

# Ostomy

A U S T R A L I A

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# National Directory of Ostomy Associations

Please contact your association (from the list below) for all ostomy issues relating to membership, appliance supply and/or *Ostomy AUSTRALIA* journal distribution.

## AUSTRALIAN CAPITAL TERRITORY

### ACT & DISTRICTS STOMA ASSN INC.

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Tues, Wed. 10.00am - 1.00pm  
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Secretary: Tanya Harber

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Casuarina NT 0811  
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Fax: (08) 8927 4990  
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All contributions must include your name and address for publication. If you do not wish your name published, please say so in your letter, and only your initials will be printed. Please also note that an electronic copy of this journal is available to non-Ostomates on our and other internet websites. The editor and publisher take no responsibility for any information contained in 'Letters to the Editor' and 'Your Say / In Your Own Write' and specifically disclaim all liability. Concerning any medical information contained in this publication, the reader is strongly advised to first obtain appropriate medical advice before implementation.

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If you do not wish to receive future advertising, we suggest that when you respond to any advertisement, you tell the company you do not wish to receive future advertising. Most of the companies have assured us that they will comply with your request. If you do have any problems, contact the company concerned or advise the Editor of *Ostomy AUSTRALIA*.

**Please take this advice into account when responding to company promotions and competitions.**

Consumers of stoma appliances are entitled to lodge a complaint with the Therapeutic Goods Administration if they have concerns regarding the way in which appliances are advertised. Any such complaints should be directed to TGA Complaints Resolution Panel, PO Box 764, North Sydney NSW 2059.

## PRESIDENT'S MESSAGE

The Stoma Appliance Scheme (SAS) is now in its forty-first year, and its basic operation has not changed since its inception. This, despite the fact that the number of products has expanded exponentially to comprise over 2,600 individual items which are distributed to over 40,000 Ostomates. Distribution is performed by twenty-two individual ostomy associations operating under Guidelines issued by the Department of Health. The cost of the Scheme now exceeds \$85 million annually.

Associations were originally formed, by Ostomates, to provide mutual support for fellow Ostomates as they adapted to the challenge of new ways in which essential bodily functions are managed. The introduction of the SAS addressed one element of that role by providing ostomy appliances. The other activity, providing advice on how to adapt to living with a stoma, remains a key responsibility of all associations.

The medical fraternity responded by developing nursing specialists whom we now know as Stomal Therapists. These nurses have a detailed knowledge of the products available under the SAS and how to address medical conditions which impact the effectiveness of the various products that individual Ostomates can use.

But the fundamental working of the Scheme has not changed in its forty years. Very few organisations continue to operate on the same model over four decades and survive.

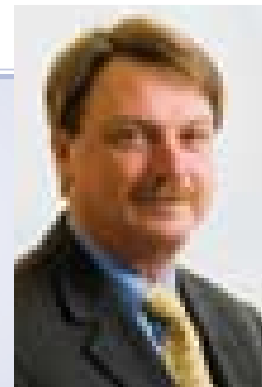
The ostomy movement still relies heavily on volunteers to deliver products essential to the wellbeing of Ostomates. Most associations are finding it increasingly difficult to engage, train and retain volunteers in the face of an aging Ostomate population.

I believe it is imperative that we collectively review our management of the Stoma Appliance Scheme and seriously consider how we can streamline operations and improve efficiency. We also need to consider how we can provide all Ostomates with equal access to the professional skills, expertise and ongoing support of Stomal Therapists.

The stoma movement still relies on twenty-two highly independent organisations that have significant freedom in the way they are managed and operate. The vast majority of commercial and larger not-for-profit organisations have evolved a strong central management structure with clearly defined operational and governance processes and procedures. Those organisations have a tiered management and operational structure that facilitates efficient and cost-effective service delivery to their customers or members.

The question we should be asking ourselves is:

**How can we build on the solid foundation that we have developed over the past fifty years to ensure that all Ostomates have access to both appliances and clinical services that will give them the most benefit from the Scheme?**



**Imagine a situation where every Ostomate had ready access to a Stomal Therapist at least twice a year. Consider a situation where the distribution of ostomy appliances and co-ordination of clinical services was managed by a single organisation which operated only for the benefit of Ostomates.**

The Stoma Appliance Management System (SAMS), funded by ACSA, is designed to be a common and integrated computer system that will allow associations to deliver appliances to their members. The system is currently being tested at Ostomy Association of Melbourne and should be ready for roll-out to other associations by the time this article is published. However, that system by itself, will not provide Ostomates with an integrated package of products and services that deliver the support needed to achieve optimal health and lifestyle outcomes.

The ACSA Executive is engaging with the Australian Association of Stomal Therapy Nurses (AASTN) and the Commonwealth Department of Health to explore how a co-ordinated and comprehensive support system for Ostomates could be established. The information collected by the ACSA subcommittee that was established by the 2015 ACSA Conference will make a significant contribution to developing options to establish the support system.

The ostomy movement is facing a period of significant change as government reviews the escalating cost of health care. We have an opportunity to review how associations are structured and use technology to improve the efficiency of the way we manage the Scheme. We also have an opportunity to direct the savings generated from improved efficiency into managing the delivery of co-ordinated and integrated clinical nursing services.

Taking the ostomy movement into the twenty-first century may require some radical changes to the way our associations operate. During a period of change, we need to remember that our associations were formed with the purpose of supporting fellow Ostomates. We are at a point in time where we have an opportunity to improve that support by potentially changing the way we operate.

**Geoff Rhodes** PRESIDENT



After almost five years as Editor of the *Ostomy AUSTRALIA* journal, I have decided to put away my quill and inkpot, and will be handing the role over to Peter Fuller (pictured), commencing with the August 2016 issue.

Peter has worked in journalism and public relations in Australia and Europe over more than four decades. He has written for corporate publications, done time as a ministerial speechwriter, and edited histories and reports for the Australian Government and the education sector.

He works as a consultant editor and publications specialist. In between he mows the lawn, battles ivy, reads, and plays chess.

Peter is married and has two sons and Canberra has been his base since 1969. An Ostomate since 2003, Peter will stand down as President of the ACT and Districts Stoma Association later this year.

We wish Peter all the best in his new role and I hope that he enjoys it as much as I have over the past few years.

Personally, I have learned a lot from the many letters and emails received from Ostomates or their family and friends. The positive attitude and strength of character of many of those who have contributed stories, suggestions and questions is truly admirable. Many have told how the strong support they received from family, friends and even some strangers, helped them through some difficult periods. Many of those stories also described (sometimes very graphically) their mental and physical struggles in coming to terms living with a stoma.

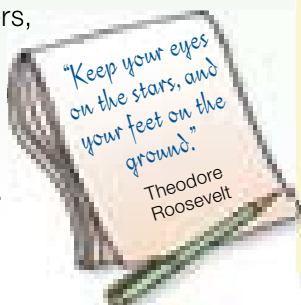
For many Ostomates, receiving a stoma was the lasting result of essential and sometimes life-saving surgery. While for many other Ostomates, their stoma finally provided them with desperately needed respite and a return to an almost normal life after having struggled for many years suffering from a debilitating disease (diseases which often require extremely strong medications with sometimes very unpleasant associated side-effects).

Fortunately, these days approximately half of all new Ostomates are candidates for reversal of their stoma due to the considerable improvement of modern surgical techniques and outcomes, as well as the advanced medicines and ancillary treatments now available.

Conversely, there is still considerable stigma surrounding someone having a stoma. Public awareness and acceptance is gradually improving but I feel still has a long way to go in Australia.

Thank you once again for all your letters, helpful hints and stories, as well as the articles from the various ostomy associations and support groups. Relaying your stories, suggestions and helpful hints via this journal over the past five years has been my privilege.

Take care and stay healthy.  
**Kim Lyell** EDITOR (Retiring)



**NEW!**

### Editor's Contact Details

#### **NEW POSTAL ADDRESS**

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## Help!

*Ostomy AUSTRALIA* needs  
your stories, experiences,  
helpful hints, etc

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Hard copy submissions may be posted to:

The Editor, *Ostomy AUSTRALIA*  
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PO Box 1260 Canberra City ACT 2601

Please ensure that your contribution does not  
specifically name any doctors or nurses,  
unless they have agreed in writing to his/her name  
being published, refer to them as 'my surgeon'  
or 'my doctor'.

Similarly, try to avoid specific use of an appliance  
company's name when it may suggest advertising in  
articles and letters.

Remember, all contributions must include your name  
and address. However, if you do not wish your name  
published, please say so in your letter, and only your  
initials and State will be printed in the journal.



**Electronic copies of this journal and  
several earlier issues are available to  
Ostomates and others via the ACSA website  
and internet search engines.**

# LETTERS TO THE EDITOR

## Dear Editor

The packing slip which accompanies our ostomy supplies also shows the amount of the benefit received. It has made me realise how lucky we are in Australia to have access to the Stoma Appliance Scheme.

My last order was for sixty pouches and sixty wipes, and the total benefit was \$344.34. Can you imagine having to pay this yourself every time you need more supplies?

Count your blessings:

1. You are still alive, and
2. You are fortunate to live in Australia.

**John Geeves, QLD**

---

## Dear Editor

I am exactly like Ray Garske [*Reflections after Fifty Years with an Ileostomy: Your Say, in your own Write: December 2015 issue*] where appliances are concerned. I only change every second or third day, which cuts down on the amount of ostomy supplies I need to order.

I use drainable pouches and wafers and have done so for the past thirty odd years. The only thing I don't like are some of the clamps available. Instead, I use other clamps and secure these with a rubber band.

I hope my current supplier never switches completely to Velcro closures as I really feel uncomfortable and unsafe with them and they can be very messy when I need to empty my pouch.

**Maureen Challinor, NT**

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## Dear Editor

It was good to read Barry Osborne's letter in the December 2015 edition of the journal [*'X' Marks the Spot: You're Say, in your own Write*].

He exactly echoes my experience regarding wearing slightly oversize wasted trousers and braces, etc. Also, having your shirt hanging over your trousers "enhances" those of us who aren't tall, and have an "ample" waist! When I do wear braces which are on show, I am often complimented on how "fashionable" they are nowadays.

Thanks for the wonderful journal!

**David Gardiner, WA**

## Dear Editor

I have an extensive history with Crohn's disease and thought my graduation picture may show



others that some dreams do come true. Through adversity I studied for years, and qualified as a Counsellor with two majors. I graduated in 2007 and still support Crohn's and Colitis patients whenever they need it.

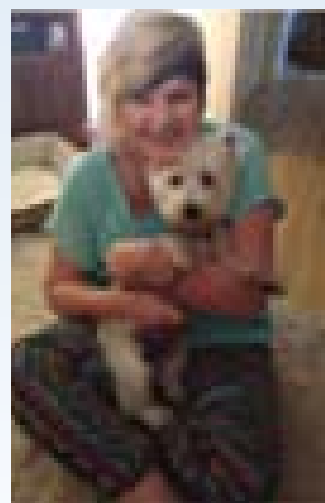
I am now a Counsellor, author and guest speaker. I do volunteer phone counselling or occasional visits to hospital to speak to patients if referred from my Stomal Therapy Nurse.

At the Gold Coast University Hospital there are now three educational days for nurses a year, where dietitians, Stomal Therapy Nurses, ostomy supply companies, surgeons and gastro specialists speak, so I am honoured to be part of sharing my story of living with Crohn's Disease.

It is seven years since my first book was written, and another is in the pipeline for the future. I also have a website: [www.climbingtheladderoflife.com](http://www.climbingtheladderoflife.com)

I have also recently joined Body Shop from home, so a new little adventure for me and I adore their products.

I endured over twenty-five operations and have short bowel syndrome, so visit the hospital weekly for magnesium infusions. Due to Crohn's disease I could not have children so I have a pooch that gives me unconditional love and the feeling of being a mum.



I believe that in life, if we focus on what we are grateful for every day, there is no room for negative emotions. I bless each day.

**Nichola Hamilton, QLD**

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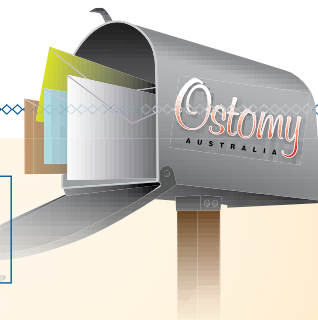
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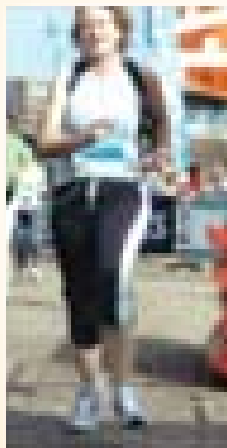


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## Get Out and Enjoy Life

Submitted by: **Anne Kelly**

It's going on fifteen years since I had surgery to remove a tumour from my large bowel and have a permanent colostomy created. I wasn't very happy for the first twelve months afterwards! However, I have had the most wonderful years that I may well not have had, seeing my children grow up, seeing three grandchildren come into the world, and changing my career to working in disability support programs.



As a friend of mine said, "You don't let it stop you doing anything, do you?"

I LOVE swimming and after the operation told the wonderful surgeon that if I couldn't swim any more I'd rather be dead - poor man!

I spent many hours with a psychologist after the surgery to get back on top of things, and my husband and family have been a tower of strength for me since I was diagnosed. I work full time, love my work, swam in the Masters Games in Sydney in 2009, spend lots of time with family and friends, and love jogging and doing fun runs.

Here are my tips:

- Drainable bags, particularly those with a clip if you have a colostomy, are great whenever you're out and about. I only use closed bags at night.
- I take an acidophilus tablet every evening to reduce wind. Yoghurt is good too.
- When you need to, just excuse yourself from that meeting and go out for a few minutes.
- Eat and drink whatever you want (but fizzy drinks in moderation).
- Tell people, or don't tell people – it's completely up to you.
- Get out and about as much as you can and enjoy whatever you used to enjoy!

## Live Life to the Fullest

Submitted by: **J.W., QLD**

I have now been an Ostomate for twenty-four months. I was diagnosed with rectal cancer in September 2013 and had my operation in January 2014.

My surgeon and Stomal Therapy Nurse were wonderful and I was released after ten days in hospital.

The stress of managing and the feeling of loneliness were extreme but with a loving husband and family I adjusted to my new life. If I was feeling down my son would say, "Mum you're alive".

Things went well for nine months but unfortunately I developed a rectal hernia. February 2015 saw me back in hospital for six days having a repair which set me back for a few months. While there I made contact with several other Ostomates, which was a great help.

During all this time, I have looked forward to the *Ostomy AUSTRALIA* journal arriving. Reading and knowing of the experiences of others has been amazing and has helped with my feeling of aloneness.

My husband loves traveling in the outback and reading an article in the August 2014 edition from Kerry Kimbrey on her travels [*I've Become a 'Gator'*] gave me the courage to give it a try. We have since travelled up Cape York, to the Burdekin Dam and have been to Karumba twice. Next year we hope to go to the Kimberley region in our camper trailer.

Not everything has gone perfectly and some of the toilet facilities do make life hard, but it is easier with plenty of planning. The occasional accident and stress in the shower without a toilet close by is not always good, but then what is life without some struggles.

You also get some weird looks when you ask to use the disabled toilets (there are very few in the outback). One lady said, "You could if you were disabled" but she did apologise when I explained the situation.

I am determined now to live life to the fullest as we never know what is ahead for us, and hope I have been an encouragement to someone else who is wondering about traveling.

## Trouble with Hernias

Submitted by: **Tony Russell, SA**

I had colorectal surgery eight years ago and as a result I have a stoma and wear colostomy bags. I use a two-piece appliance which in itself works well, but I am having increasing problems with one of my two hernias. My parastomal hernia is on the lower left abdomen and I have another, a post incisional hernia, which is a bit above and to the right of my navel. I support the second hernia with a normal support belt which keeps it in check.

It is the parastomal hernia which is steadily getting



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larger and larger and needs support. However, none of the belts (that I have seen) adequately manages my hernia/stoma combination. If I have a belt strong and tight enough to properly support the hernia it inhibits the passage of, let's call it "poo" for short, moving from my stoma and into the pouch. This would be manageable enough if I could tell when my stoma is likely to become active, i.e. I could remove the belt for the process. However, my stoma definitely has a mind of its own and becomes active willy-nilly at any time of day, so I have to be sure the "poo" can escape into my pouch 24/7. If I leave the support belt in place the voiding "poo" builds up enough pressure to force the base-plate to come unstuck and of course that is messy.

What I would like to see is a support belt with a hole in it large enough to allow for pouch attachment, i.e. through the hole in the support belt. The hernia would then be supported by the rest of the belt. I have contacted support belt manufacturers in this regard but had minimal response, they either don't understand the problem or are not concerned about it because nothing has been forthcoming. I've actually tried modifying my own belts but they fall apart after some use.

Surely I can't be the only Ostomate with this problem. I would be interested to hear from anyone who reckons they've cracked it.

But the facts remain as I have stated in that you can't just put a support belt over the whole area because it causes gross leakages as the base plate is forced off the skin. The alternative, which I am doing, is to cease trying to control the parastomal hernia and so it just gets bigger and bigger, with ever increasing possibility of a distorted colon and blockage.

I have also discussed this with my surgeon who suggested he could relocate the stoma but he wasn't sure it would help for long as the same problem would probably arise at the new stoma site.

Please, someone needs to do some serious research into a solution and not just put it in the too hard basket leaving us with a nasty problem.

*[Editor's Note: (most) Stomal Therapy Nurses in Australia are negative about cutting a hole in hernia belts, saying that it could actually increase hernia problems.*

*An earlier journal article included the following: "Research indicates that if a hole is cut in the support garment, it will then mimic the situation that caused the hernia in the first place, so it cannot minimise the hernia risk. Hernias may sometimes be forced through the stoma pouch opening in support belts with holes and replicate the original cause of a hernia."]*

## Keep It Simple

Submitted by: **D. Dodds, QLD**

I agree with Don Cameron's comments in the December 2015 edition of the journal [*Simple: You're Say, in your own Write*]. Why do some people make a

simple job of changing an ostomy bag so complicated?

My bag change takes about four minutes every fourth day. When I left hospital after my operation ten years ago, I too used wipes to remove the used bag, and then more wipes to attach a new bag.

That was until about six years ago when I developed a skin eruption. As we do not have a Stomal Therapy Nurse at our hospital, I contacted an STN at the closest large hospital. She advised me to cease using the wipes as they may contain a chemical that may have caused my skin problem.

Since that day I have stopped using wipes, and on the rare occasion I have a skin problem I now use Calamine Lotion. My method is even simpler than Don's, as I only change my bag every fourth day and I use a hair-drier to make sure the area around my stoma is dry.

I also found it amusing to read that some people use a plastic bag to keep their bag dry. These bags are waterproof; I go swimming with my bag without any problem. As Don said, KEEP IT SIMPLE!

In conclusion I wish to thank the people at the North Queensland Ostomy Association for their courteous and prompt attention to our needs in North Queensland.

## Simple Again

Submitted by: **Jim Orman, NSW**

I was very taken by Don Cameron's article "*Simple*" in the December 2015 edition of the journal. I too have been an Ileostomate for many years (since 1972 at the age of twenty-nine). I have been through some of the more primitive systems and remember them with little affection.

My objective is to spend the minimal possible time maintaining the ileostomy while still ensuring odour-free and hygienic conditions. There is no need to spend life dedicated to the stoma. I like to fix it and forget it!

I have used a very simple system for the last very many years. I use a closed-end pouch (32mm) that clips to a flange which comes attached to the wafer. Wafers last two to three days but do sometimes "lift" after twenty-four hours or less and need changing. There does not seem to be any correlation between activity and length of time that the wafer stays in place, though driving in my 4WD seemed to add longevity rather than shorten it.

The wafer needs changing once you feel burning around the stoma, though by using a protective powder after wiping around the stoma, you can get additional hours or more from the wafer after the burning feeling is initially felt.

Warm wafers stick best so I cut the wafer to size, put it in the waist of my underpants while I remove the old



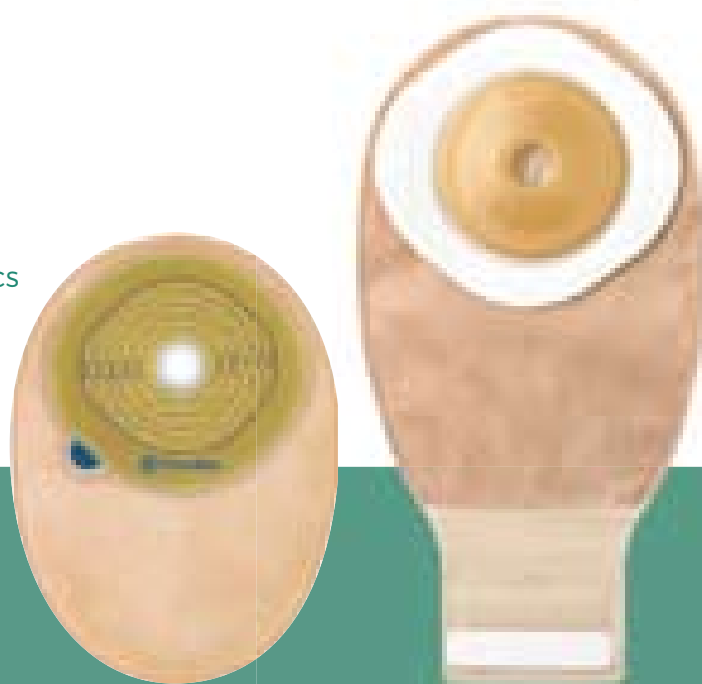
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wafer and clean the skin area. By the time I need to apply the new wafer, it is at body temperature, which is excellent. I also note the date and time on the new wafer when I cut it, so I know how long it has been in position at a later time. I have had wafers in place for more than three days, and really they should not stay there that long.

I use closed pouches with a filter. I set the pouch up as follows:

First, I fold two squares of toilet paper lengthwise to make a cover for the filter exit and tape it vertically on the bag. Then I tape a piece of thin clear plastic over the top of the toilet paper (manufacturers please note ... perhaps you could deliver the bags set up like this).

And while on that subject ... Why is the filter on the front of the bag where any leakage will go to outer clothes? Here is my logic. The filter WILL fail once moisture from inside the bag penetrates it. If there is no protection there will be leakage onto your clothes. The addition of toilet paper will absorb a very considerable amount of the leakage so there is no rush to change the bag. Just take the toilet paper off the next time you need to empty the bag, and put a "filter sticker" (which comes with most ostomy bags) over the filter hole, sealing it. Leave the plastic outer cover in place in case of any further leakage, which is unusual but possible. I know that this might not sound simple but it really is once you get into it, but most of all it is fast.

What all this means is that for several hours after putting a new bag in place, gas will not be a problem. After the filter clogs, then gas will build in the bag, but provided this is not excessive the occasional trip to the toilet allows you to release gas from the bag.

I put a new bag on after my shower in the morning, and another on when retiring at night. Bags are rinsed in the sink and thrown in the bin, or if I am not able to do that I put the used bag in a nappy-bag and put the lot in the bin. I salvage the outer plastic cover for use with the next bag. Plastics last many days without picking up odour.

Now the really simple part. To empty the bag, unclip it, empty it and clip it back on. That takes typically under ten seconds. And that means you are resuming normal life very quickly. Sometimes toilet paper is required to wipe around the rim but I seldom need to do that. No need for messy clean ups that often go with drainable bags.

One other thing I have done in my house is to install a ferocious fan in the toilet room. When I change or empty a bag, gases are whisked away in seconds. The fan I have is a Mistral kitchen exhaust fan that automatically closes after use (the blades simply flip into a flat position). I have had the same fan for ten to fifteen years with no problems.

I lead a very active life, always have and will continue to do so as long as I can by using the system outlined above.

## No More Velcro Closures Please

Submitted by: **Vanessa, SA**

In regard to Ray Garske's letter in the December 2015 issue of *Ostomy AUSTRALIA* [*Your Say, in your own Write*], I whole-heartedly agree with his opinion on Velcro closures and filters. I too, have had an ileostomy for many years. I use a one piece drainable bag which I change once a day. The bag is emptied between three and eight times throughout the day and night, as needed.

For years, I used a certain brand until they discontinued that product line. I was most upset because by this time most brands had introduced the roll up, Velcro style closures. Upon being forced to find a new bag, I trialled many products and had great difficulty in finding the right one for me. Many consultants advised of how wonderful their Velcro closures were but they did not offer an alternative closure.

I finally found a supplier with a product which is perfect for me and they even supply a plastic clip with each box. Thank you! This product also does not have a filter. I realised many years ago that filters were pretty much useless for me as they did not remove the gas from my bag and I always felt smelly. When I have a gas build up, I just go to the toilet, release the air, spray a little perfume and I'm on my way.

Sometimes so-called innovative design changes do not always meet the requirements of the user. Bag manufacturers please keep in mind that NEW does not necessarily mean BETTER.

.....

## Life With and Without a Neurogenic Bladder

Submitted by: **G.L., NSW**

Just suppose your most prevalent thoughts of childhood were of wet beds, wet pants and total embarrassment or trepidation wherever you went. That is my childhood as I mostly remember it and is probably why I was very shy by nature.

A non-existent family life probably didn't help the situation much, as I was raised in a house attached to our family business, a corner grocery and green-grocery shop which we operated from 8am to 8pm daily. A breakfast time of 7.30am was strictly adhered to and was the only time my mum, dad, two brothers and I had any real time together.

During my sixteenth year I spent three months in hospital with rheumatic fever when I was just three months into my Day Secretarial Course at technical college. In 1962, I decided to return to college and get this Certificate, which led to a job as a stenographer in a New South Wales government department.

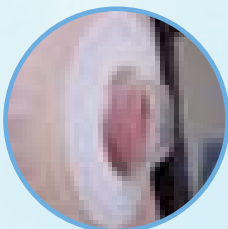


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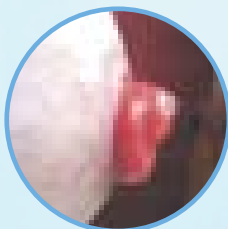
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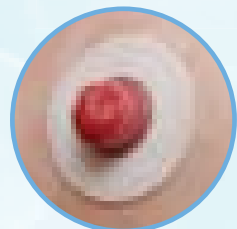
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At twenty years of age, in 1966, I married and moved from one seven day-a-week business to another. Between late 1967 and 1974, I had already lost five babies from three pregnancies and firmly believe this to be a contributing factor in the worsening condition of my bladder, especially my first pregnancy where I carried triplets for eighteen weeks. In 1975, I gave birth to twins ten weeks prematurely but we lost our little boy two days after birth. Our little daughter survived and is now forty years of age. In 1977 we had another son who is currently thirty-eight years old.

In 1983, I resumed my other career as a stenographer in a government department but as the years progressed my bladder became more unmanageable. I mentioned my bladder problem to a local GP and was told perhaps I was drinking too much. On referral to a urologist in a nearby town, it was decided that I had not one but two incontinence problems and he was unable to help me.

Another GP referred me to a urologist in Sydney and in late 1995, I began travelling to Sydney on a regular basis. A fascial sling operation was performed in 1997 but unfortunately that only fixed one of my incontinence problems and worsened the other. I had to keep a daily record of fluid input and output, which included self-catheterisation of the fluid being retained after each trip to the toilet.

As a result, I carried a bag which contained measuring jugs, catheters and a change of "nappies" which by now I was wearing at all times. The nearest toilet to my work station was eighty-nine steps away and might as well have been on the moon on some days so accidents were quite a usual occurrence.

Then, in July 2000, I decided to fall over and break my seventh and eighth vertebra. As I was able to take early retirement at the age of fifty-five, that was exactly what I decided to do, especially as I'd been diagnosed with osteoporosis as well. Luckily, when all the ink was dry, I made it home in time to watch the Sydney 2000 Olympics on television, so some situations still have a bonus along the way.

By 2002 and after several tests on different occasions lead to the same comment of "your bladder has given up the ghost", it was decided to my amazement that a cystectomy and ileal conduit operation was the best solution. I naturally assumed that one such test saying "your bladder has given up the ghost" would have been sufficient but it was something they must have needed to say on a regular basis.

Finally it was decided to proceed with the operation, so on my fifty-seventh birthday I went "under the knife" as they say. Three days after this surgery I experienced a pulmonary embolism which, for any of you who have had this little gem, can be quite a wild ride. I had three clots to the lung and couldn't seem to find any air anywhere.

Luckily I was able to stop taking the Warfarin I'd been prescribed about four months later.

Normally that would have been the end of this story but you have to take into account the "me" factor. I appear to have the happy knack of bucking the system, so to speak. Six weeks after surgery I went to Sydney to see the urologist and got a clean bill of health.

However, by ten weeks I had developed my first hernia. In 2003, I had a repair to a parastomal hernia and two bowel constrictions. In early 2005, I had a mesh applied to the hernia and suffered my second pulmonary embolism, two clots this time, which resulted in my now being on Warfarin for life. Those of you on Warfarin will know what I mean and, hopefully, the rest of you won't need to know.

Late 2005 saw modification of the hernia mesh to stop constriction of the ureters and a catheter to encourage free passage of urine to the urostomy pouch and, although I spent most of the winter in bed that year, I still managed another broken bone (this time my right ankle). In July 2006, I had more repairs and meshing to the hernia and re-siting of the ileal conduit to the other side of my stomach.

In February 2011, I needed repairs to two hernias and a bowel constriction. The mesh had caused constrictions to the bowel and ureters once again, requiring a catheter linking the stoma to the urostomy bag as well as the consumption of laxatives on a daily basis to maintain passage of urine and faeces. Failure to do so causes backflow of urine to the kidneys and severe kidney pain.

So I don't have too many problems provided I drink plenty, exercise sufficiently (I find at my age that five thousand steps is enough on a daily basis) and don't sit for long stretches of time, as well as take the medications required to keep my system functioning.

Along the line I also managed to squeeze in a divorce in 2002, so you might say I'm having a busy life.

Most of my pleasures in life come from my family and friends and my love of country music, particularly sung by my cowboy in America. You've got to have fun when you can and not lose your sense of humour. It can possibly be your best friend of all.

You know, this year someone told me that I wasn't seventy years old but actually only eighteen years old with fifty-two years' of experience, and I think they might be right.

Write in to have ...

**YOUR  
SAY**

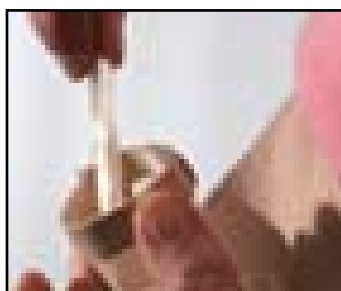


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# STOMA REVERSAL FACTSHEET

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When a stoma is formed, a loop or an end of healthy bowel is pulled up onto the surface of the abdomen to create an artificial opening where faeces (poo) can be passed out of the body, instead of through the anus (back passage). This stoma may be either permanent – if there is no longer enough bowel left to make a continuous pathway from healthy bowel to anus - or temporary.

Temporary stomas are usually formed to allow the bowel to heal properly after it has been cut and reattached (anastomosis). This temporary stoma will usually be formed as a loop ileostomy (from the small bowel) or less commonly as a colostomy (from the large bowel).

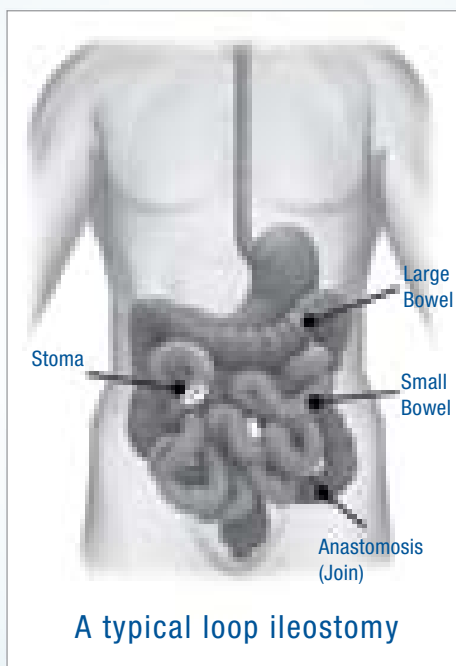
Reversal of a loop ileostomy is a relatively simply operation as the bowel has already been joined up at the initial surgery. It involves closing the stoma and returning the bowel to the abdominal cavity.

However, if it is a colostomy it often requires a larger operation as the ends of the bowel will need to be joined up at the time of closure. Occasionally the surgeon may want to form a temporary loop ileostomy to allow the healing of the join and avoid a leak.

This will be discussed and explained by your surgeon prior to your surgery and will only be considered if it will be a straightforward and successful procedure.

## Is a stoma reversal right for you?

Many people believe that, after a stoma reversal, their bowel habits



A typical loop ileostomy

will return to how things were before they became ill. However, the reality is that even with a successful reversal there will still be a piece of your bowel missing and this will change the way your bowel works in the longer term.

There are several factors to consider when weighing up the risks associated with stoma reversal. These include:

- where the cancer was in your bowel and how near to the anus it was. The shorter the length of bowel remaining in the rectum after surgery, the more difficult it is to create a safe join (anastomosis), and to avoid affecting the sphincter muscles of the anus. This could increase the risk of being unable to control your bowel movements and the potential to leak from your bottom (incontinence)
- if there were any complications with infection or inflammation in or around the bowel or the join (anastomosis) after your initial surgery

- if you have also had radiotherapy or chemotherapy that has affected the health or function of your bowel
- if your health has deteriorated since your surgery, or if it is not safe for you to have further surgery.

## When should it be done?

- Your medical team will carefully consider the timing of a stoma reversal. For example it cannot be done while you are receiving chemotherapy. Your bowel needs to be active to maintain its health and so there is an optimum time to have the reversal operation done - usually between three and twelve months after it was first formed. This allows the bowel time to heal properly following the original surgery, but is also very important to reduce the risk of losing the muscle tone and health of the unused part of your bowel.

Once the stoma is formed, the muscles of the pelvic floor and anus can also start to grow weaker from lack of use, unless you continue to exercise them, which is highly recommended.

There are some important questions you may want to ask your stomal therapist nurse advisor when discussing the possibility of a stoma reversal:

### **How much of your rectum was removed?**

The rectum is the lowest part of the large bowel and is responsible for holding faeces until you are able to use a toilet. Some of this storage area may have been reduced if the tumour was in your

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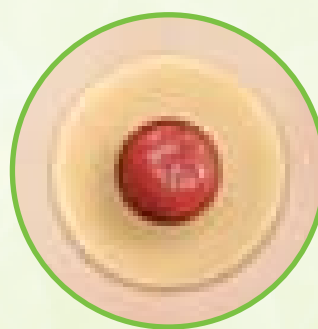
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rectum and the newly shaped bowel will need some time (and practice) to get used to this.

### **How much of your colon was removed?**

The colon absorbs water back into the body as the faeces travels along its length. If your colon has been shortened, there is less time for this water to be reabsorbed so your faeces will be looser.

### **How might this affect your bowel habits?**

Depending on which part of your bowel was affected, and the type of surgery you had at the time, there may be scar tissue and changes to the shape of the bowel which will affect how well it is able to work and store the faeces, at least for the first few weeks or even months. Looser, watery faeces and wind can cause problems with urgent feelings of needing to 'go' quickly. Occasionally, problems with leaking faeces can become an issue for some people, especially in the beginning, until they adapt to their circumstances and find a new routine.

### **The operation**

If the operation is reversal of a temporary loop ileostomy the hard work has already been done at the first operation and therefore there are no more incisions as the closure is done through the stoma site.

However if it is a colostomy then a larger operation is required to rejoin the bowel and this can be done as a laparoscopic procedure or an open operation.

However if the stoma is as a result of a Hartmann's procedure then the bowel will need to be rejoined and this is a bigger operation.

This can be done either laparoscopically, or as an open operation. Laparoscopy

means using small cameras and instruments to work through the existing stoma and small cuts in the abdomen. Open surgery follows the same scar line from your first operation.

Your reversal operation and the possible risks will be carefully explained by your specialist team. The decision to go ahead and reverse the stoma, and the type of surgery planned, will be based on your needs and wishes as well as your current general overall health and your previous treatment.

### **What are the other risks and side-effects?**

No surgery is entirely without risk, however specific problems that can arise include:

**Ileus** – a temporary 'shock' reaction to the surgery and some medicines. The bowel becomes paralysed or is slow to start working again. The treatment is just to rest it, by not eating or drinking until you start to pass wind again. You may need an intravenous drip to make sure you don't become dehydrated during this time.

**Bowel obstruction** – a physical blockage of the bowel or problems with adhesions (bands of tight scar tissue) causing narrowing or constriction of the bowel.

**Anastomotic leak** – where the newly joined ends of bowel don't heal properly, causing a leak from the bowel into the abdomen. This can be caused by infection, or by poor blood supply to the bowel tissue at the join. It can often be treated using antibiotics, but in some cases may need another operation to repair it.

Very occasionally a reversal operation is not successful, and for a variety of reasons a new stoma will need to be formed.

### **After the operation**

You will be able to leave hospital three to ten days after reversal surgery, depending on the type of surgery, how the operation went, and how well you have recovered generally.

As you recover from surgery and establish a new routine, you may be supported by other members of your multi-disciplinary team. This might include a dietitian, colorectal nurse specialist and/or community nurses.

Stoma reversal surgery can be disruptive to work and social routines, and the rules about no driving and no bending for up to six weeks after surgery will apply once again. You should avoid putting strain on the repaired tissue and bowel by avoiding all heavy lifting or physical work, for up to ten months. It is important to make arrangements before your surgery for changes to your job or for support in your daily routine.

### **Regaining bowel control**

In the days and weeks following surgery, it is likely that you will have to re-establish a new bowel routine. There is no way to predict how long this will take; it will vary from person to person and it is important not to expect too much during these early days. Here are a few common problems to be aware of:

- increased frequency of bowel movements
- increased urgency – little or no warning of when you need to go
- diarrhoea or loose faeces
- pain in your bottom on passing faeces
- passing small amounts of faeces frequently (stool fragmentation)
- leaking faeces or being unable to control your bowel (faecal incontinence)

- increased wind, and being unable to distinguish between wind and faeces.

This group of bowel symptoms is known as Anterior Resection Syndrome.

It is also useful to note that radiotherapy and chemotherapy can have a lasting effect on your bowel function, and this may not become obvious until you have completed all your treatment and surgery, or sometimes even years later. Specialist support and advice are available to you if this is the case.

### **Managing your diet**

You may find it useful to follow a low-residue diet, eating little and often, gradually starting to increase the variety and amounts you are eating. Large meals and eating later in the day may cause problems. It is common to experience bowel movements during the night, for example, which might disrupt sleep and affect your quality of life.

If it helps, keep a 'food diary' so you can record what you eat, when you eat and the effect this has on your bowels (including what happens and when).

Jelly sweets, marshmallows, bananas and mashed potato are also good for firming up watery faeces. You may need to limit known culprits like beer, red wine, very high fibre vegetables, cereals and fruits, and spicy or very fatty foods.

### **Controlling symptoms**

If diet alone doesn't help, you may need to consider taking medicines to help with the symptoms. Medication to control diarrhoea (e.g. loperamide or codeine phosphate) or a bulk forming medication can help to give more reliable control for regular activities or special occasions. Your GP or specialist

nurse will have more information about what may be best for you, and how to manage the dose of medicines to prevent other complications and side-effects from them.

Constipation can also be a problem following stoma reversal, in which case it is important to continue to drink plenty of water (around eight glasses per day) and to balance your diet to include high fibre foods that are easy to digest.

Common remedies to help with excess wind and cramps may include fennel or peppermint tea.

### **Protecting your skin**

You may find it helpful to use moist toilet paper to gently clean your bottom and gently pat dry after each bowel motion. Barrier creams like those used to protect baby's skin can also help to prevent your bottom from getting sore as a result of frequent trips to the toilet.

### **Retraining your rectum, anus and pelvic floor**

The longer your rectum and pelvic floor muscles have been out of use, the more likely it will be that you will need to exercise to make them strong again. It can help your recovery if you start pelvic floor exercises while you have your stoma and before the reversal operation. You can get help from your specialist continence team if the problem does not seem to be improving.

### **Problems with continence**

Leaking of faeces and urgency are common problems in the first six to eight weeks after stoma reversal and can persist intermittently for several months as you start to develop a new routine. Having a problem controlling your bowel can be upsetting. It is a natural reaction to try and prevent an

accident by either tensing all your muscles and holding your breath or rushing to find a toilet. A better course of action is to sit or stand still, breathe deeply and contract your anal sphincter until the urge passes. The leaking should gradually settle, although you should continue to use a pad to protect your underwear until you feel confident again.

### **Be honest! Talk to someone**

It is very important to be honest with yourself and your healthcare team about your bowel function and about any issues or complications you are having, especially during the recovery. Embarrassment, anxiety, fear, vulnerability and feelings of social isolation because of an unpredictable bowel habit, are all common after any kind of bowel operation. If you are having problems coping, or things don't seem to be quite right, don't suffer in silence and do talk to your GP. They can refer you to the specialist continence team if the problem does not seem to be settling down, or if it's limiting your ability to be independent and mobile again.

### **How Bowel Cancer Australia can help**

If you would like to talk through your concerns or get more information before you make a decision about a stoma reversal operation, you might prefer to talk to a member of our Peer-to-Peer Support Network – someone who has already been through a stoma reversal, and who can answer questions and give impartial support, via telephone or email. They can also continue to support you after the operation, if you wish. Alternatively, you can contact Bowel Cancer Australia's Stomal Therapy Nurse Advisor. ●

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Proven  
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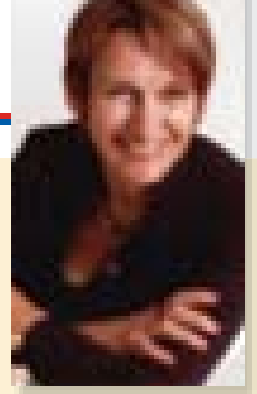
Gitte wanted an active life without constant leakage worries. Switching from a flat appliance to the new SenSura® Mio Convex Soft gave her new confidence.

“The first time I wore it, I thought why hasn't anyone told me about this before?”



\*Coloplast clinical study, 2014. Data on file.





### Dear Carmen

There were times I knew my body needed water, but however much I drank I still didn't feel quite right. Now I know why: *electrolytes* – and your recommendation of *St Mark's Electrolyte Mix* (1 litre water, 6 tsp sugar, ½ tsp salt, ½ tsp bi-carb). But I do have a couple of questions:

- Why is there so much sugar? I try not to have sugar, so is it possible to have less sugar (e.g. 2 tsp sugar to the same amount of salt and bi-carb)? Or even less sugar than that? Do the ratios matter?
- I found that making up a whole litre for the day didn't work for me, as I'd forget about it. So what I now do is make up a tub of the dry mixture - in a ratio of 2 tsp sugar, ½ tsp salt, ½ tsp bi-carb, but maybe ten times this amount. I mix it all up. Then when I want some, I'll just put some (e.g. a teaspoon) of the mixture in a mug, add a little hot water, mix it up, add cold water ... and drink. Do you think that is OK?

Thanks Carmen for all these years that you have served us. I've never written in before, but have been blessed by your kind and caring replies, and I'm sure many other people have been too.

Regards, A.T., WA

### Dear A.T.

As far as I am aware the amount of sugar is what makes this concoction more palatable. It is also important not to replace the sugar with something like a diet cordial as no-calorie/low-calorie drinks may have sorbitol in them which can contribute to more fluid loss through the bowel. Most mugs hold about 200mls which is one-fifth of a litre. As you only put two teaspoons of sugar in your concoction this makes three teaspoons per litre. You will have to do the maths yourself to get the right amount of your mixture to put in your mug of water.

Thank you for your enquiry and also your kind words of support.

Sincerely, Carmen



### Dear Carmen

I have had an ileostomy now for over eight months and I am having difficulty finding the right ring and bag for comfort. Every day I am finding myself scratching around my stoma and on my stomach where the bag adhesive covers my skin. My STN has asked me to try numerous types of bags and rings but I haven't yet found one that is comfortable for me. It doesn't help when I suffer with dermatitis.

I also find having a bag hard to deal with at times, as

I haven't had a decent night's sleep since coming out of hospital in mid-May 2015. Every night I get up three or four times to empty my bag, and during the day at work I am always looking down to see if the bag needs to be emptied, which is about five or six times a day. As soon as I empty my bag it fills up again. Is this normal?

I suffered for nearly twenty years with chronic stomach pains due to adhesions ensuing from previous operations, which finally ruptured my colon in April last year. I had all of my large colon removed and most of my small intestines in emergency surgery as my body was shutting down and I was dying.

I am waiting to see a surgeon to find out about reversing my stoma, which again I am not sure about as more adhesions might develop after this surgery.

I was told that all I have left is one-and-a-half metres of small bowel. My STN and someone I spoke to at my ostomy association in South Australia don't think a reversal would be a good idea for me. What are your thoughts with me only having one-and-a-half metres of small bowel? What problems could I face?

I am only a small person weighing forty kilograms and on discharge from hospital was down to thirty-six kilograms. My normal weight before surgery was around forty-three kilograms. Is it normal for someone with an ileostomy to find it hard to gain weight?

I hope you can answer some of my questions.

Regards, Judy

### Dear Judy

Thank you for your letter. You sound like you have had and still are having a really rough time.

Firstly, you have to acknowledge to yourself and accept that with only one-and-a-half metres of small bowel left and no large bowel, your body's capacity for re-absorption of fluid is limited, so your ileostomy will always be 'high output'. It will also affect your ability to absorb the nutrition from the food you eat. I presume you have seen a dietitian about this and they would probably have recommended high energy, high protein foods for you to consume. Further, the loss of electrolytes in your ileostomy output should also have been discussed with you and the importance of drinking the correct fluids to prevent dehydration and electrolyte imbalance.

There are high-output ostomy bags available and also large collection bags which can be connected to some high-output bags for use at night if you like. These, although unsightly can make a difference to not having to get up at night to empty your bag. Please ask your Stomal

## Annual General Meeting 2016

**When:** Saturday 9 April 2016

**Where:** Nurses Memorial Centre  
Slater Street  
(off St Kilda Road)  
Melbourne

**Time:** 2pm – 4pm

### **Guest Speaker:**

Professor Ian Hayes, colorectal surgeon from the Royal Melbourne Hospital, who will discuss the varied types of bowel surgery related to different diseases.

Afternoon tea will be provided and Trade Displays.

Gold Coin Donation.

**Enquiries and RSVP:**  
helshae@hotmail.com  
or phone 03 9796 6623

## November 2015 Meeting

YOU Inc. tries to hold a major meeting annually with an appropriate guest speaker. It was with delight that YOU welcomed **Melanie McGrice**, a dietitian from **Nutrition Plus** to the Nurses Memorial Centre on Saturday 7 November 2015.

It was heartening to have a good attendance of old and new members, many of these were members from YOU's closed Facebook page.

Prior to the keynote speaker, an informal YOU Talk was held. Sitting in a circle, everyone introduced themselves with a short chat about themselves. Once again this idea has proved to be a great way to help people relax knowing others share their fears in adapting to all the challenges of life as an Ostomate.

It was perfect timing, as Melanie McGrice then arrived for her presentation, which was informal but informative.

Following this was plenty of time for a chat and an opportunity to enjoy the delicious afternoon tea. Thanks to the companies for their trade displays, which are always an important component of YOU meetings.

- Feel free to check the YOU Inc. webpage: [www.youinc.org.au](http://www.youinc.org.au)
- YOU Inc. has a closed Facebook page with 120 members. Search for "Young Ostomates United Inc" on Facebook and ask to join!



Helen, Melanie McGrice, Kim, Judy Wells, Lilian and Steph



Kane, Carol and Helen

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Therapy Nurse to show you these.

As I don't know exactly what bowel you have left it is worth asking the question about a reversal, you may still have a rectum as this is not always removed with a colectomy. The rectum is the reservoir part at the end of the large bowel. If you still have this there may be a possibility for reversal but you would probably still have frequent trips to the toilet both during the day and night, plus the fluid nature of the bowel actions may 'overwhelm' your anal sphincter and you may well suffer from faecal incontinence. Your issues with absorption of nutrients would not go away either.

The high output from your stoma will also affect the longevity of the seals and bags. My recommendation to anyone with skin irritations is to avoid chemicals on your skin as much as possible, i.e. avoid adhesive remover wipes and skin barrier wipes and use plain water and a soft cloth to clean all residue off your skin or put a capful of vinegar in a cup of water to assist with this. Use a simple hydrocolloid bag/baseplate with built in convexity instead of a seal if you can.

Having just said to avoid chemicals I now need to say that itchiness is often because of skin dryness and as you already suffer from dermatitis you may find using a tiny amount of Hollister's skin conditioning crème to the skin under the adhesive may help with this (available from your stoma association; code 7220). Occasionally one may have to resort to using a hydrocortisone lotion. This needs to be prescribed and it is important that a lotion is prescribed not a crème as your appliance won't stick to this.

I hope this is helpful.

**Sincerely, Carmen**



**Dear Carmen**

I have had a colostomy since 2003. It is a 'spoutless' colostomy accompanied by a parastomal hernia resembling a volcanic crater.

For the past ten months or more the crater has been host to a cluster of what I can only describe as yellow blisters about the size of orange pips. They are not smooth and rounded like conventional blisters but rough and craggy, rather like cauliflower. I took the problem to my Stomal Therapy Nurse who was very reassuring and told me that I was doing all the right things but advised that I should change my appliances more frequently than the then every five days, suggesting that I change every three days or maybe even every two days. Reluctantly I cut it back to every three days (but it has since climbed back to every four days).

A few weeks ago I had a bigger than usual bleed from my stoma which panicked me and sent me hotfoot to the hospital in the middle of the night where a doctor discovered a tiny

graze within the crater which might have been responsible. A consultant there later advised that I should get my parastomal hernia repaired and that is to happen in due course. I am currently awaiting word from the hospital for an upcoming colonoscopy, the results of which will determine the course of action that the surgeon will take.

In the meantime, I have these infernal blisters. They are within the crater and are subject to mucus and other mess. I dab them impotently with Friars' Balsam at every bag change and use stoma paste around the outer lip of the crater, which seems to maintain the status quo.

Is there any specific medication that I could be using to improve the situation?

**Regards, Tony Lanning**

**Dear Tony**

Thank you for your interesting letter and enquiry.

I think when you have a stoma below the surface of the skin and with your hernia and crater I suspect that you cannot and do not get the stoma appliances directly abutting the stoma. This would mean that there is exposed skin. Over time the skin has probably thickened and the yellow blisters are not really blisters but hyperkeratosis lesions which need to be flattened and covered by your stoma appliance. I suspect this is not possible.

I think it is a good idea to have the colonoscopy to also rule out tumour recurrence at the stoma site although you have not told me why you have the colostomy so I don't know that you actually had a cancer in the first place.

Certainly getting your parastomal hernia fixed and possibly your stoma re-sited should mean you can get a closer fitting stoma appliance and avoid exposure of the skin around your stoma to the faecal output and moisture.

In the meantime if these lesions are from general exposure you may like to try and cover them with a thick layer of Stomahesive Paste and change your appliance much more frequently so that you can repeat this covering with the paste or try using a seal gently moulded over the 'blisters'.

Please do visit your Stomal Therapy Nurse again as actually seeing these lesions can help identify what they are.

**Sincerely, Carmen**



### NEED MORE HELP?

Please send any questions or concerns you might have to Carmen, our journal's Stomal Therapy Nurse.



# Bulletin Board

## COLOSTOMY ASSOCIATION OF NSW INC.

### *Change of Association Name*

The business name of **Colostomy Association of NSW Inc.** has officially been changed to **NSW STOMA LIMITED**.

So as to better reflect our new business name, we have also changed our email address to **info@NSWstoma.com.au** and our website to **NSWstoma.com.au**

We are pleased to advise that our existing phone and fax numbers, street and postal addresses, support services, operating hours and ostomy products provided, all remain unchanged.

## NORTH QUEENSLAND OSTOMY ASSOCIATION

### *New Email Address*

Our new email address is:  
**admin@nqostomy.org.au**

## QUEENSLAND STOMA ASSOCIATION

### *Business Hour Changes*

Our business hours have changed to:

Monday to Thursday: **8.30am to 2.30pm**

Last Saturday of each month: **8.30am to 12.30pm**

Fridays and Public Holidays: **Closed**

## YOUNG OSTOMATES UNITED INC

### *Annual General Meeting*

Please join YOU at our Annual General Meeting and listen to guest speaker, Professor **Ian Hayes**, a colorectal surgeon from the Royal Melbourne Hospital who will discuss the varied types of bowel surgery related to different diseases.

**Where:** Nurse's Memorial Centre, Slater Street (off St Kilda Road), Melbourne

**When:** Saturday, 9 April 2016

**Time:** 2pm – 4pm

Please contact Helen Ebzery via email (**helshae@hotmail.com**) or phone **(03) 9796 6623** if you would like to attend the AGM so we can get a better idea of numbers for catering purposes, etc.

## GREATCOMEBACKS®

**Do you have an inspiring story you want to share with others to help make a difference?**

ConvaTec is proud to launch the Great Comebacks® Awards Program to Australia and New Zealand for 2016.

The Great Comebacks® program enables people living with Crohn's disease, ulcerative colitis, bowel cancer or an ostomy to share their story to inspire others who are facing these diseases or transitioning into life after surgery.

By sharing your inspiring story and the impact a Stomal Therapy Nurse has had on your recovery via the Great Comebacks® website you or your Stomal Therapy Nurse could be eligible to receive a Great Comebacks® Award!

Winners of the Great Comebacks® award will receive a commemorative plaque and certificate and will be invited to act as a program Ambassador within the Australia and New Zealand region.

**Applications for the Great Comebacks® Australia & New Zealand  
Awards close 30th September 2016**

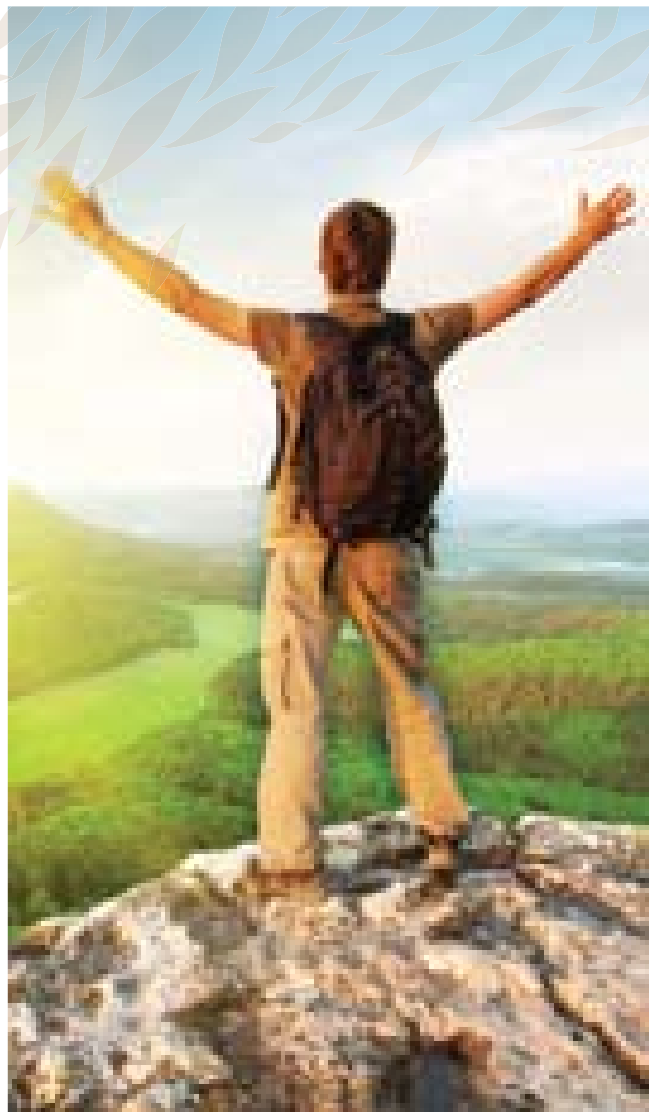
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## Obtaining Additional Stoma Appliances

Happy belated New Year readers! Ask Kylie enquiries for 2016 have been a little slow during the first part of the year so I thought this edition of *Ostomy AUSTRALIA* may be a good opportunity to consider in more detail the subject of obtaining additional stoma appliances through the Stoma Appliance Scheme (SAS). Addressing additional stoma supply needs seems to be a hot topic for discussion between associations and members, particularly since the update of the *Application for Additional Stoma Supplies* (PB050) form in October 2015 to reflect the requirements of the *Privacy Act 1988 - Australian Privacy Principles*.

The Australian Stoma Appliance Scheme is a Federal Government program that provides subsidised stoma appliances to eligible persons who need them. While the standard monthly allowance of products provided through the Scheme should be adequate to meet the needs of most Scheme registrants under normal circumstances, sometimes a situation may occur where the normal allowance of one or more products may not be adequate and a temporary increase in the Scheme allowance may be needed. Examples may include: during illness which causes a higher than normal output, during chemotherapy or when skin excoriation affects appliance adhesion.

As required by the Commonwealth Department of Health, to be eligible for a temporary increase in SAS listed product allowances, a Scheme registrant must be under the care of a medical professional (either a registered medical practitioner or a Stomal Therapy Nurse). If during a review the medical professional considers that a temporary increase in supplies is clinically justified, he or she will complete an *Application for Additional Stoma Supplies* (PB050) form. The *Application for Additional Stoma Supplies* (PB050) is an online-fillable PDF form which can be accessed through the Department of Health's website at [www.health.gov.au/stoma](http://www.health.gov.au/stoma) (then select the Forms option). Only current versions of the form (reference PB050.1510 as at the time of writing) will be accepted by the Department of Human Services (Medicare).

An *Application for Additional Stoma Supplies* (PB050) may be issued for a period of up to six months. For an additional supply request to be valid, the following criteria must be met:

- a full description of the product and the amount of additional quantity authorised must be provided,
- the reason for the additional supplies must be specified,
- a review date which is up to but not exceeding six months from the date on which the form was issued must be specified,
- the authorising medical practitioner must provide their full details as required and sign and date the form where indicated, and

- the SAS registrant (or a responsible person as defined by the Privacy Act) must sign and date the form where indicated.

In addition to the above, additional supply requests which will result in a total supply of more than twice the normal monthly allowance of any one SAS listed product must be accompanied by a separate written clinical justification for the additional supply quantity, which provides details of the basis for which additional products are required, including detailed medical reasoning as to why additional supplies are necessary and the implications for the member if those supplies are not approved. Requests which will result in more than four times the normal monthly allowance of any one product must also be approved by the Department of Health.

The completed *Application for Additional Stoma Supplies* (PB050) form should be submitted to the stoma association where the registrant normally obtains their stoma supplies. The association will check the validity of the form within the requirements of the SAS Operational Guidelines, will record the details of the additional supply authorisation as necessary and will send the completed form to the Department of Human Services (Medicare) for their information.

For more details about obtaining additional stoma supplies under the Stoma Appliance Scheme, please contact your association.

## Increase to Association Membership Fees

As advised last year, during 2014 the Department of Health approved a \$15 increase to the Stoma Appliance Scheme (SAS) Service Fee, which is to be phased in over three years at \$5 per financial year, commencing July 2015.

As your ostomy association's annual Membership Fee is aligned with this SAS Service Fee, the second of these three scheduled \$5 increases will be applied to the 2016/17 uniform national Membership Fees (due 1 July 2016).

The following SAS Service Fees\* adjustments apply to all SAS registrants:

FINANCIAL YEAR	FULL	CONCESSION <sup>^</sup>
2015/16	\$50	\$40
2016/17	\$55	\$45
2017/18	\$60	\$50

\* excluding GST (Membership fees do not currently attract GST)

<sup>^</sup> registrants who present a current Centrelink issued pension or healthcare card ●

Please send your "Ask Kylie" questions via email to [feedback@australianstoma.com.au](mailto:feedback@australianstoma.com.au) Alternatively, hard copy submissions may be sent to The Editor, *Ostomy AUSTRALIA*, C/- ACT & Districts Stoma Association GPO Box 1260 Canberra City ACT 2601

Submitted by

**Carmel Boylan RN, BN, STN, MN (NP)**  
AASTN National President  
(Australian Association of Stomal  
Therapy Nurses)

Hello to everyone from Perth, Western Australia. I thank Kirsti Dixon for her hard work as past President and will endeavour to fulfil the role to the best of my abilities.

This is my first report as President and I would therefore like to give you an insight to my background. Originally from the Emerald Isle, I moved to Perth in Western Australia in 1986. I am currently employed at Princess Margaret Hospital for Children (PMH) and prior to this I worked as a Stomal Therapy Clinical Nurse Consultant in both the adult private and public sector. So while my current patients are 'little people', I have a good understanding of the needs of the adult Ostomate.

Congratulations to Helen Nodrum and her team for hosting a very impressive 40th AASTN National Congress in Melbourne. The Congress, which was held in partnership with the APFCP Congress, provided opportunity for delegates to attend presentations from both programs. At times it was indeed difficult to choose which topic to attend as all were of great interest. A total of 817 delegates attended; 147 trade representatives, 240 nurses and the remainder were medical registrants. The social program was well organised and no doubt everyone who attended had ample opportunity to see the sights of Melbourne.

At the Congress three of our well known and deserving colleagues were awarded life membership - Elizabeth English (SA), Keryn Carville (WA) and Patricia Walls (QLD). These three ladies have been tireless contributors to stomal therapy nursing over a number of years. They have willingly shared their knowledge, developed and implemented educational programs nationally and internationally, encouraged others to take on the STN role, and continue to promote the speciality. Their dedication to their patients,

community and nursing colleagues is immeasurable; we are honoured to have them as colleagues and friends.

The conference program and presentations demonstrated the dedication my colleagues have to their profession and the hard work that is been undertaken continuously to improve the patient journey whilst in hospital and provide ongoing support in the community.

I know I speak for my fellow Stomal Therapy Nurses when I say we are available to provide support to you, the Ostomates

and your family/partner.

Please keep in touch with your Stomal Therapy Nurse and seek assistance for issues related to stoma management and skin care. On the other hand we value your opinions, tips for stoma management and the support you can offer each other.

Until next time keep well, **Carmel.**



## Corsinel®

## Ostomy Support Underwear

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All models are available in low and high waist

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Comfortable to wear and supportive fit

Latex free

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Flat seams for optimum comfort

Air and moisture permeable material

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Designed as regular underwear

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Corsinel has been developed especially to support a parastomal bulge which has appeared in connection with a stoma.

The upper part of Corsinel underwear supports the hernia and makes the user look good. The lower part is made from a softer material making the garment easier to apply and take off. The combination of the two kinds of material makes Corsinel more comfortable and makes it stay in place.

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To purchase directly, visit Statina's online store on [www.statina.com.au](http://www.statina.com.au)

For more information, call Statina Healthcare on 1300 365 404.

\*Only applicable to eligible customers.

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[www.corsinel.com.au](http://www.corsinel.com.au)



Almost 7 out of 10 people will develop a hernia within 1 year of stoma surgery<sup>1</sup>

It is recommended to avoid heavy lifting after surgery



What is a hernia?

A hernia is one of the most common problems following a stoma formation.

A hernia presents as a bulge under the skin. The surgical cut made through the abdominal wall to form a stoma, creates an area of weakness in the abdominal muscles, and loops of bowel can stick out through that weakness.

A bulge around your stoma may indicate a hernia. If you think you have developed a hernia, consultation with a Health Care Practitioner is recommended.

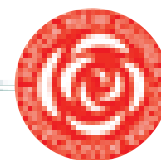
Australia's Number 1 Support Garment Range<sup>2</sup>

Omnigon Support Rating	MODERATE	INTERMEDIATE	FIRM
Pants			
Waistbands			
Belts			
	<ul style="list-style-type: none"><li>• After surgery</li><li>• Wear during light exercise</li><li>• To prevent or to support a small bulge</li></ul>	<ul style="list-style-type: none"><li>• Wear during daily activities as prevention (housework, shopping, golfing)</li><li>• Support a more developed hernia</li></ul>	<ul style="list-style-type: none"><li>• Wear during active work or sports as prevention</li><li>• Support a developed hernia</li></ul>



For advice on Support Garments and for your FREE copy of our Guide contact our Customer Service Team 1800 819 274

1. Thompson, J. Parastomal hernias revisited, including a cost-effectiveness analysis: is an ounce of prevention worth a pound of cure? 2009; 29(2). 2. Data on file, 2016.



Submitted by: **Janet Yaki**, Founder and Interim President Papua New Guinea Stoma Association

I recently received some nice feedback (below) from an Ostomate in Papua New Guinea (PNG) on the impact of the various ostomy products supplied via donation to the **Papua New Guinea Stoma Association**. The Ostomate, a retired Port Moresby medical practitioner who received his colostomy in late 2014, has expressed his written appreciation to the donors in Australia. Many other Ostomates have also expressed the same appreciation in their feedback.

On 3 October 2015 we presented a video for **World Ostomy Day**, with a theme of **"Many stories, one voice"**. The website link to this video may help donors know and understand where and how their ostomy donations are being used:

[www.emtv.com.pg/article.aspx?slug=Olsem-Wanem-Episode-32-2015&subcategory=Olsem-wanem](http://www.emtv.com.pg/article.aspx?slug=Olsem-Wanem-Episode-32-2015&subcategory=Olsem-wanem)

Thank you all, **Janet**

*I am a Medical Practitioner by profession and operated a private practice in Port Moresby, PNG for fifty years. I am now eighty years of age. In November 2014, it was discovered that I had a blockage in my intestine. Therefore, I underwent an urgent operation – a colostomy. The operation was a success and I continue to live a normal a life.*

*Admittedly, adjusting to life with a stoma has not been easy and there are challenges physically and psychologically. The latter has been a little more demanding, particularly as in my case "the shoe is on the other foot". I have been blessed to provide medical care and attention to others for five decades but over the past twelve months have instead been the recipient.*

*The ostomy bags and other related supplies have been extremely helpful and have assisted*

*me tremendously in living as a human being. The bags are generally very comfortable and convenient. Without the generous donation of these supplies my family and I would incur a huge financial cost in purchasing them at local pharmacies in PNG or acquiring them from relatives that reside in Australia. After undergoing a major operation the prospect of a financial burden on my family would be distressing psychologically. An issue I prefer to avoid at my advanced age.*

*The disability does not get the attention it requires in PNG with respect to Government funding and support in comparison to other diseases and disabilities. Cultural sensitivities do not help the cause. We can only hope that this will change in future. At this juncture I would like to point out that much commendation should be accorded to **Mrs Janet Yaki of the***

**Papua New Guinea Stoma Association** for her tireless and continuous efforts in running the organisation and providing the necessary support, training and after care for Ostomates. The fact that Janet herself is an Ostomate is also a great encouragement and positive example for others.

*Sincere appreciation cannot be adequately expressed to the donors, Ostomates of Australia and the **Gold Coast Ostomy Association**. Your donations have been extremely helpful, a relief financially and have had a positive impact on me since I became an Ostomate nine months ago.*

*Tanikiu raho herea iai bouge (Thank you very much to you all).*

**Dr Goasa Gomara Damena, MD**  
PORT MORESBY, PNG

## Keep Ostomy Bags and Wipes out of the Pipes!



**Just because something is flushable doesn't mean it will break down in wastewater systems. Technically, ostomy bags and wet wipes are flushable, but that doesn't mean they should go down the toilet.**

### The quick and dirty facts

- About 75% of all sewer blockages involve flushed wet wipes.
- One in four people in Sydney is flushing wet wipes.
- Sydney Water has removed more than 1,000 tonnes of wet wipe materials from its wastewater system in the past two years. If laid end-to-end, that's enough wet wipes to reach Los Angeles and back again.

(Info provided by Sydney Water)

### What are flushed wet wipes and ostomy bags doing to wastewater systems?

Flushed wet wipes and ostomy bags can block pipes, which can then lead to sewage overflows into homes or creeks. Should a flushed wet wipe reach the wastewater treatment

plant, it collects there into tangled and sodden balls in the system's screening process. If the wet wipes aren't removed there, then they may end up in our oceans and creeks. No one wants this!

Workers at Sydney Water's Malabar wastewater facility confirm the havoc being wreaked by these products, telling that they have to remove serious blockages caused by flushed wipes at least once every two weeks. Queensland Urban Utilities says responding to blockages now costs their organisation approximately \$2.5 million a year, with wet wipes largely to blame.

As can be expected, growing maintenance costs will soon start coming out of our own pockets in the form of higher water bills. Simply keeping wet wipes and ostomy bags out of the

wastewater system could prevent all of these problems and save water utilities - and, ultimately, the public - a significant amount of money.

**No matter what the packaging says, flushable wipes (and ostomy bags) are not flushable.**

**Only human waste and toilet paper should ever be flushed.**

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# Tips for Apprentice Urostomates from an Old Hand

Submitted by: Irvine Nicholson, SA

Before bladder cancer led to my stoma in 1997 I was a happy chap, freed from a demanding profession and enjoying with my wife, our retirement to the Queensland tropics. Shock, uncertainty, fear and clumsiness arrived with the diagnosis and the surgeon's skill. There followed fumbled changes of pouches, unexpected failures, periods of apparent success ("Now I've got it!") then yet more 'accidents'.

Could we travel? Could I continue with sports (my wife used to call me a "balloholio")? Yes, we could. Yes I did - and still do. Even with a now fifteen-year-old parastomal hernia of pineapple size.

At eighty-five I am now reduced to table tennis (of a fair standard) at an over-fifties table tennis club. Other hobbies keep me busy.

I haven't had an "accident" while away from home in years. Though very rarely I have had the tube come adrift from my overnight bag, giving me a rude awakening. I also once forgot to close the tap of the bag after its cleansing but the bedroom carpet didn't catch a drop.

Earlier skin irritations near the stoma are now years behind me, long gone. No skin problems, no failures and leaks (well, hardly any); just boring routine bag changes.

So what's my secret? Time, persistence, trial and error have led to a successful ROUTINE (which deserves its capitals).

**Dear apprentice, please form your own ROUTINE by adapting what follows to suit your personal situation. Mine evolved over a few years. Develop your own ROUTINE as soon as possible.**

## MY GEAR

Base-plates (15mm – 30mm) and their accompanying urostomy bags (i.e. two-piece system, and how lucky to eventually find a plate my stoma fits neatly without having to cut to size); a box of elastic adhesive tapes; cleanser wipes; bottled skin-conditioning cream (milky consistency), a tube of protective paste; a box of tissues; a good little magnifying mirror on a stand (mine is a circular, about 75mm diameter, on a horizontal swivel axis allowing accurate positioning for me to clearly see my stoma). Overnight drainage bags, a sturdy foil oven roasting dish and a rectangular plastic tray to hold that dish; plastic bags (I re-use supermarket vegetables and fruit bags) and sandwich bags. And my "Appliance Usage Recording Chart".

## MY ROUTINE

My routine is now tried, tested and fixed (apparently, so far). It also leads to extremely economical use of supplies from my association, which I collect every two months.



## THE METHODS:

Finicky? Obsessive?  
They work for me!

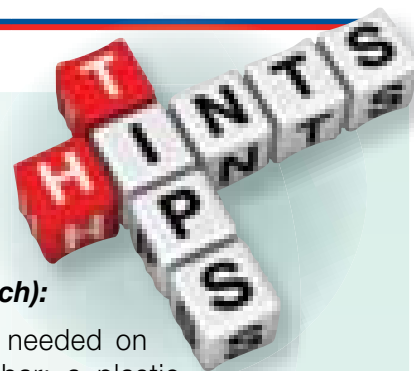
### Day 1 - Major change (i.e. base-plate and pouch):

1. I set out all the gear needed on the bathroom vanity bar: a plastic vegetable bag hung over my two vanity bar cupboard doors where they meet so that the bag is open and ready for the used gear; a tissue folded twice to quarter size; a mirror to make the stoma clearly visible; a bottle of cream (well shaken) and a tube of paste (to the left of my hand basin). To the right, a cleanser wipe already pulled part way out of its tear-open packet; a pile starting with the pouch, then two banana-shaped protective tapes and finally the base-plate on top.
2. Hoping, usually successfully, for no trickles or spurts outside the shower, empty the pouch into the toilet, then carefully peel the old base-plate, etc from the stoma area. I do it from top down with one hand, using my other hand to hold down the skin from which the base-plate is being removed. Sometimes a last moment "Ouch!" moment means that perhaps I should re-shave a bit down there. Then I wipe the now revealed area with toilet paper (more from former habit than necessity). Flush the toilet, turn towards the vanity bench and put the used plate/pouch into the old vegetable bag.

**Carefully** clean the area with adhesive-removing wipe and put the used wipe in the old vegetable bag.

Then it is into the shower. In her brief training session, my post-operation Stomal Therapy Nurse told me to "Treat your stoma as you do your bottom; wash it, dry it, cover it, forget it and get on with whatever." Shower as usual; first thoroughly lather and wash the area around the stoma, avoiding touching the stoma itself with your hands (it can bleed easily, though this is generally not worth worrying about; usually, so be careful).

I get wet under the shower, turn it off, then with liquid soap from a press-down tap bottle, I first wash the stoma area then the rest of me, lathering all over before rinsing off under the shower. The falling water shouldn't hurt the stoma (unless turned on very fast).



## HELPFUL TIPS

1. *Nothing to drink after 8.30pm the previous night to prevent untimely spurts at just the wrong moment and place before the new pouch is on (if any, and then hopefully in the shower).*
2. *The banana-shaped tapes each have two peel-off glue covering strips. Slightly peel each of these for quick access or face a fumbling delay later when you must get to that final "pouch on" relief.*

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### 3. Then begins the quickest, but most careful part:

Dry the stoma area thoroughly and carefully, avoiding the stoma itself, then I dry the rest. Pleased that I adjusted that mirror earlier to save time now, I put the base-plate under my armpit to warm up while I smear a tiny spot of the cream with my finger tip, just enough to dampen a centimetre wide band round the stoma (it is easy to get far too much from the bottle). Then I squeeze a thin circle (2mm to 3mm wide) of the paste **not quite touching the stoma**, all round it.

Using the mirror, as carefully as I can I place the base-plate so the stoma protrudes through the hole, but not touching the plate (you don't want to have to peel off a glued-on plate from the stoma itself ... what a thought!). Once in place I stroke the base-plate radially outwards using the fingers of both hands, one for each side of the plate. Twenty or thirty strokes each side are worth the valuable time to assure secure adhesion. Vitally, I then stroke with one finger round and round the stoma itself half a dozen times to seal that adhesion. **The secret of healthy skin is to prevent any contact with urine due to ill-fitting base-plates or leakage under the base-plate.**

Next, the extra safeguard of two protective sticky tapes to cover the base-plate edge and surrounding skin, one at each side of the plate, overlapping 3cm or 4cm below the stoma. Again each one is stroked a dozen or so times to press and firm it securely in place. I don't bother with a third tape to close the gap at the top.

Then the pouch is fitted to the base-plate ring and clip-locked. Another one done (of over a thousand I reckon since the operation). Very occasional inconvenient drips might cause the plate just being applied to have a doubtful seal; actual spurting before the pouch is on means a good clean up instead of a relieved realisation of success (do that later; first dry the skin and get that pouch on).

Finally with gentle pressure I cover the plate area with two overlapping hands and count to one-hundred to ensure maximum adhesion. Necessary? No leaks. The removed gear and tissues then all go into the old vegetable plastic bag and that into the landfill bin. Then I mark my Usage Chart.

### Day 4 - Minor changes (pouch only):

So easy! Into the bathroom, empty the pouch into the toilet, remove it, clean the plate area around the stoma with toilet paper, attach the new bag and clip-lock it. Then place the old pouch into a sandwich bag and put that into the landfill bin. Done (and don't forget to tick the Usage Chart again).

### Every Night - Overnight Bag:

My overnight bag comes with separate nozzles

to link it to the pouch. First I wet the bag's tube-end (with saliva) and work the nozzle on as far as possible. The other end of the new tube curves into the bag, so for about 100mm I straighten it by nipping and stretching the inside of the curve. Then, bit by bit, I stretch the rest of the full tube towards the nozzle end to reduce its curve (and lengthen it a bit?). Now it suits my bag layout.

The foil roasting dish just lies flat in my plastic tray. It is a basket type, flat-bottomed rectangular shape, so I cut down its too high sides to make it more of a tray which lies on the floor beside my bed. From it, the tube rests on the tray wall (shorter side) and goes onto the bed.

I then sit on the edge of the bed and firmly push the nozzle into the pouch outlet. I swing my legs onto the bed and lie on my back with the tube under my leg and the pouch straight between the legs. Once so linked I adjust the tube-bag link by rotating it a little, if needed, to ensure that the tube lies without any twist in it. I can now lie on my back or either side and can turn easily without the risk of straining the link tube and bag.

In the morning I take the night-bag and empty it in the toilet, lay it on the bathroom floor, squeeze a drop or two of washing-up liquid into the end of the tube (using a little nozzle from a discarded small plastic squeeze bottle which previously contained cosmetic cream). The end of the bag's tube is then held into the tap to start about half-filling the bag. Fortunately my tap has a grid and the tube nozzle 'jams' against a hole facilitating an easy fill. The very slightly foamed water is then poured down the hand basin plughole. Fold the 'empty' bag to bring the tap-end and tube-end together and gently squeeze from the fold to get any remaining foam and air out of the bag. Do remember to close the tap! I then use an old tube-end cover, like a pen cap, which nicely fits the open end of the tube for daytime storage in a drawer.

### Every Four Weeks:

A new overnight bag.

My ROUTINE works well for me. Simple, efficient and almost one-hundred-percent secure; even now. Hygienic? Yes, plus no skin problems, no worries, no smells; and good for the taxpayers. It is just a bit of a nuisance.

I hope these principles can be applied by and for you.

**"A change is as good as the best". ●**

#### HELPFUL TIPS

1. *Be sure to leave 2cm to 3cm of urine in the pouch (as it hangs vertically) to initiate the flow from pouch to bag.*
2. *When picking up the night-bag by its top, stop up the nozzle-end of its tube with a finger tip of the other hand or you might invent a new water pistol.*
3. *Nightshirts are better than pyjama or shorts, with less interference and free movement of the pouch, etc.*





# Are you worried about embarrassing pouch leaks?



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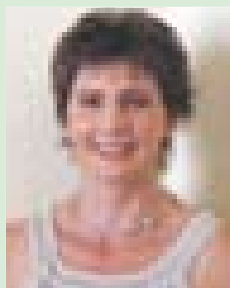


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1800 819 274**



# Nutrition for Ostomates

Submitted by: **Margaret Allan**, VIC



*Margaret Allan is a qualified Nutritionist. She advises both Ostomates and the general public on diet and health-related matters.*

*Margaret is based in country Victoria and is available for consultations by appointment.*

*She can be contacted via email at [margaret@foodfirst.com.au](mailto:margaret@foodfirst.com.au)*

## ***In this article Margaret discusses Zinc and its importance for optimal health in Ostomates, particularly during the winter months.***



**Zinc** is an essential mineral that plays an important role in all human living cells, as virtually every cell in the human body contains zinc and it is involved in more bodily functions than any other mineral. It is distributed across all body tissues and fluids and is considered one of the building blocks for cells.

Zinc is often overlooked and undervalued as a primary driver for health, and in the clinical setting a zinc deficiency is often under-recognised as a causative factor in many chronic signs and symptoms.

### *Some of the essential functions of zinc include:*

- Supporting the production of hydrochloric acid in the stomach to assist with digestion of food
- Metabolising carbohydrates and synthesising proteins, which are both important macronutrients for good health
- Manufacturing part of the haemoglobin molecule, which transports oxygen around the body
- Being involved in the production, storage and release of insulin which supports healthy blood sugar levels
- Influencing the health of the thyroid gland, which is involved in many functions in the body itself
- Assisting in growth and development throughout the lifespan
- Balancing mood, so there are less ups and downs throughout the day
- Helping to heal wounds such as cuts and grazes quickly and appropriately
- Supporting behaviour and learning
- Stabilising and strengthening cell membranes so cells can defend against damaging free radicals
- Helping the body to dispose of these harmful free radicals
- Synthesising the active form of Vitamin A, which is important for clear vision
- Assisting with sense perception, such as normal taste and smell
- Helping the body to detoxify alcohol
- Enhancing the production of white blood cells, which strengthens the immune system so it can defend against pathogens such as bacteria, viruses and fungi



As you can see, this is a very long list! Zinc is important for many functions in the body and supports good health in a multitude of ways.

Zinc deficiency is most prevalent in pregnant women, young children, the elderly and the poor, and I have to say it is the nutrient deficiency that I identify most frequently in my clinical practice. It is typically evident in all types of Ostomates as well.

### *Moderate indications of zinc deficiency include:*

- Loss of taste and smell, resulting in food appearing tasteless and consequently a desire for strong flavoured foods
- Loss of appetite, particularly in the elderly
- Physical and mental fatigue
- Poor wound healing
- Rough, dry skin
- A weakened immune system, resulting in increased incidence and severity of infections

### *Indications that a zinc deficiency is more chronic and severe include:*

- Hair loss
- Weight loss
- Chronic unexplained diarrhoea
- Problems with the eyes, such as poor vision, light sensitivity and dry eyes
- Poor healing of ulcers
- Mood imbalances such as depression and /or irritability
- Skin issues such as dermatitis
- Poor growth, especially in children
- Anaemia
- Joint pain

The best sources of zinc in the diet (more than 5mg per 100g of food) are red meats and offal such as beef, lamb and veal, as well as oysters which are particularly rich in zinc.



Healthy adults tend to consume approximately 5mg to 15mg of zinc per day via the diet, however less than half of this is absorbed in the gastrointestinal tract.

Unfortunately zinc absorption is influenced by many factors, and consuming enough in the diet does not always guarantee adequate zinc status. A calcium rich diet, for example, may lead to a zinc deficiency due to the two minerals competing for absorption in the intestinal tract.

Zinc deficiency can develop quickly when dietary intake is consistently low or impeded, over a matter of days or weeks depending on the age of the individual. Luckily, when the body is deficient in zinc, more is absorbed in the gastrointestinal tract and once zinc status is sufficient, less is absorbed. The human body is amazing in this way!

Zinc is available in plant foods as well as animal foods but the amount per gram of food is less, and degree of absorption is also reduced. For this reason vegetarians can also be at risk of zinc deficiency. Pumpkin seeds, sunflower and sesame seeds contain good amounts of zinc, but these must be consumed very carefully by ileostomates and Colostomates in particular because excess consumption may cause a blockage.

Zinc deficiency can alter the structure and optimal function of the intestinal tract, and a prime clinical focus for me when working with all my patients, whether Ostomate or non-Ostomate, is to support the function of the digestive system so that optimal health is maintained as much as possible. Zinc is absorbed in the small intestine, and as I stated earlier, even healthy individuals absorb less than half of the zinc ingested via the diet. Therefore, for those with intestinal issues such as small bowel resection as in the case of ileostomates, or residual intestinal inflammation from a disease process which may be the case for some Colostomates, then malabsorption of zinc can be an even greater concern.

Also of particular concern for ileostomates is the fact that chronic diarrhoea can lead to zinc deficiency, but zinc deficiency can also be a causative factor for chronic diarrhoea. Therefore assessment of zinc status in this group is of prime importance to prevent further nutrient loss. Some medications can also interfere with zinc absorption.

A low zinc status can also lead to immune system deficiencies, and consequently an increased risk of infections of all types, i.e. bacterial, viral or fungal. Therefore an adequate zinc status is important for Urostomates as well to defend against urinary tract infections. In the December 2015 article I touched on the role of vitamin D in enhancing the immune system's response to both bacterial and viral agents. Zinc

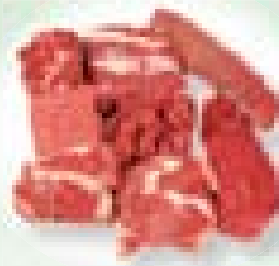
can now be added to the list of important nutrient for Urostomates in maintaining health.

As the winter months are approaching, strengthening the immune system to enable it to defend against winter ailments is critical. During this time everyone with a chronic illness that weakens the immune system is more vulnerable to colds and flu's etc. This certainly applies to the elderly in general and Ostomates in particular, with those falling into both groups of considerable concern. Even mild zinc deficiency can lead to reduced immune system functioning.

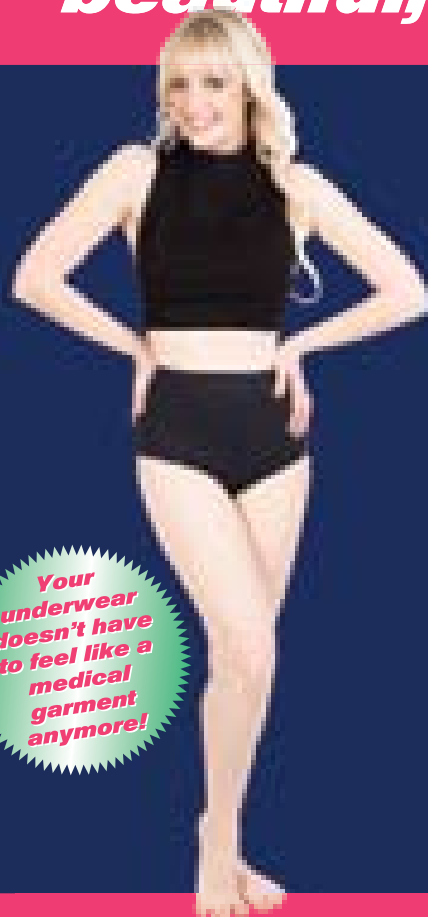
Therefore, given that zinc is found in highest quantities in foods of animal source, hearty winter soups, stews and casseroles made from red meats and/or offal are valuable additions to the diet during the colder months. Consuming oysters as much as possible can also be beneficial if the taste appeals.

Alternatively, if dietary intake is consistently inadequate and clinical signs and symptoms of zinc deficiency are evident in yourself or a loved one, and increasing dietary intake is not easy, then supplementation may be required. I can be of assistance in this regard by sourcing a zinc supplement that is appropriate for individual needs and circumstances. This can be a simple and relatively inexpensive method of gaining adequate zinc status and therefore fortifying the immune system so that optimal health is retained, especially during the winter months.

Wishing you good health and happy days, **Margaret.**



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# National Directory of Ostomy Support Groups

## NEW SOUTH WALES

### ALBURY/WODONGA BORDER DISTRICT

Meets: 10.00am on the second Tuesday of each month Feb to Dec.  
Venue: Hilltop Accommodation Centre,

600 Keene Street, East Albury NSW  
Contact: Alex Watson 0428 578 385

### BATHURST

Meet on the first Tuesday of March, June, September & December at Daffodil Cottage  
Contact: Louise Linke  
(02) 6330 5676

### BROKEN HILL

Meet: Every 3rd month or as required.  
Venue: Broken Hill Hospital Conference Room.  
Contact: Tarndra (08) 8080 1333

### CENTRAL COAST

Meet: 1.30pm to 3.30pm on the third Wednesday in Feb, May, Aug and Nov at a different venue each meeting. For further information, phone the Stomal Therapy Service on  
(02) 4320 3323

### COFFS HARBOUR

Meets 2:00pm to 3:30pm  
2016 meeting dates to be advised.  
Venue: Sawtell RSL Club, First Avenue, Sawtell.  
Ostomates & friends welcome.  
Contact Mandy Hawkins STN on  
(02) 6656 7804

### EUROBODALLA REGION

Meets first Sunday of Feb - Apr - Jun - Aug - Oct - Dec at 11am  
Venue: Laughter Room, Moruya Hospital.  
Phone: Betty (02) 4476 2746

### FAR NORTH COAST

Meet at Lismore Workers Club  
225 - 231 Keen St. Lismore.  
11.30am - 2.00pm  
1st Saturday March, July, December.  
Contact: Marie: (02) 6686 7248

### FAR SOUTH COAST

Bega & Surrounding Areas  
Meets second Sunday of Feb - Apr - Jun - Aug - Oct - Dec at 11.00am at a different venue each time. Flyers are sent to Ostomates 10 days beforehand.  
Inquiries:  
Eileen. Phone: (02) 6492 2530  
Geraldine. Phone: (02) 6492 2366

### GRAFTON & DISTRICT

Meets first Thursday of each month from 9.00am to 11.30am  
Contact: Anne: (02) 6641 8200

### GRIFFITH & DISTRICT

Griffith and the surrounding areas (100km radius including Leeton, Coleambally, Yenda, Hillston, Hanwood, Coleambally)  
Enquiries: Barry (02) 69635267 or 0429 635 267  
Email: ann.bar@bigpond.com  
Karan: 0434 785 309

### HASTINGS MACLEAY

Meet: The Old Hospital at 10am to 12noon on the third Wednesday in Feb - Apr - Jun - Aug - Oct - Dec.  
Inquiries: Neil 0427 856 630 or Jenny (02) 6586 0270

### ILLAWARRA

Meets: 10.00am to 12 noon.  
2016: Wednesdays 17 Feb - 13 Apr - 15 Jun - 17 Aug - 19 Oct -14 Dec.  
Venue: Education Room, Figtree Private Hospital, 1 Suttor Place, Figtree 2525.  
(Xmas luncheon venue to be advised)  
For further information contact Helen Richards CNC STN (Wollongong Private Hospital) on (02) 4225 5046 (Mondays only) or Julia Kittscha CNC STN (Wollongong Hospital) on 0414 421 021

### MANNING/GREAT LAKES

Meet: 10.00 am to 12 noon on first Wednesday in Feb - Apr - Jun - Aug - Oct - Dec.  
Venue: Skills for Life Building, 5-9 Elizabeth Ave. Taree NSW (wheelchair accessible)  
Website: www.mglostomy.co.cc  
Contact: Karla MacTaggart on  
(02) 6592 9469

### NEWCASTLE DISTRICT

Meet at 1.30pm on last Saturday in Feb - May - Aug (AGM) - Nov.  
Venue: Hamilton Wesley Fellowship Hall, 150 Beaumont St. Hamilton.  
Enquiries: Geoff (02) 4981 1799 or Eleanor (02) 4997 5141 or Maree (02) 4971 4351

### ORANGE & DISTRICT

Meet: Mar - June - Sept - Dec From 12 noon.  
Venue: 15 Oliver St, Orange. NSW  
Contacts: Louise: (02) 6330 5676 and Joanne: (02) 6362 6184

### SHOALHAVEN

Meet: 2.00pm. 2016 meeting dates to be advised.  
Venue: Nowra Community Health Centre, 5-7 Lawrence Ave, Nowra.  
Contact: Margaret or Tracey on  
(02) 4424 6300

### SYDNEY - LIVERPOOL / CAMPBELLTOWN AREA

Meets Thursdays from 1.00pm to 3.00pm in the Heritage Auditorium at Camden Hospital (Menangle Road, Camden).  
2016 meeting dates to be advised.  
For further information, please contact: Diane or Lu (STNs) on  
(02) 8738 4308

### SYDNEY - PENRITH AREA

Meets: 2.00pm. 2016 meeting dates to be advised.  
Venue: Learning and Development Centre at Nepean Hospital, located behind the multistorey car park in Somerset Street. Entrance via the rear side door.  
Enquiries: Naomi Houston (Stomal Therapist) (02) 4734 1245

### SYDNEY - NORTHERN AREA

Meet: First Wed. 10.00am - 11.30am monthly in the Jacaranda Lodge, Sydney Adventist Hospital, 185 Fox Valley Rd. Wahroonga.  
Contact: San Cancer Support Centre  
(02) 9487 9061

### TWEED

Meets: third Tuesday of March, June, September and December from 12 to 2pm.  
Venue: South Tweed Sports Club.  
Contact: Jane Bright on 0409 671 162

### WAGGA & DISTRICT

Meets: first Wednesday of each month from 10:00am to 11:00am.  
Venue: The Men's Shed, 11 Ashmont Ave, Wagga Wagga  
Enquiries: David (02) 6971 3346 or 0428 116 084  
Baz (02) 6922 4132

## VICTORIA

### BAIRNSDALE & DISTRICT

Available for people to talk to and for home visits in the local area.  
Contacts: Janine: 0418 854 562  
Derelle: 0448 458 997  
Email: bdosg@hotmail.com

### BENALLA / WANGARATTA

Meets 2.00pm on the third Monday of each second month.  
Venues: Wangaratta Masonic Centre, 99 Appin St. Wangaratta in Apr - Aug - Dec and Benalla Masonic Centre, Cnr Benalla St. & Walker St, Benalla in Feb - Jun - Oct.  
Contact: Rex Nankervis  
(03) 5762 2080  
Email: rexmarn@bigpond.com

### MILDURA

Meet: Every third month  
Venue: Mildura Base Hospital Conference Room  
Contact: Tarndra (03) 5022 3333 or Norma 0409 252 545

### MOUNT WAVERLEY

Our support/social group meets bi-monthly on the fourth Wednesday; alternately at Mount Waverley Youth Centre or at a local restaurant for a luncheon.  
Contact: Ron Butler on 0403 163 327 or crocote@gmail.com

### NORTHERN

A Melbourne based Support Group with a welcome to all with a stoma.  
Venue: Darebin RSL Function Room, Preston.  
Contacts: Peter: (03) 9460 1125 and Krys: (03) 9431 2779  
STN Email enquiry: genevieve.cahir@nh.org.au

### SOUTH GIPPSLAND

Socials held on the first Tuesday of each month at 2:00 pm. Please contact Thea on (03) 5655 2628 for more information.

### SUNRAYSIA / RIVERLAND

Venue: Sunraysia Cancer Centre  
Enquiries: Norma Murphy  
0409 252 545

### WARRNAMBOOL & DISTRICT

Meets at 10.30am on the second Friday of the month in Feb - Apr - Jun - Aug - Oct - Dec.  
Venue: The Seminar Room, SWHC Community Centre, Koroit Street, Warrnambool  
Contacts: Heather on (03) 5561 1159 or Terry on (03) 5562 5093  
Warrnambool Ostomy rooms (Fridays) 5563 1446

## WESTERN AUSTRALIA

### ALBANY

Meets in the Albany District Hospital Conference Room at 9.30 -11.00am on the third Friday every three months.  
For details: Terry: (08) 98474701

### GERALDTON

Meets: 2.30pm last Saturday every second month.  
Venue: Bluff Point CWA Rooms  
Contact: Dawn Hall: (08) 9921 8533

### MANDURAH / ROCKINGHAM

Meet third Friday of each second month from Jan.  
Meetings are held at different locations each time normally over a barbecue lunch.  
Visitors welcome.  
Contact: Bethwyn: 0439 927 491

### PERTH (WAOA)

Venue: 19 Guildford Road, Mt Lawley  
Weekends: third Saturday of every month 11-1 pm.  
General: fourth Tuesday of every month 2-4pm.  
New Members: second Tuesday of every month 2-4pm.

## QUEENSLAND

### BEENLEIGH

Meets 10am - 12noon on last Monday of the month from Feb to Nov at Beenleigh Community Health Centre,  
10 -18 Mt. Warren Blvd. Mount Warren Park QLD.  
Contact: Pat Miers (07) 3827 9811

### BRISBANE

Operated in the Greater Brisbane Area by Qld Stoma Association and Qld Ostomy Association.  
Phone: (07) 3359 6500  
Website: qldstoma.asn.au/bosvs.htm  
Operating hours: 7 days, 8am to 8pm

### GOLD COAST

Supporting Ostomates Needs Group. Meet every three months at various venues.  
Private and Confidential,  
C/- PO Box 703, Labrador, QLD 4215  
Phone: 0429 126 163  
Email: gcsong@live.com.au  
Facebook: www.facebook.com/goldcoastostomysupport

## LOGAN

Meets 10am - 12noon on third Monday of each month at Logan Central Community Health Centre Corner Wembly & Ewing Roads  
Contact: Pat Miers (07) 3827 9811

## MACKAY

Meets at 2.00 pm on the fourth Friday of every odd-numbered month (Jan - Mar - May - Jul - Sep - Nov).  
Venue: Gordon White Library on Phillip Street, Mt Pleasant.  
Contact: Graham Stabler for further information on 0428 776 258 or email  
grahamstabler@bigpond.com

## REDCLIFFE

Meets first Tuesday each month at 10.00am in the Shillam Room, Redcliffe Cultural Centre - off car park Irene Street, Redcliffe.  
Enquiries: Dorothy Douglas (07) 5495 1335

## ROCKHAMPTON

Meet: 1.30pm third Saturday, Feb - May - Aug - Nov.  
Venue: Community Health Centre, Bolsover St. Rockhampton  
Contact: Frank & Marge Noy  
Phone: (07) 4921 0728

## SOUTH BURNETT

Meet second Tue. each month at 10am.  
Venue: Nanango Community Health Centre, Brisbane St. Nanango. QLD  
Contact: Anne Davoren  
Phone: (07) 4171 6750

## SUNSHINE COAST

Meets at the Small Meeting Room, Library Support Building, Cotton Tree, Maroochydore on the second Monday of every month from February 2016, commencing at 10am.  
Enquiries:  
Winifred Preston (07) 5476 6313 or presto1849@hotmail.com  
Evan Fuller (07) 5447 7158 or eful@bigpond.com  
Laurie Grimwade (07) 54459008 or sid.and.laurie@gmail.com

## WIDE BAY

Meets from 1.00pm to 3.00pm on the third Thursday each month at Wide Bay Ostomates, 88a Crofton Street, Bundaberg West.  
For information please contact Heather James: 0406 472 486 or leave a message on (07) 4152 4715

## TASMANIA

"SEMI COLONS" - a support group for men and women impacted by Colorectal cancer. Meets in Hobart on the third Thursday of every month, from 2.00pm to 3.30pm.  
Enquiries: Cynthia Taafe, Senior Officer Support Services, Cancer Council Tasmania on (03) 6212 5715

## NORTH & NORTH-WEST

**North:** Meets 10.00 am on the first Monday of Mar - Jun - Sep - Dec at the Cancer Support Centre, 69 Howick Street, Launceston.

**North-West:** Meets 10.00 am on the

second Monday of Mar - Jun - Sep - Dec at the Ulverstone Senior Citizens Club, 16 Edwards Street.  
Contact: Adrian Kok  
(03) 6326 4664

## SOUTH AUSTRALIA

### CENTRAL

Meet: Third Tuesday of Jan, March, May, July, Sept, Nov.  
When: 2pm.  
Where: Ileostomy Assoc Centre, 73 Roebuck St, Mile End.  
Information: Val: (08) 8381 1646

### FLEURIEU

2016 meeting dates to be advised.  
Meet: 10.00am until 12 noon at the Flinders Rural School, Bay Road, Victor Harbor.  
Please contact Sue McKay STN for further information on 0412 692 418

### SOUTHERN

Meet: First Wednesday of Feb, April, June, Aug, Oct, Dec.  
When: 2pm.  
Where: Elizabeth House, 112 Elizabeth Rd, Christie Downs.  
Information: Val: (08) 8381 1646

## NORTHERN TERRITORY

### DARWIN

Meet: 5.00-6.00pm on the first Tuesday of every month.  
Where: Cancer Council NT, 2/25 Vanderlin Drive, Wanguri NT 0810  
Contact: Marg Lavery:  
(08) 8944 1800

### YOUTH GROUP

Doris Steyer,  
Telephone: (02) 4296 5354

### YOUNG OSTOMATES UNITED (YOU)

Tel: Helen (03) 9796 6623  
Web: www.youinc.org.au  
Email: helshae@hotmail.com  
Facebook:  
Young Ostomates United

### BOWEL GROUP FOR KIDS INC

Tel: (02) 4659 6067 or 0431 857 188  
Email: enquiries@bgk.org.au  
Web: www.bgk.org.au

### PARENTERAL NUTRITION DOWN UNDER

Secretary on (02) 9987 1978  
Email: contactpndu@gmail.com  
Web: www.parenteral-nutrition-down-under.webs.com

### MITROFANOFF SUPPORT AUSTRALIA

PO Box 256, South Melbourne, Victoria 3205  
Email: info@mitrofanoffaustralia.org.au  
Web: www.MitrofanoffAustralia.org.au

## Stoma Appliance Scheme Product Suppliers



### AinsCorp

PO Box 572, Niddrie, Victoria 3042  
Toll Free Number: 1300 784 737  
Email: service@ainscorp.com.au  
Website: www.ainscorp.com.au



### Dansac

PO Box 575, Port Melbourne, Victoria 3207  
Phone: 1800 331 766  
Email: customerservice@dansac.com.au  
Website: www.dansac.com.au



### Coloplast

PO Box 240 Mt Waverley Vic 3149  
Freecall: 1800 653 317  
Email: au.care@coloplast.com  
Website: www.coloplast.com.au



### ConvaTec

PO Box 63, Mulgrave, Victoria 3170  
Freecall: 1800 335 276  
Email: connection.au@convatec.com  
Website: www.convatec.com.au



### Future Environmental Services

PO Box 319, Blairgowrie, Victoria 3942  
Phone: +61 3 5985 2828  
Email: health@futenv.com.au  
Website: www.futenv.com.au



### Hollister

PO Box 599, Port Melbourne, Victoria 3207  
Freecall: 1800 335 911  
Email: customerservice@hollister.com.au  
Website: www.hollister.com.au/anz/



### Nice Pak Products

Free call: 1800 506 750  
Email: healthcare@nicepak.com.au  
Web: www.nicepak.com.au



### Omnigon Pty Ltd

PO Box 171, Moonee Ponds, Victoria 3039  
Freecall: 1800 819 274  
Email: info@omnigon.com.au  
Website: www.omnigon.com.au



### 3M Australia

Locked Bag 19, North Ryde NSW 1670  
Phone: 136 136  
Website: www.3m.com.au



### Statina Healthcare Australia

3/30 Leighton Place, Hornsby, NSW 2077  
Toll Free Number: 1300 365 404  
Email: sales@statina.com.au  
Website: www.statina.com.au

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