

BERRIEN COUNTY CANCER SERVICE

7301 RED ARROW HWY.

STEVENSVILLE, MI 49127



**OSTOMY
NEWSLETTER**

November - December 2009



what matters.™

FREQUENTLY ASKED QUESTIONS

Excerpted from Diet & Nutrition Guide, UOA 2002, Via: Cleveland, O.A., OH

Question: How soon after ostomy surgery can I return to a normal diet?

Answer: Physicians and ostomy nurses suggest that you begin slowly, depending upon your recovery and/or other medical complications. Add back one new food at a time. If you experience any problems, discontinue for a few weeks and try again.

Question: In the past, certain foods caused me some trouble with digestion. How will they affect me since my ostomy surgery?

Answer: Check them out. You may find that some of those foods will continue to be troublesome and others may not.

Question: Will my ileostomy continue to produce output even if I do not eat?

Answer: Yes, the small intestine will continue to produce gas and digestive juices. An empty digestive tract seems to produce excessive gas. Eat small meals to keep something in the gut. Peristalsis happens!

Question: After ostomy surgery, I have gained excess weight. What happened? What types of food should I eat?

Answer: The relaxation of dietary restrictions, freedom from debilitating illness and malabsorption promotes a rapid gain in weight. Follow the same weight reduction diet as recommended by nutritionists and dieticians. Eating small quantities of a well-balanced diet and increasing water/fluid intake will assist with weight reduction.

Question: What is meant by “low residue” diet?

Answer: Low-residue refers to a dietary regime which eliminates bulk-forming, hard-to-digest or high-fiber foods.

Question: Will spicy foods cause any damage to my stoma?

Answer: If you can tolerate spicy foods through your digestive system, the output through your stoma should not cause any harm. The stoma is formed from the lining of the bowel and it is tough and can tolerate those spicy foods.

Question: What effects will oral odor control medications have on my ostomy?

Answer: Some individuals who have a colostomy report that they experienced some constipation from bismuth products found in oral odor control medications. Individuals who have an ileostomy have more benefits and fewer side effects from oral preparations (chlorophyll tablets, bismuth subgallate and bismuth subcarbonate). Most foods do not affect an individual with a urostomy. A strong urine odor may be an indication of dehydration and the need for increased fluid intake. Check with your doctor or ET nurse about oral preparations and don't exceed the recommended dosage.

Pouchitis

Pouchitis, a non-specific inflammation of the ileal reservoir, can be a long-term problem for some patients. This usually occurs during the first two years after pouch reconstruction. Most have symptoms, including steadily increasing stool frequency that may be accompanied by incontinence, bleeding, fever and/or a feeling of urgency. Most cases can be treated with a short course of antibiotics.

Patients who undergo total abdominal colectomy and ileal pouch reconstruction for familial polyposis rarely, if ever, develop pouchitis. Of those who have ulcerative colitis, approximately 20 to 30 percent experience at least one episode. Among patients experiencing pouchitis symptoms, 5 to 7 percent may have chronic symptoms that require repeated antibiotic treatment. Even in severe cases, pouchitis rarely requires pouch removal.

If you have any or all of these symptoms, notify your surgeon, primary physician or gastroenterologist immediately.

Physical Activity After Surgery

Certain activities such as driving or lifting may be restricted initially after surgery. With time, we encourage normal physical activity, including participation in sports.

Functional Results

Stool frequency and continence are the two main factors that determine optimal pouch function. Patients who have four to five bowel movements a day with nearly perfect continence are considered to have the best functional results.

Stool Frequency

A variety of factors, including age, eating habits, type of reservoir reconstruction and quality of the anal sphincter muscles, can affect stool frequency. At the time of the ileostomy takedown, the ileal reservoir has a fairly small capacity. Therefore, it's not uncommon to have 10 or more bowel movements a day. As the ileal reservoir adapts and stretches to its normal capacity, stool frequency will decrease.

Most patients experience a decline in stool frequency during the first six to 12 months after surgery. Younger patients usually have fewer bowel movements than older patients. Other factors that can affect frequency are the amount of fiber in your diet .

Continence

During the early years of pouch reconstruction, continence was a major problem. However, current techniques give approximately 95 percent of patients near-perfect control during the day and 90 percent good to excellent control at night. Adjusting your eating habits and using certain medications can improve continence.

What is Ileal Pouch Reconstruction?

Ileal pouch reconstruction has allowed patients with conditions such as ulcerative colitis, familial polyposis and certain types of colon cancer to avoid living with a permanent ileostomy and external appliance after colectomy.

The procedure involves removing the colon, rectum and anal canal lining and using the end of the small bowel (ileum) to create a new rectum. Developed in the late 1970s by British and Japanese surgeons, ileal pouch reconstruction has become the new "gold standard" for patients undergoing colon removal. Since the first procedures, surgeons have improved both the pouch and the technique, eliminating many complications.

Doctors began doing ileal pouch reconstructions in 1984. Since then, more than 500 individuals from age 11 to 68 and from as far away as Alaska and the Middle East have been helped. Ileal pouch patients have gone on to lead normal lives. Along with graduating from college, working, getting married and enjoying social activities their disease had kept them from in the past, some have participated in a variety of athletic activities, including football, basketball, skiing, and other strenuous sports.

Indications for Ileal Pouch Reconstruction

Most ileal pouch recipients have a history of familial polyposis or ulcerative colitis that has failed to respond to more conservative treatments. Additionally, some have hereditary cancers that require colon removal.

Ulcerative colitis

Ulcerative colitis is an inflammatory bowel disease that causes ulceration of the colon (large intestine). Because ulcerative colitis involves only the colon, we can use the lower part of the ileum to create an internal pouch.

Unless you have specific health problems prohibiting surgery, you may be a candidate for total abdominal colectomy and ileal pouch reconstruction if you have:

- Severe or fulminant disease that does not respond to medication;
- chronically active disease that requires long-term treatment with immunosuppressant drugs or steroids;
- recurrent or persistent flare-ups or disease that compromises your quality of life;
- secondary complications such as skin disorders (i.e., pyoderma gangrenosum);
- or evidence of cancer or dysplasia (abnormal cells)

Familial polyposis

This genetically transmitted disorder manifests itself as a large number of polyps in the colon. The disease often begins in adolescence. If untreated, the chance of developing colon cancer is 100 percent,

with the majority of cancers occurring by age 40. If you have few or no polyps in the rectal region, one option is to remove the colon and leave the rectum. Patients who have this condition may be candidates for ileo-rectal anastomosis (joining of the ileum and rectum). If you have a significant number of rectal polyps, total colectomy with ileal pouch reconstruction is preferred.

Hereditary non-polyposis colon cancer

Recent research has identified patients and families who are genetically susceptible to this type of colon cancer. If hereditary non-polyposis colon cancer runs in your family, total abdominal colectomy with ileal pouch reconstruction is an option for decreasing your risk of colon cancer.

Factors for Unsuitable Candidates

Patients who are not good candidates for total abdominal colectomy and ileal pouch reconstruction include those who:

- have Crohn's disease;
- are incontinent and have poor sphincter muscle tone;
- have had previous sphincter injury; or
- have undergone partial removal of the small bowel.

In addition, some patients who are obese or who have heart and/or lung disease may not be candidates.

Ileal Pouch Reconstruction Procedure

Ileal pouch reconstruction is one of the most extensive and complex gastrointestinal procedures used today. The first part involves removal of the colon and rectum. Next, we mobilize the small bowel's blood supply and mesentery (membranous tissue attaching the ileum to the body wall) to determine whether the ileum will reach the anal canal. Most patients' small bowel will extend the necessary length, and we employ a variety of techniques to make the ileum reach the anal canal. In the unusual event that the small bowel does not reach, we may have to create a permanent ileostomy.

Prior to pouch construction, we remove the anal canal lining, taking care to prevent injury to the anal sphincter. The pouch is then created using the design most appropriate for you.

After construction of the pouch, the reservoir outlet is sutured to the anal canal, and a temporary ileostomy is placed to protect the extensive anastomoses and allow the newly created pouch to heal. It is usually positioned slightly below and to the right or left of the navel. The enterostomal therapy nurse will work with you before the procedure to determine the best place for the ileostomy.

Ileostomy takedown

After approximately two months, you will return for ileostomy takedown. We remove the ileostomy, allowing the pouch to begin functioning on its own. Following the ileostomy takedown, normal ileal pouch function and bowel movements will begin. You will also have a small scar where the ileostomy used to be.

INCIDENTALLY

By Marjorie Kaufman, Los Ileos News

No one can tell me at a glance that I have an ostomy. Only those close to me know it for sure. Perhaps that is why it is difficult for me to recognize a curious fact: some people do not realize it's a BLESSING, not a DOOM! One wonders whether this knowledge might have some value to the human race — at least that part of the human race that tends to look upon an ostomy as a disaster. Acceptance is part of being happy. People need happiness as much as they need food; without it they're devoured by restlessness and discontent. How many people who think they resent an ostomy would, if they were truthful, recognize it as the thing they most needed to enjoy life again? How many could, with a simple change in mental outlook, admit it's a BLESSING? Many people never learn, they never achieve the peace of mind and contentment this knowledge brings. They spend their lives in a prison where an ostomy is the eternal punishment. An ostomy is not DOOM— that's a mental attitude. Nothing is a joy or a burden; only thinking makes it so. How can we avoid that feeling of compulsion that makes an ostomy a burden? We don't disclaim it. There's no use kidding ourselves about that. Nevertheless, there are things we can do to take the edge off the feeling of compulsion and make things more pleasant. We need to expend our mental and physical energies. If these energies are not expended in constructive fashion, they turn inward and poison our minds and bodies with resentment and dissatisfaction. We need that warm sense of accomplishment, to be needed, wanted, and useful. We need it to give balance to our lives. Contentment depends not so much on the BLESSINGS as on the attitude of the person who has it.

ILEOSTOMY AND SALT

Via: UOA Resource Library & Ostomy Support Assoc. of Ft. Worth, TX. New Directions

The salt output from an ileostomy is very high, around one teaspoon per day, as opposed to almost none in the feces of a person with an intact colon. Therefore, the proper intake of salt by the person who has an ileostomy is very important. The body, however, seems to compensate for the salt and water loss by discharging less salt than normal through the urinary tract and through perspiration. The intake of too much salt is avoided, in that it increases ileal output. Urine output is generally less with an ileostomy. Therefore, it would be advisable for the person with an ileostomy to increase their water intake above normal so as to increase urine output. In this way, the possibility of kidney stone development can be kept to a minimum.

The Ostomy Support Group will meet with the Cancer Support Group at BCCS on November 17th and December 15th.

BERRIEN COUNTY CANCER SERVICE
7301 Red Arrow Highway – Stevensville MI 49127
Stevensville: (269) 429-3281 Niles: (269) 683-7460

OUR MISSION: To provide free skilled home nursing services, equipment, information and supplies at cost for cancer patients and their families in Berrien County.
FOR YOUR INFORMATION: at BCCS, we accept donations of ostomy supplies. We would be happy to give these supplies to anyone who can use them. Please have your supply numbers ready and call our Stevensville office to see if we have what you use!

WOULD YOU LIKE TO HELP . . .

Contributions to our non-profit 501(c) (3) corporation are tax deductible.

Donations to our General Fund help to balance our current budget.

Memorial contributions are made in memory of a friend or loved one who has passed away. For memorial contributions, we need to know the name of the person being memorialized as well as the name and address of their next-of-kin so that we may send them a tribute card.

Honorary contributions are made in honor of someone yet living. For honorary contributions, we need to know the name and address of the person being honored so that we may send them a letter of recognition.

Any contribution may be mailed or brought to our Stevensville or Niles offices.

ENDOWMENT FUND

The Berrien County Cancer Service has its own Endowment Fund to ensure that we will be available for as long as needed. Donations to this fund may be mailed or brought to our Stevensville or Niles offices.

We have partnered with the Berrien Community Foundation and the Michigan Gateway Community Foundation to enable donors to take full tax credit advantage from the Michigan Community Foundation Tax Credit.

To make this type of donation, please send payment directly to:

Berrien Community Foundation
2900 South State Street, Suite 2 East
St. Joseph, MI 49085

Michigan Gateway Community Foundation
111 Days Avenue
Buchanan, MI 49107

A letter to be used as a receipt and for tax purposes will be sent for all donations.

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