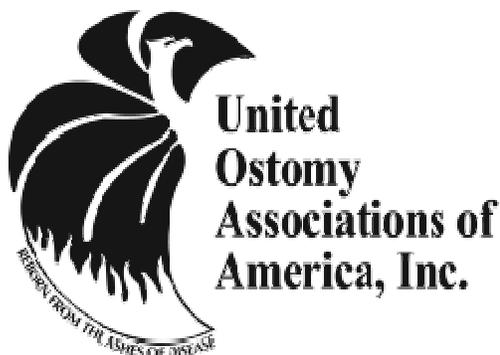


The New Outlook

Ostomy Association of Greater Chicago



August 15, 2012
Meeting—Wednesday, August 15 at 7:30 PM

Lutheran General Hospital

Special Functions Room, 10th floor
1775 Dempster St., Park Ridge, IL

No Board Meeting

Last Months' Meeting (our 423th)

Not one person gave the excuse that it was too cold outside to come to our meeting. It was another beautiful hot summer's day in Chicago. We had many members bring tasty treats for our Hospitality Table to celebrate a special day in their personal lives, like a birthday or stomaversary.

Our featured speaker for the evening was one of the highest regarded ostomy nurses in the world, Jan Colwell, CWOCN from the University of Chicago. If you have ever seen a young ostomy nurse, I bet that when he/she was educated as an ostomy nurse that he/she learned from the textbook written by Jan. In addition, Jan was recently the president of the WOCN Society and is currently president of FOW.

Jan gave a very interesting presentation on our most important ostomy issue . . . keeping a secure reliable seal on our skin barrier. Our goal is to live life to its fullest. We require an odor-free pouching system lasting a predictable time, is easy-to-use, gentle on our skin and so comfortable that we do not even know we have it stuck onto our tummy.

Jan showed dramatic examples of peristomal skin conditions that require only routine management skills to resolve. For example, one person had raw skin all around his stoma with a skin barrier that was clearly worn out to its edge. Jan teaches that one goal is not to wear a skin barrier as long as possible, but to wear one before damage to our precious peristomal skin ensues. We have many people with new ostomies visit us that wait until their pouching

system leaks before changing it. This is a poor practice. We promote good pouching system habits.

For our October meeting, Peggy Bassrawi, RN, will be hosting the UOAA certification training for people with ostomies to become Ostomy Visitors. If you would like to become a Certified Ostomy Visitor, be sure to attend. The meeting may go a bit longer than usual to accommodate all the material.

Hollister Intl. is inviting all people with ostomies and their personal guests to attend a private celebration. They have a special day planned at their worldwide headquarters in Libertyville, IL. As a side note, we have attended Hollister, Intl. events before, and they are simply wonderful. This is your personal invitation. Plan to join us and share a great day with us.



October 6, 2012

Make sure you do not miss an important announcement by updating your e-mail address with us at **uoachicago@comcast.net**. Also, to ensure delivery, make sure we are in your address book or safe sender list. Our e-mail list is private and never shared or sold.

Ostomy—the new normal

Ostomy Association of Greater Chicago (OAGC)

Established 1975

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Wound Ostomy Continence Nurses (WOCN)

Bernie auf dem Graben <i>Resurrection Hospital</i>	773-774-8000
Alyce Barnicle <i>LaGrange Hospital</i>	708-245-2920
Nancy Chaiken <i>Swedish Covenant Hospital</i>	773-878-8200
Terry Coha <i>Children's Memorial Hospital</i>	773-880-8198
Jan Colwell & Maria De Ocampo <i>University of Chicago</i>	773-702-9371 & 2851
Lorraine Compton <i>Our Lady of Resurrection Hospital</i>	773-282-7000
Jennifer Dore <i>Evanston Hospital</i>	847-570-2417
Beth Garrison Robert Maurer	312-942-5031
Joyce Reft Laura Crawford <i>Rush Presbyterian--St. Luke's Hospital</i>	
Madelene Grimm <i>Skokie Hospital--North Shore University Health System</i>	847-933-6091
Connie Kelly <i>Northwestern Memorial Hospital</i>	312-926-6421
Kathy Krenz & Gail Meyers <i>Centegra-Northern Illinois Medical</i>	815-338-2500
Marina Makovetskaia & Kathy O'Grady <i>Lutheran General Hospital</i>	847-723-8815
Bari Stiehr & Diane Davis-Zeek <i>Northwest Community Hospital</i>	847-618-3125
Nancy Olsen & Mary Rohan <i>Little Company of Mary Hospital</i>	708-229-6060
Barbara Saddler <i>University of Illinois</i>	312-996-0569
Catherine Smith <i>Advocate Christ Medical Center</i>	708-684-3294
Sandy Solbery-Fahmy <i>Saint Francis Hospital</i>	847-316-6106
Nancy Spillo <i>Resurrection Home Health Services</i>	847-493-4922

National UOAA Virtual Networks

- *Pull Thru Network* (Parents of children with bowel and urinary dysfunctions): Bonnie McElroy 205-978-2930
- *UOAA Teen Network*: Jude Ebbinghaus 860-445-8224
- *GLO* (Gay & Lesbian Ostomates): Fred Shulak 773-286-4005
- *Young Ostomate & Diversion Allia. of Amer.*: Eric En 714-904-4870
- *Thirty Plus*: Kathy DiPonio 586-219-1876
- *Continent Diversion Network*: Lynne Kramer 215-637-2409

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OAGC Meeting Dates

August 15—Ostomy Slam

September 19--Certified Tai Chi instructor, Qi Gong, will give a class on breathing techniques believed to improve digestive functions.

October 6—World Ostomy Day. Hollister, Intl. has invited people with ostomies and their personal guests to a private celebration. More to follow.

October 17—Peggy Bassrawi, RN will host the specially designed UOAA training seminar allowing our members to become Certified Ostomy Visitors.

December 12—Our Gala Holiday Party

Southwest Suburban Chicago

The Southwest Suburban Chicago Ostomy Support Group is an entirely volunteer ostomy association dedicated to the mutual aid, education and moral support of people with ostomies and their families. Meetings are held at 7:30 PM on the third Monday of each month throughout the year, except July, August, December and January.

For information regarding this special ostomy group serving Chicago's greater southwest side, please call Edna Wooding, WOC nurse and association president, at 708-423-5641. All meetings are held at Little Company of Mary Hospital, Evergreen Park, Mary Potter Pavilion, L Level, 2850 W. 95th St.

Northwest Community Hospital

The Northwest Community Hospital Ostomy Support Group meets at 800 W. Central Road, Arlington Heights. They wish to extend an invitation to all of our readers to visit them. The WOC nurses at the hospital lead the group. For more information, please contact Diane Zeek, RN, at 847-618-3215, dzeek@nch.org.

They meet from 1:00 PM until 2:00 PM in the Busse Center, B1 level, Rooms LC7-8 of the Learning Center. This building may be accessed from the garage at the west end of the Busse Center. It is easiest to enter from Central Road.

Meeting Dates for 2012

October 11

December 13

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Sherman Hospital Ostomy Group

There is a new ostomy support group in Elgin having meetings at Sherman Hospital. They now meet on the second **Wednesday** of every month and they alternate times as follows.

August—7:00 PM, Room A
September—2:00 PM, Room C
October—7:00 PM, Room A
November—2:00 PM, Room C
December—7:00 PM, Room A

The contact person for any information is
Heather LaCoco, BSN, Case Manager
Surgical Care Sherman Health
224-783-2458
Heather.Lacoco@ShermanHospital.org

A smooth sea never made a skillful mariner.

Urostomy Fluid and Infection

By Juliana Eldridge, WOC Nurse

People with the urinary diversions of a urostomy no longer have a storage area, a bladder, for urine. Therefore, urine should flow from the stoma as fast as the kidneys can make it. In fact, if ones' urinary stoma has no drainage after even an hour, it is of serious concern. The distance from the stoma to the kidney is markedly reduced after urinary diversion surgery. Any external bacteria have a short route to the kidney. Since kidney infection can occur rapidly and be devastating, prevention is essential.

Wearing clean pouches and frequent emptying are vital. Equally important is adequate fluid intake, particularly fluids that acidify the urine and decrease problems of odor. In warm weather, with increased activity, or with a fever, fluids should be increased to make up for body losses due to perspiration and increased metabolism.

It is important that you be aware of the symptoms of a kidney infection.

- Elevated temperature
- Chills
- Low back pain
- Cloudy, bloody urine
- Decreased urine output

All ileal conduits normally produce mucus in the urine, which give it a cloudy appearance. Blood in the urine is a danger signal. Thirst is a good index of fluid needs.

Note well: If urine is collected for urinalysis, either routine microscopic (R&M) or for culture and sensitivity (C&S); or if one is asked to give a sterile urine specimen, be sure your doctor and nurse know a sterile specimen must be taken directly from the stoma and not from the pouch. Bacteria build up in the pouch constantly. One will always get a false positive test result if the sample is taken from the pouch instead of the stoma.

If they are not sure how to do this, do the following:

- Remove the pouch
- Clean the stoma
- Bend over
- Catch the urine in a sterile cup

Did you know that we have our own Internet site? Next time you are on your computer, check out our awarding winning site

www.uoachicago.org

A Note about Adhesions

A compilation of published information

An adhesion is a scar tissue that binds together two anatomic surfaces that are normally separated from each other. They are most commonly found in the abdomen, where they form after abdominal surgery, inflammation or injury. Lysis—destruction or dissolution—of adhesions is a surgery performed to free adhesions from tissues.

Although sometimes present from birth, adhesions are usually scar tissue formed after inflammation. The most common site of adhesions is the abdomen, where they often form after peritonitis—inflammation of the abdominal lining—or following surgery, as part of the bodies healing process.

Abdominal adhesions infrequently bind together loops of intestine resulting in intestinal obstruction. The condition is characterized by abdominal pain, nausea and vomiting, distention and an increase in pulse rate without a rise in temperature. Nasogastric intubation and suction may relieve the blockage. If there is no relief, an operation is usually required to cut the fibrous tissue and free the intestinal loops.

Although scar tissue within the abdomen can occur after any abdominal operation, they are more common after a ruptured appendix. Most adhesions cause no problems, but they can obstruct the intestine in about two percent of all patients. These obstructions can occur several years later. The adhesions can also block the ends of the fallopian tubes, possibly causing infertility. Adhesions can occur elsewhere and can be the cause of other disorders; e.g., they can lead to glaucoma when located in the eyes, and when located around the heart can result in pericarditis. Here are some questions to ask your doctor.

- How do I know the issue is an adhesion?
- Could it be a growth, cancer or some other condition?
- Do you recommend surgery to remove the adhesions?
- What is the procedure going to be like?
- Will the adhesions redevelop?

It is difficult to say who does us the most mischief—our enemies with the worst intentions or our friends with the best.

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A MEMBER OF TRINITY HEALTH

Ileostomy, a Guide

By Linda Gross, CWOCN

(Continued from July edition)

Eating and digestion

There is no such thing as an ileostomy diet. An ileostomy is not a sickness. There is usually no health reason for not eating the foods you ate in the past. If you have a special diet because of heart disease, diabetes or other health problems, you should ask your doctor about a diet that will work with both that challenge and your ileostomy.

You may wonder if you will be on a limited diet after surgery. Here are a few simple guidelines about your diet.

Doctors have their patients follow a low-residue diet the first weeks after any abdominal surgery. This includes only foods that are easily digested and excludes raw fruits and vegetables. Be sure to find out when you may start a regular diet. Eat all foods that you like except those restricted by your physician.

Try one food a day that you have not eaten since surgery. Eat small portions at first and then gradually increase the amount. Chew very well. Let us dramatize this once again, chew your food very well. If a small serving gives you cramps, diarrhea or odor, eliminate that food from your diet temporarily and try it again in a few weeks. If it still bothers you, try it again in a few months. Remember again, you must chew all your food into small pieces.

With hard foods, such as nuts, salads, vegetables etc., the way it goes down your throat is the exact way it will come out your stoma. In addition, some foods tend to clump. These may be eaten in smaller quantities with plenty of liquids with no serious issues. Eat a can of nuts, and you are asking for trouble.

Eat a well-balanced diet. You need proteins, fats, carbohydrates, vitamins and minerals, just as you did before your illness. Your diet should include dairy products, vegetables and fruits, meats, fish or legumes high in protein like cereals, bread and plenty of water every day. Always check with your doctor for any restrictions particular to your physiology.

Watch for foods that cause watery discharges with cramps or partial obstruction of the small bowel. Some foods may tend to clump together to form a mass difficult to digest or expel. If this occurs, the ileostomy may squeeze out the water and retain the pulp. Nuts, kernel corn, popcorn, coconut, Chinese vegetables, coleslaw and raw celery are among the trouble makers if eaten in large quantities. Many people with an ileostomy find that these foods may be tolerated in small amounts if chewed well and eaten in combination with other foods. Experimenting is the only way to find out for sure. However, common sense should tell you that there never would be a time when you can swallow olive pits. If you swallow a marble, be prepared to see a surgeon to have it removed surgically on an emergency basis.

Eat regularly. Skipping meals to avoid gas or discharge is unwise because your small intestine will be more active and more gas and watery discharge might result. Some people find it best to eat a smaller amount of food four or five times a day.

Drink plenty of liquids. A minimum of one to two quarts a day is recommended. Liquids are defined for our purpose as non-alcoholic and non-caffeine drinks like clear fruit juices, teas, broths and most importantly, water. Dehydration and loss of electrolytes are possible if not enough fluids are consumed in a day.

Foods which are difficult to digest such as whole corn, peas, Chinese foods, skins, seeds, raw fruits and vegetables, popcorn, nuts, high fiber foods etc., will appear in the pouch undigested. Even if you chew these well, they will come out the same size they went in. Medication in the form of coated tablets or time-release capsules may also come out

whole in the pouch. They will be of no benefit at all. Beets and tomato juice will make ileostomy output turn a reddish color rather like blood, but there is no harm done. Food dyes may change the usual color of the ileal discharge to the color of the dye. This is normal. If you drink Green River soda, your output will be green. When you cake where the frosting has food dye to color it, your output will be the same color as the dye. Red Velvet cake will make it seem like you are bleeding. Of course, this is just color and will do no harm in itself.

Depending on your own personal chemistry, milk, beer, iced beverages, alcoholic drinks may cause a watery discharge. This is usually temporary and does not warrant avoiding these drinks if used in moderation. People with ileostomies are more sensitive to problems if large quantities of food and drink are consumed at one time. Use common sense. Do not overeat. Do not drink to excess. Use moderation and your body will reward you with good health.

How long is it before intestinal contents flow through the stoma after eating?

This varies with each individual. It may take anywhere from 20 minutes to several hours after eating. Some people with ileostomies find their movements occur regularly after eating; others find their movements are irregular. What you eat or drink, your mood and your health may affect how long it takes, as does the length of the remaining ileum and many other personal characteristics of your digestive system.

Feeling discouraged

After surgery, there may be times when you feel discouraged and blue, alone and isolated and unable to enjoy life again. This is normal. Do not be upset. There are many reasons for these reactions; e.g., serious illness, medications, lengthy hospitalization and the surgery itself. Those withdrawing from long-term prednisone use may go through a difficult adjustment period, because of the body's physical dependency on this drug. All these may cause feelings of fear, insecurity, dependence and discouragement.

Having to accept the ileostomy and learning to manage it causes other reactions. Because the whole experience is so new to you, you may feel awkward, frustrated and uncertain. You may lack confidence in yourself. Your self-esteem has been jolted; you are sensitive about what people say and do; you

wonder if you will ever be your same old self again. You may think that no one understands how you feel. This might be a good time to ask for an ostomy visitor from your local ostomy association. In fact, the best thing might be going to a local UOAA affiliated support group meeting. You can meet other people who have gone through ostomy surgery.

Feeling discouraged is real, natural and exhausting. If you did not have these feelings, you would be superhuman. The only way to get rid of these feelings is to face them and release them. You might cry, be hostile, angry or react in ways that are unusual for you. Talking to a trusted friend, a relative, a nurse, a clergyman and especially another person with an ileostomy will help you discover new hope and encouragement to return to life and living.

Helping Patients Adjust

By Dr. Kosta Karvounis, to the physician community

The patient with an ostomy is apt mistakenly to imagine a future life of ostracism. Even though he/she may have been ill and limited in activity for a long period, it will be difficult for him/her to acknowledge the inability voluntarily to control his/her bowel or urine function.

As his/her family doctor, you may be able to handle the patient's questions and emotional difficulties better than the consultant may, who is a stranger to the patient. However, the best medicine is a visit by a healthy, happy, fellow human being with an ostomy. It is also important that the patient is associated with an ostomy nurse.

If the patient is a woman, the sight of a person with an ostomy in a slim sheath without a telltale bulge can provide assurance. In addition, the ostomy visitor can answer the type of questions the patient might be reluctant to ask others. The following are typical questions new people with ostomies ask, and the answers an ostomy visitor can provide.

Can I have intercourse? When the patient asks about the potential for sexual intercourse, it is a harbinger of a successful adjustment. A man might be concerned about his ability to perform, a woman possibly about her ability to attract and satisfy. All too often, the subject is skirted or, even worse, is handled negatively with, "What difference does it make at your age?" or "This operation is going to save your life— isn't that enough?"

According to the United Ostomy Associations of America, it is estimated that approximately 10-20

per cent of males with ileostomies suffer impairment of sexual function and potency. Fortunately, this challenge is only temporary in the majority of cases.

Males who have had urinary ostomies early in childhood can usually perform sexually, but they may be sterile. More than half of the males who have urinary surgery as adults for bladder malignancy are impotent. The average age for this surgery is 74.

Males with colostomies vary in their degree of sexual potency from full potency to complete impotency. In many instances, potency is retained, but in these cases, the patient is sometimes sterile. In some patients, potency is lost due to the extent of the surgery. In a few cases, regardless of the type ostomy, it may take as long as two years to regain potency. Again, any challenge with male potency is usually only temporary.

Is marriage possible for me? Many people with ostomies are married. An ostomy is not a barrier to becoming married. The first ostomy nurse, Norma Gill, was married after her ostomy surgery. Moreover, no marriage breaks up solely based on the ostomy, although it may put added pressure on an already weak relationship as will any serious illness or emotional event. In fact, a remarkable 82% of people with ostomies remain married to the same spouse a year after surgery. This compares to 76% of the non-ostomy population.

Can I have a child? A patient contemplating pregnancy should consult her physician for evaluation of her individual situation, but an ostomy in a woman does not preclude a successful pregnancy. In addition, an ostomy is not an indication for a caesarean section. Many women with ostomies have normal vaginal births. There is a need, however, for close medical care during pregnancy. The stoma may tend to enlarge or protrude. This may require a temporary change in the woman's pouching system to permit the modifications to the size and location of the stoma. A woman with an ostomy might require more careful monitoring of her diet and fluid needs. However, on the other side, ostomy women never worry about constipation or hemorrhoids like their non-ostomy friends.

Can I travel? The patient can go anywhere in any type of vehicle. An ostomy alone does not stop someone from climbing mountains; riding horseback; flying in airplanes; driving in autos;

riding bicycles; taking cruises; etc. All ostomy patients should buy a copy of the book, *Yes We Can!* by Barbara Kupfer. It is an excellent resource on traveling; offers all types of valuable advice on traveling with an ostomy and tips for everyday living.

Will I be able to sleep soundly at night?

Any comfortable position may be assumed with a correctly applied pouching system. Having an ostomy will improve the sleep of a patient who has previously been sick. Most people do not sleep directly on top of the ostomy. Although, sleeping on it is not the worst thing one can do.

Can I participate in sports? People with ostomies report enjoying many types of sports: water skiing, body surfing, skin diving, tennis, golf, baseball, football, hockey, weight lifting, running, bicycling, hiking, boxing . . . you name it. Rough contact sports require special protection for the stoma. However, there are professional athletes in all types of sports with stomas. An ostomy alone is not a reason not to participate in sports. You can assure your patient that he/she will be back on the golf course, hitting them as well as always. The desire of most people with ostomies is to return to his/her usual routine of living. There is every reason to believe that he/she will do just that.

How Long Will You Live

By L. Wruble, M.D

Well, prepare, for good news! There have been a few long-term studies of the postoperative life of people with an ostomy. The findings that have been made known were mainly done since the 1990s into the 2000s and reported in 2011. What do you think is the ultimate outcome? What may a person with an ostomy expect in terms of health and life expectancy?

The studies that have been done indicate that the health of a person with an ostomy is the same as that of anyone else. Of more importance, there is no difference in their life expectancy from the general population. Every part of the intestinal tract works in harmony, so it might be expected that the removal of one part, such as the colon, might affect the rest. However, the studies reveal no indication of this. Diseases of the intestinal tract such as gallstones and peptic ulcers are not found to be in higher incidence after ostomy surgery. There is, however, an increase in the formation of kidney stones in the person with

an ileostomy, possibly because of the increase in the absorption of certain chemicals that stimulate the formation of stones.

There is an enormous amount of data, which indicates that women with ostomies have no more problems with their pregnancies than women without ostomies are. The gastroenterologist's major thrust in therapy has always been through the patient's diet. In recent years, however, it has been found that diet really has small value in most gastrointestinal conditions. According to dietary studies, there is no one food that affects a person with an ostomy out of proportion to other foods. To sum up, I would say that the diet of the person with an ostomy should be a normal diet and that the outlook for his or her health is on a par with that of the population as a whole.

Temporary Ostomies

Nancy Brede, WOC nurse

Temporary ostomies are surgically created with the intent of reconnecting in the future. The anatomy of the gastrointestinal system or urinary system is left intact.

Permanent ostomies are created with the intent that the ostomy surgery will not be reversed: usually the anatomy in the gastrointestinal or urinary system has been removed. Permanent ostomy surgery is usually performed when disease or injury prevents maintaining the anatomical structures needed for reversal.

A large number of temporary ostomies involving the colon are done on an emergency basis. The colon becomes obstructed or blocked and stool cannot pass through. Because of the emergency nature of the surgery, the bowel cannot be cleaned and prepped ahead of time. Reversals—re-anastomosis or hooking the normal anatomy back up—then can be done later, when infection is not as likely and proper healing can take place.

The most common situations and diseases requiring a temporary ostomy are

- Cancer of the colon with obstruction—or other abdominal cancer affecting the colon
- Hirschsprung's disease, a disorder or malfunction in infants that prevents passage of stool. Due to lack of nerve cells in certain areas of the large intestine, stool is not moved through and an ostomy is necessary.

- Diverticulitis, small out-pouching in the wall of the intestine, called diverticula, becomes infected. The diverticula may rupture or cause obstruction.
- Crohn's disease may necessitate a temporary ostomy to allow the diseased bowel to heal.

People with temporary ostomies face many of the same problems people with permanent ostomies have. It is just as important for them to obtain support, reassurance and teaching as it is for persons with permanent ostomies. They must learn proper skin care, stoma care and pouching techniques. Often, stomas are not ideally situated on the abdomen, because of the urgency of the surgery. Thus, pouching and skin care can pose difficult problems.

Following temporary surgery, measures need to be taken to improve the patient's health. He/she must be in the best condition physically to undergo the major surgery for reconnection. There is also a time for the patient to deal psychologically with past surgery, upcoming surgery and possibly a newly diagnosed disease. It may be a difficult time with all the changes and new challenges. Often, there are many fears and unanswered questions. Other people with ostomies and WOC nurses may provide reassurance and the answers to many questions.

Discussion Groups

Ostomy Association of Greater Chicago

Recently, we had a discussion group at one of our regular monthly meetings. The discussion groups were made up of colostomy, ileostomy, urostomy, spouses and alternate procedures were formed from the approximately fifty participants. Special guests from Hollister, Inc. helped provide these minutes.

Each panel had a moderator that led a roundtable discussion of topics. As you can imagine, there were different answers for each question. Here are some highlights, of course, respecting the privacy of all individuals involved:

Q When is the best time to consult a WOC nurse?

A Generally, when you are having a problem or concern and want the advice of a trained, ostomy medical professional.

Q What tip would you pass on to someone who just had ostomy surgery?

A As difficult, as it may be for us to believe, people really struggle to find authoritative sources of

information. One person with an ileostomy asked shyly if others experienced discharge of effluent while they were sleeping. When assured by the rest of the table that this was normal she was visibly relieved that she was "normal." The kicker is that she has had her ostomy for seven years and this discussion group was her first time to do a reality check!

Q What do you like about the products that you use or what would you suggest?

A Generally, we mostly use the products that we were introduced to at the hospital.

Q How do you know when to empty your pouch?

A This may seem a silly question to someone without an ostomy—as in when it is full! Duh! However, given there is no sensory feedback with an ostomy other indicators are required. Many times a "gentle hand pat" near the pouch was the tactile feedback used. However, also others were anticipatory and emptied by schedule rather than need.

Q Do you feel a need to tell people that you have an ostomy? Why? Or, why not?

A Generally the answer was no, but in special situations; such as, when one person who regularly uses a Turkish bath where the clothing option leaves little doubt.

Q What emergency ostomy supplies do you carry and where do you carry them?

A This was a most interesting question because the answer has been affected by post 9/11. That is, we generally carry an emergency kit small enough to fit into a purse, pocket or satchel. This may have, at one time, included a pair of scissors. Now, this will cause trouble at every security screening . . . particularly airports. One potential remedy, which will not work at airports, is carrying a UOAA issued card that identifies us as having an ostomy. One person showed us their Hollister, Intl. issued "Stoma Card" of a ten-year vintage for that same purpose, in order to identify the card carrier as having an ostomy and doing so in a dozen different languages.

Q What was your most embarrassing ostomy moment?

A You guessed it . . . there were many interesting stories! Picking one, an obviously dignified woman was surprised at her granddaughter's parent-teachers

conference because her granddaughter had used her ostomy pouch for show-and-tell . . . complete with graphical demonstration.

Ileostomy and the Closed-End?

By The New Outlook

We have found more and more people with ileostomies using closed-end pouches with a two-piece pouching system. We would like to explore some of the reasons they are used because they may provide a viable alternative for you.

There is no doubt that drainable pouches require some effort. Some have clips and some are clip-less, which each have positive and negative features. However, they also may be easily drained in all types of environments. Moreover, a person with an ileostomy has the option of using a one-piece system with a drainable pouch, which offers a low profile, a low cost and easy maintenance.

A two-piece system using a closed-end pouch is a convenient option. If used as a full-time system, one could simply dispose of the old pouch and attach a new one whenever it gets full. Of course, one would be spending \$15 to \$20 a day just on pouches, which may not be prudent. There are also pouch liners that only cost about \$.30 each of which none of them simply flush down the toilet. One still must place the used liner into another plastic bag and then throw it out.

Nevertheless, we found that most users just empty the closed-end pouch by removing it from the flange and dumping it out, wiping off the ring and then snapping it back onto the flange. This does weaken the flange—snapping it on and off about six to twelve times a day for up to seven days. ConvaTec Natura flanges may be snapped on and off about 80 times and still keep their integrity. It may be prudent to replace the pouch every two days. This method is relatively simple to implement except that it requires more mechanical and athletic ability to implement than drainable systems.

It is important to note that if you decide to try a closed-end pouch, make sure that it does not have a filter, otherwise it will probably leak. When filters become wet, they either leak or become plugged up. Neither of these options services the community of people with ileostomies very effectively. People with ileostomies generally have output that is too liquid for filtered pouches. Pouches with filters can never be rinsed out. They are made to be used only

one time—like the way a person with a colostomy would use them.

A standard closed-end pouch is smaller than a drainable pouch but holds the same volume of effluent . . . more or less. They are easily concealed beneath one's clothing or bathing suit and they are more comfortable. They also come in mini sizes for special occasions—like intimate moments or short exercise routines.

The biggest reason for using a closed-end pouch is that it has no clip. Clips will, at one time or another, stab the user in the leg or poke him/her in private places best left un-poked. The clip on a drainable pouch tends to rub against one's leg. This does not happen when using a closed-end pouch. Although the quality and performance of the new clip-less pouches resemble that of a closed pouch with the added benefit that they may be drained through the bottom.

There is also another minor point. A closed-end pouch cannot have the clip fall off. If you are worried about this happening, a closed-end pouch is a solution. However, modern clips rarely, if ever, fall off if used correctly. Nevertheless, it only has to happen once to make one apprehensive. People who wear the new clip-less pouches have the added benefit on never having a clip fall off either.

Remember: Because today's pouches—both drainable and closed-ended—lie so flat and fit so well, chances are good that you are the only person who knows that you have an ostomy. However, we do want you to know about lifestyle alternatives available to people with ostomies.

Traveling Internationally

By Scott Bowling

At a recent meeting of the Metro Maryland Ostomy Association, one of their members shared with them an experience he had while traveling with his parents.

He was in the Tokyo International Airport, and noticed something unique on the wall sign as he was approaching the restroom areas. Like most others, it had all the international symbols: male/female, a wheelchair signifying accessibility, etc. However, one symbol and a note at the bottom of the sign were new to him, and to all of us. It said, "Equipped with facilities for people with ostomies," and displayed what he pointed out to me to be the international sign

for an ostomy, see the upper right corner of the picture by the wheelchair.

My first thought was, quite honestly, why would any person with an ostomy need special facilities? I have never had any issues utilizing a public restroom. However, I soon realized the potential need and significance of such a facility.

None of us really requires a special area or toilet to empty our pouch. If we have an unexpected leak and need to change our pouching system in a public restroom, it would be nice to have the facilities available in a private setting. We would be able to clean the ostomy area as we would at home.

Being intrigued by this, I did a little research and found that Tokyo is not unique in its signage and offering of such facilities. Facilities for people with ostomies are available in at least one public restroom at most major international airports in China, Thailand, Spain, Italy, France, Greece and Great Brittan. (Note the following pictures of the ostomy facilities.)

Thanks to the advocacy and awareness work being done by our local ostomy support group as well as the many other groups across the nation, UOAA and IOA. Today, people and companies are becoming increasingly aware of what an ostomy is all about and the special concerns people with ostomies have when traveling. People everywhere are generally more than willing to be of assistance to people with ostomies. All we need to do is be confident enough in ourselves to ask for assistance when and where needed. I hope you are having a great summer and safe travels.



Save the Date: October 6, 2012 World Ostomy Day & Ostomy Awareness Day

Friends and Fellow UOAA Members,

As you may already, October 6, 2012 is both World Ostomy Day and Ostomy Awareness Day. This worldwide event is designed to raise ostomy awareness to the public and the global community. In conjunction with this day, many national associations are conducting events to celebrate. This will be a great way to promote advocacy and to enhance the public awareness of the important work of ostomy associations. This is an excellent means to encourage others with ostomies while educating friends and families that such groups exist to support them.

In the Chicagoland area, we are pleased to announce that an event is being planned with the support of one of our important partners, Hollister Incorporated. Please save this date on your calendar and share with your local groups. More details will be coming out next month.

Thank you for your interest and for sharing this information. This will be a great day and we are very thankful for Hollister's support.

Regards,

David B. Rudzin
President UOAA

P.S. The UOAA works to provide educational, informational and supportive materials to the, over, 325 Affiliated Support Groups Nationwide. We convene bi-annual conferences to promote educational seminars, support for those affected and socialization with those who live with it daily.



Ostomy Association of Greater Chicago

Confidential Membership Application

We invite you to join our association. You are especially welcome if you have an ostomy, are preparing for surgery, are a healthcare professional and/or have a loved one who has had surgery. We are a completely volunteer-operated ostomy support group. Our mission is to support, educate and advocate for people with ostomies.

Name _____

Address _____

City _____ State _____ Zip _____

E-mail _____ Phone _____

Type of Ostomy Colostomy Ileostomy Urostomy Continent Procedure

Date of surgery _____ Age Group <21 22-36 37-50 51-65 66-80 80<

Attend one of our general meetings. There are always friendly people to talk with you. You may even want to participate in our association's leadership. We always need talented people to share in our good work. Membership is free (our funds come primarily through donations). Please mail this application to

Judy Svoboda, President
605 Chatham Circle, Algonquin, IL 60102
Or e-mail information to uoachicago@comcast.net.

Joseph B. Kirsner, 1909-2012

Renowned professor who loved his patients

July 11, 2012 | By Mitch Smith, Chicago Tribune reporter



Dr. Joseph Kirsner of the University of Chicago, a pioneer in gastroenterology, was awarded two lifetime achievement awards from the Crohn's & Colitis Foundation.

Dr. Joseph B. Kirsner won the same lifetime achievement award twice.

That was one indication of the impact of the University of Chicago gastroenterologist's career, in which he developed treatments for inflammatory bowel disease, researched risk factors for colon cancer and helped raise the profile of his specialty.

"He made contributions to the literature in every aspect, in every corner of gastroenterology," said Dr. James L. Franklin, a former student of Dr. Kirsner's who later wrote his biography. "At the time he became involved in this special interest, not a lot was known about these diseases. His contribution to the clinical understanding of these diseases was seminal."

This is maturity:

To be able to stick with a job until it is finished;
to be able to bear an injustice without wanting to get even;
to be able to carry money without spending it; and
to do one's duty without being supervised.

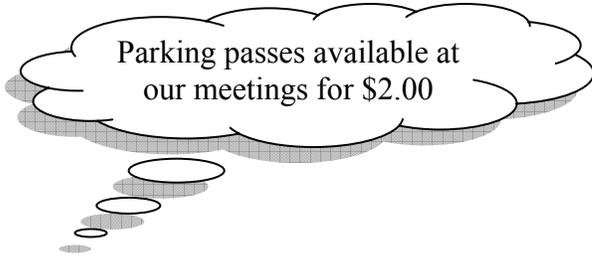
The secret of contentment is knowing how to enjoy what you have.

If we find not repose in ourselves, it is in vain to seek it elsewhere.

Pure gold can lie for a month in the furnace without losing a grain.

The New Outlook
514 Knox St.
Wilmette, IL 60091

Return Service Requested



We invite you to attend our general meetings. Relatives, friends, doctors, and nurses, as well as our members—any interested people—are invited and welcome. Our association has a team of trained volunteer listeners available to discuss the concerns of patients. Healthcare professionals and families are urged to use this free benefit. When you know of a patient who would like to talk to a person who has been there and done that, please call the visiting chairperson (see page 2).