrs P, a 49 year old female was admitted to the surgical department with sudden onset of epigastric pain, which followed a one week history of postprandial pain. Following investigations and subsequent surgery Mrs P experienced wound complications, which led to the involvement of the Counties Manukau DHB Wound Care Service.

On receipt of a referral for advice and support in the management of Mrs P's wound, the Wound Care Team used the H.E.I.D.I. acronym to guide their holistic assessment and the development of a treatment plan.

When assessing a patient and planning their wound care it is important to base your treatment plan on a full holistic assessment. To aid this approach an acronym such as H.E.I.D.I. can be helpful. This tool guides the assessor in looking at the patient's current situation and plans care using five key headings. The headings are History, Examination, Investigations, Diagnosis and Interventions. As well as assisting in the initial assessment and treatment planning, this tool aides in providing a structure for documentation and has been found particularly helpful in the holistic assessment of wounds (Rice & McGuiness, 2011).

History

Mrs P is an independent individual who mobilises with a stick and manages her own activities of daily living (ADLs) when at home. She is unemployed and has a history of Type II diabetes, which she felt she managed well. On admission Mrs P had a BMI of 71. As a result of her obesity she presented with a grade 3 abdominal panniculus (apron).

Following CT investigation it was found that Mrs P had two umbilical hernias, possibly resulting from previous midline surgery which was performed as a result of a motor vehicle accident (MVA) in 1997.

The findings of the CT scan subsequently led to Mrs P undergoing a laporotomy, umbilical hernia repairs, with on lay of mesh.

Three weeks post surgery and following the removal of both the sutures and drain Mrs P developed a fever. The laparotomy wound began to show signs of infection, with both local erythema and tenderness at the lower aspect. This was rapidly treated with IV antibiotics however; Mrs P developed both a 70% dehiscence of the surgical wound and a 15cm x 15cm area of tissue necrosis distal to the wound.

Following a full review by the surgical team it was identified that Mrs P's overall condition made her a poor candidate for further surgery. On ward sharp debridement was suggested.

In light of this, and pending a full review by the wound care team, a short term plan was made to contain the wound and manage the wound exudate with Negative Pressure Wound Therapy (NPWT).

Examination

Following the receipt of Mrs P's referral, a member of the Wound Care Team arranged to assess Mrs P at the point of her next planned dressing change.



Image 1 on initial assessment of wound.

Wound Assessment

When assessing a wound the Wound Care Team encourages the use of the T.I.M.E. framework, as this supports the assessor in considering all local wound characteristics in the development of their treatment planning. When used to guide documentation, this tool will also support future wound reassessments, as it will highlight any changes in the wound. (EWMA, 2004).

On Ward Management of an Extensive Laparotomy Wound Breakdown *...continued*

ALAN SHACKLETON

Using the TIME framework the following observations were made:

- Tissue
 - The visible tissue of Mrs P's wound suggested that approximately 80% of the wound bed consisted of necrotic adipose tissue. The remaining 20%, the upper (proximal) wound wall, was healthy and presented as well perfused granulation tissue.
- Infection/Inflammation
 - Odour - Upon entering Mrs P's room there was a strong offensive wound odour.
 - Erythema - The peri wound at the time of the assessment had very little erythema but had areas of erosion due to moisture damage.
 - Temperature - The peri wound area was slightly warm to the touch and systemically Mrs P still had an increased temperature.
 - Wound swab - This was taken at the last dressing change and showed multiple organisms present, including *Klebsiella pneumoniae* (ESBL+ve) sensitive to Cefoxitin. Antibiotics were being given intravenously.
 - Wound Pain - After further discussion, Mrs P identified that the peri wound area was sensitive to touch but otherwise free of pain.
- Moisture
 - Amount - The amount of fluid output from the wound had filled two and a half NPWT canisters (750mls) over the last two days and had begun to leak under the distal portion of the dressing.
 - Appearance - The wound exudate both within the NPWT canister and in the wound was a light brown colour, thin in consistency and malodorous.
- Epidermal edge
 - Internal - At the time of this initial assessment the majority of the wound edges were obscured with necrotic tissue.
 - External - The lower (distal) portion of the peri wound had areas of erosion due to fluid leakage.

As well as assessing the wound it is important to look at both the effects of the patients overall condition on the wounds ability to heal and the effect the wound is having on the patient:

- Nutrition - due to the large amount of fluid being lost via the wound, Mrs P was losing essential nutrients that were required to both maintain the body and rebuild the wound. A dietician assessment was requested.

- Patient perspective - On discussion, Mrs P identified that her main concerns consisted of, the need to return to the operating theatre as she felt extremely anxious about the chance she may not live through another surgical procedure. Mrs P also identified the odour from the wound, as this was a permanent reminder of the wound. She felt embarrassed when her family visited and uncomfortable when the wound exudate ran out of the bottom of the dressing into her groin, wetting her bed.

Investigation/Diagnosis

As Mrs P was still presenting with a fever and no local signs of wound infection spread, it was considered that urosepsis could also be contributing to Mrs P's systemic signs of infection, possibly due to the poor management of wound exudate. This was confirmed with a midstream urine culture that showed *Klebsiella pneumoniae* (ESBL+ve). This was treated with a course of Ertapenem.

Intervention

Due to Mrs P's large abdominal apron and with no way to visualise the base of the wound it was difficult to identify the extent of the necrotic tissue. It was clear that this tissue was harbouring bacteria and needed to be removed.

Taking into consideration Mrs P's anxiety around returning to the operating theatre, concerns regarding the wound odour and exudate management and the surgical teams request for ward based sharp debridement options needed to be explored. The best method for removal of the non-viable tissue needed to be discussed with Mrs P and her family.

The outcome of this discussion was for the Wound Care Service to conservatively sharp debride (CSD) the wound on the ward, with the option of topical anaesthetic in the form of Lignocaine 2% gel if needed. The surgical team had agreed to review the wound at regular intervals to monitor progress and provide support where needed.

Approaches to wound debridement can be varied, with multiple methods available to clinicians, such as autolytic, enzymatic/chemical, biological, mechanical, surgical and conservative sharp debridement. The choice of wound debridement method is often based on the patient/wound assessment, availability, and the clinician's knowledge of wound care and their level of skill.

With the ever increasing role played by nursing staff in the care of both acute and chronic wounds and wound debridement being an internationally recognised requirement in wound care best practice, nurses are being asked more and more to not only make decisions around debridement but to assess and perform CSD within their clinical setting.

On Ward Management of an Extensive Laparotomy Wound Breakdown ...continued

ALAN SHACKLETON

As this procedure was to be undertaken by a Registered Nurse outside of the operating theatre, limitations were placed as to the level of debridement to be undertaken. The target was set not to remove all non-viable tissue but to CSD the wound. CSD has been defined by the National Institute of Clinical Excellence (2005) as the removal of dead tissue, above the level of viable tissue, with a scalpel or scissors. This use of CSD is reserved for skilled practitioners who have had their practice in CSD recognised.

Once a full description of the procedure was given to Mrs P and she gave her consent, CSD of the necrotic tissue was performed. Mrs P found that this procedure caused no discomfort and the Lignocaine 2% gel was not needed.

Following wound debridement the wound was cleansed and a silver NPWT dressing was applied with an appropriate contact layer. The rationale for this dressing choice was to:

- Manage the wound exudate
- Reduce any surrounding oedema
- Control the bio-burden within the wound, thus reducing odour and chance of infection spread
- Bolster the wound
- Maintain fluid movement at the wound bed, thus encouraging autolytic debridement between dressing changes.

The antimicrobial silver foam was only needed to two weeks and was then changed to a standard NPWT foam.

After one month of dressing changes and episodes of CSD a healthy, well perfused wound bed was evident.



Image 2 One month after commencing sharp debridement and NPWT on the ward

Shortly after image 2 was taken Mrs P returned home to have her wound treated by her local District Nursing team.

Five months after the original wound breakdown Image 3 was taken and shortly after this Mrs P was discharged from the surgical teams care.



Image 3 Five months after initial surgery and wound breakdown

Conclusion

A well structured holistic assessment when developing a wound treatment plan is essential. This should take into account local wound assessment and any relevant investigations. All assessments should then be included in a discussion with the patient; giving them the opportunity to highlight any concerns that they may have. The resulting outcomes can then be considered and discussed with key parties before formulating a treatment plan.

In the case of Mrs P, neither the surgical team nor Mrs P were willing to undertake the risks involved in undergoing wound debridement in the operating theatre. Through the use of Conservative Sharp Debridement and Negative Pressure Wound Therapy all target outcomes were achieved and the wound went on to heal with no further complications.

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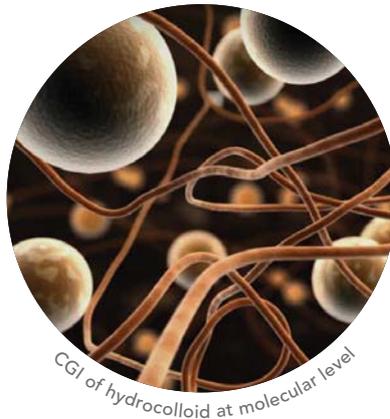


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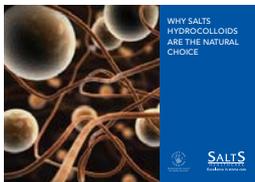
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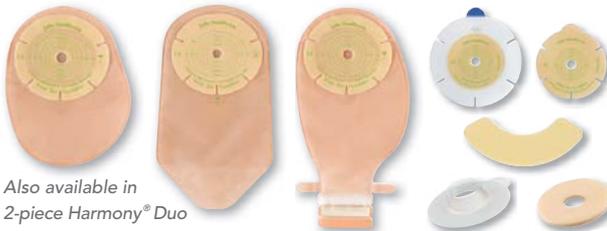
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Nothing Prepared Us for Mr M

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Rachel works part time as a Stomal Therapy Nurse in Northland after qualifying through the NSW College of Nursing in 2008. Prior to this, Rachel worked in a surgical inpatient ward with a colorectal focus.



As Stomal Therapy Nurses we will all come across patients who have stomal granulomas at the mucocutaneous junction of their stoma.

Granulomas

Granulomas develop as part of an inflammatory response. There are a number of causative factors, more than one of which may be present in any individual patient.

Likely causes are:

- Inaccurately sized or ill fitting appliances
- Abrasions / rubbing at the mucocutaneous junction
- Trauma to the epidermis of the skin during removal
- Constant faecal irritation
- Allergic reaction to components in the pouching system
- Inflammatory response to the foreign material such as the sutures securing the mucocutaneous junction

Why some people are constantly troubled by granulomas and others never develop them is unknown.

In our practice we often identify patients with granulomas at their routine two yearly review. The granulomas have often caused the patient no problems. However, some experience bleeding and due to the uneven contours of the peristomal plane may have difficulty adhering their appliance. Standard practice is to apply silver nitrate, supply stoma powder with instructions on use and then look forward to the issue resolving.

Less frequently a patient will call our service reporting significant bleeding from the stoma and intense pain. These patients can be highly anxious, often they have tried to address the issue themselves and have been hoping for a spontaneous resolution. Generally, once established the granulomas progressively increase in size becoming more fragile. This situation can lead to excessive bleeding.

Mr M

When Mr M contacted our department he was so desperate that he was prepared to travel for over an hour to be reviewed in our clinic that day.

Mr M's history included both an abdominal perineal resection and a left hemicolectomy for synchronous tumours of the rectum and the splenic flexure. These procedures resulted in an end colostomy formed in the transverse colon. Mr M was 55 years of age when

he had this surgery. He worked for a lines company monitoring powerlines. Mr M was married with a very supportive wife. Just prior to coming forward for surgery they had lost their only son in a RTA. Due to the diminished length of colon left insitu from surgery and his enjoyment of the occasional beer Mr M used a drainable appliance. This appliance had been his product of choice for the last nine years.

Review of his previous assessments revealed that Mr M had been noted to have granulomas. Over a prolonged period these had gradually increased in size and number but had generally remained small and easily controllable with silver nitrate.

Nothing prepared us for the issues revealed when Mr M removed his appliance.



Fig 1: On initial presentation

Assessment

It was important that a full review of Mr M's history was undertaken to determine possible causes for his condition. Other causes such as Crohn's disease or recurrence of his cancer could not be excluded.

Mr M's flange was examined to ascertain any evidence of leaks and to determine if the aperture was cut to the correct size. No evidence of leakage was found however Mr M had been gradually increasing the size of the flange aperture to accommodate the growing field of lesions. This exposed the area to continuous faecal contamination. Mr M's actual stoma size was 32mm however; he was cutting the flange to 45mm. This left a circumferential area of 13mm exposed to contamination. The area was painful, bleeding easily on contact or with flange removal. The area was too extensive for silver

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nitrate alone to be an effective method of treatment if these were granulomas.

After a joint consultation with my colleague it was considered prudent for Mr M to be reviewed by a surgeon for possible biopsy to establish a definitive diagnosis and for possible diathermy as a treatment option. Mr M preferred to use his private medical insurance and be referred to a surgeon in the private health sector. The surgeon believed that these were not typical granulomas. He had some concerns that Mr M may have a viral condylomata. Condylomata are a warty type growth.

His biopsy results identified nothing sinister and confirmed that the lesions were granulomata resulting from chronic irritation. The treatment plan was to locally curette the area, control any bleeding and allow the area to heal by secondary intention. This approach was minimally invasive and any ongoing re-growth could be controlled with silver nitrate application. The surgeon noted that he was pleased with the procedure and that he was optimistic of a good outcome!!!!



Fig 2 Six week post curette and diathermy

Mr M re-presented six week after the diathermy procedure.

He believed that the granulomas had begun to re-form two weeks after the diathermy. They were now, once again extremely painful, bleeding copiously and if anything covered a larger area than before the procedure. However, the colostomy mucosa, which had not been clearly visible before the procedure was now clearly seen.

Treatment Plan

After another joint consultation with my colleagues and with no further surgical intervention likely to improve the situation we decided to isolate the colostomy, cover the granulomas to prevent contamination and apply pressure. We applied stoma powder, dusting off the excess before applying Eakin seals to cover the granulomas.



Fig 3. Use of stoma powder and seals

We then applied a soft convex Eakin Pelican drainable appliance. This ensured good adhesion, applied pressure and reduced Mr M's pain. After instructing Mr M in the key points of product use he was more than competent to be an active participant in his treatment plan. Mr M was scheduled for review in two weeks time.

At the two week review (Fig 4) pain and bleeding were no longer issues. Even though we still had some way to go Mr M was a much happier man.



Fig 4. Two weeks post initiation of the Treatment plan

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Six weeks after the treatment plan was commenced the granulomas had all but vanished. The few remaining areas were treated with silver nitrate. Use of Eakin seals was discontinued. The now even contours of the peristomal skin allowed good adhesion, with a correctly fitted appliance.



Fig 5: Six weeks after start of treatment.

I have recently reassessed Mr M and can report that he is now 12 years cancer free with no evidence of granulomas around his colostomy.



Figure 6: 2 years on from treatment

The WCET Journal Vol 33, Number 1, January / March 2013 has an article, 'Guidelines for standardising the treatment of Stoma granulomas at the mucocutaneous junction.

These guidelines recommend:

- First line treatment: Silver Nitrate.
- Second line treatment: Haelen tape (topical steroids)
- Next line treatment: Liquid Nitrogen.

When Mr M presented with this issue I was a fairly new to Community Stomal Therapy Nursing and the issues people with a stoma may develop over time. The guidance and collaboration from my senior stomal therapy colleagues were hugely beneficial. The wisdom and knowledge that comes from experience cannot be under rated and sharing of that knowledge is fundamental to our practice.

It often shocks me how long people will put up with problems before seeking assistance. The importance of having regular re-assessments can not be under estimated in identifying and promptly treating any developing issues. Patients should be informed of the need to seek advice when changes occur either from the STN, district nurse or their GP so that, appropriate referral can be made and to prompt treatment initiated.



The Outlet

New Zealand Stomal Therapy Nurses