
Antelope Valley Ostomy News

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Local News...~ by Ann Wright, RN,
CWOCN, CNS, Editor Lancaster News

Spring greetings to all! I hope you all are well and have been enjoying our lovely spring flowers! (Not the pollen, though!)

It is time again for our AV Ostomy Support Group meeting. We have been having a good turn-out, and I encourage you to come and meet some of our new participants.

The May meeting will be **Sunday May 18th, 2008 at 2:00 PM**. We'll meet in the conference room at AV Home Care. Directions are on the last page of the letter.

Thank you all again for your donations and prayers toward planning for my mission trip to Africa in July. Plans for purchasing medical supplies are being prepared, and I hope that my meeting time I'll have a report for you of our progress. It takes a lot of planning to take a team across the world! Due my absence in July, **we will not have a support group meeting in July.**

However, we will have a meeting in August. Then we will be back on schedule with our regular scheduled meetings every other month. Stay tuned for further details!

Later in the year Tami Host will join us again. Tami is from Coloplast and will bring samples and any new items from the company.

See you all May 18th!!

STOMAL COMPLICATIONS~ From: North Texas Ostomy News Via: Sherman Area Ostomy Assoc.

Many pathological conditions can necessitate the need for some type of bowel or urinary diversion known as an ostomy. For the most part, ostomies are well managed by the patient, and/or caregiver. Sometimes complications can occur. **Necrosis**— A dark, black stoma due to inadequate blood supply. This can be caused by excessive tension on the mesentery, too thick of an abdominal wall for the intestines to pass through, too tight a suture line, or interruption of blood flow.

(Note: The **mesentery** is tissue that lines the intestine and anchors the bowel to the abdominal wall. The mesentery contains blood vessels and nerve fibers that nourish and innervate the intestine.) Management of stomal necrosis is based on the extent of necrosis. If it is below the fascia level, it often requires stoma reconstruction.

Detachment — The stoma separates completely from the adjoining skin. This is caused by too much tension on the mesentery and requires surgical revision.

Recession/Retraction — Sinking of the stoma below the skin level. This can be caused by scar formation secondary to mucocutaneous separation, necrosis, peristomal skin problems, weight gain, radiation, recurrent malignancies, or excessive tension on the suture line. This can be medically managed with a modified pouching system. Severe cases may require stoma revision.

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Stenosis/Strictures - Extreme narrowing of the stoma that can threaten the normal function of stool evacuation. Multiple causes can include inadequate suturing at the fascia level, mucocutaneous separation, edema, and disease conditions which may cause scar formation that compress the stoma causing ribbon-like stool or obstruction. (More about stomal stenosis follows.)

Prolapse — Telescoping of the bowel out through the stoma. Poor abdominal wall support and increased abdominal pressure from coughing, sneezing, laughing, or tumor formation are common risk factors. Conservative management of a prolapse includes reduction of protrusion by gentle pressure, cool wash cloth and even sugar (acts as an osmotic diuretic) on the stoma, then applying a binder or prolapse belt. In some cases, prolapse is medically managed if the patient is considered a surgical risk.

Hernia — Protrusion of the bowel into the subcutaneous tissue around the stoma. This is characterized by a bulge in the abdominal wall or tension on the abdominal wall or on the abdominal muscle. This is medically managed by wearing a binder and/or modified pouching system. If herniation leads to a blockage, surgical intervention is required. To aid in prevention of a hernia, wear a binder especially when lifting heavy objects, or guarding the stoma with a hand pillow when coughing or laughing.

Obstruction — Blockage of a stoma from recurrent disease process, or twisting-kinking of a loop of bowel in the abdomen. Surgical intervention is required.

Impaction — (In colostomates). Stoma clogged by hard stool requiring stool softening with enema or a small amount of

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oil prior to stoma irrigation. Impaction may be prevented by drinking 8 to 10 glasses of fluid per day, attention to diet and regular use of stool softeners.

MORE ABOUT STOMAL STENOSIS~ *By Jane Ellen Barr, RN, CWOCN, Ostomy Wound Management Sept. 2004. Edited by Ann Wright, RN, CWOCN, CNS*

Stenosis is the narrowing of the lumen (opening) of the stoma, and can occur at either the fascial (covering under the skin) or the cutaneous (skin) level. Extreme narrowing may threaten normal stomal function, impairing the output of the effluent.

Stenosis results from stoma construction techniques, excessive scar formation, prior irradiation to bowel segment, peristomal sepsis, or externally from trauma resulting from an ill-fitting pouching system. Poor stomal construction can result from inadequate suturing of the fascial layer or inadequate excision of the skin with an insufficient opening through which to bring the stoma. Excessive scar formation results from mucocutaneous separation healing by secondary intention, necrotic stoma, retraction, repeated dilation of stoma, or frequent or continuous peristomal complications.

Stoma stenosis presents on digital examination as a small lumen at the skin or fascial level. The stenosed stoma may appear normal or the opening may appear small. If stenosis is at the skin level, narrowing of the stomal lumen or narrowing of the skin around the stoma may be visible. The patient may have narrow or "ribbon like" stools, pain at the time of stoma emptying, and excessive, explosive, high-pitched gas. The patient with a fecal stoma may complain of constipation followed by a large volume of output. With stenosis at the fascial level, the stoma may be normal in appearance but the patient may present with symptoms of partial

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obstruction. The patient may have narrow stools, high-pitched gas, or in the urostomy, projectile urinary stream and flank pain.

Stenosis management depends on its level of severity. When stenosis is mild with minimal signs and symptoms, a low residue diet, stool softeners, and adequate hydration may facilitate the movement of soft stool through the bowel lumen. If the patient presents with signs and symptoms of partial stomal obstruction, a digital exam will determine severity. If noted at the fascial level, stenosis often may be managed with gentle dilatation. Dilators may be used or the certified ostomy nurse may perform gentle dilatation. The smallest gloved finger is lubricated and gently inserting into the stoma until the fascial opening is reached. The clinician slides the finger through the fascial opening, holds for 10 seconds without any twisting motion, removes the finger, and repeats the procedure. Gradually, the finger size is increased to achieve an adequate opening. This procedure is repeated for several sessions if indicated. Dilation is considered a controversial management technique because chronic dilations have been reported to cause further stoma stenosis. If stenosis is severe, surgical revision is required.

LEAK PRODUCERS & PREVENTERS ~

Via: Southern Maryland Counties Chapter

Abruptly sitting up straight from a flat-on-your-back position can pop your pouch loose. So can bending over to clean out the bathtub, or picking up something off the floor, or stretching high to reach something. Learn to get in and out of bed on your side. Get in bed by sitting far onto the bed and going down on your elbow while holding the mattress with the other hand, and swing your legs up. To get up, roll over on your side and use your elbow to push up, while holding the mattress with the other hand and swing your legs sideways

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off the bed. Get a clamp-type reacher for reaching down and a stool for reaching high shelves. Learn to lift and carry on the side of your leg, carry things high, or drag it, or get someone to help. Ostomates get hernias easier than anyone else.

OSTOMY HINTS~ *Via: New Directions, Ft. Worth, TX Area Chapter*

Be sure to re-order supplies before they get too low. Your supplier may be out of your particular brand and will need time to notify the company. When you travel and fear that you may have an accident during the night, buy the small pads in the baby department and take them with you to place them under you when you sleep. If you have a leak, no one will be the wiser.

WHAT IS IRON AND WHY DO WE NEED IT?

~ Source: USDA/HHS Dietary Guidelines for Americans, 2005, NIH

Iron is a mineral needed by our bodies. Iron is a part of all cells and does many things in our bodies. For example, iron (as part of the protein hemoglobin) carries oxygen from our lungs throughout our bodies. Having too little hemoglobin is called anemia. Iron also helps our muscles store and use oxygen. Iron is a part of many enzymes and is used in many cell functions. Enzymes help our bodies digest foods and also help with many other important reactions that occur within our bodies. When our bodies don't have enough iron, many parts of our bodies are affected.

What is iron deficiency and why is it a concern?

Iron deficiency is a condition resulting from too little iron in the body. Iron deficiency is the most common nutritional deficiency and the leading cause of anemia in the United States.

The terms anemia, iron deficiency, and iron deficiency anemia often are used interchangeably but equivalent. Iron deficiency ranges from depleted iron stores without functional or health impairment to iron deficiency with anemia, which affects the functioning of several organ systems. Iron deficiency is a concern because:

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- Iron deficiency can delay normal infant motor function (normal activity and movement) or mental function (normal thinking and processing skills).
- Iron deficiency anemia during pregnancy can increase risk for small or early (preterm) babies. Small or early babies are more likely to have health problems or die in the first year of life than infants who are born full term and are not small.
- Iron deficiency can cause fatigue that impairs the ability to do physical work in adults. Iron deficiency may also affect memory or other mental function in teens.

What causes iron deficiency?

Iron deficiency has many causes. These causes fall into two main categories:

1. Increased iron needs

Many common conditions can cause people to need additional iron:

- Because of their rapid growth, infants and toddlers need more iron than older children. Sometimes it can be hard for them to get enough iron from their normal diet.
- Women who are pregnant have higher iron needs. To get enough, most women must take an iron supplement as recommended by their healthcare provider.
- When people lose blood, they also lose iron. They need extra iron to replace what they have lost. Increased blood loss can occur with heavy menstrual periods, frequent blood donation, as well as with some stomach and intestinal conditions (food sensitivity, hookworms)

2. Decreased iron intake or absorption (not enough iron taken into the body) .The amount of iron absorbed from the diet depends on many factors:

- Iron from meat, poultry, and fish (i.e., heme iron) is absorbed two to three

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times more efficiently than iron from plants (i.e., non-heme iron).

- The amount of iron absorbed from plant foods (non-heme iron) depends on the other types of foods eaten at the same meal.
- Foods containing heme iron (meat, poultry, and fish) enhance iron absorption from foods that contain non-heme iron (e.g., fortified cereals, some beans, and spinach).
- Foods containing vitamin C (see Dietary Sources of vitamin C) also enhance non-heme iron absorption when eaten at the same meal.
- Substances (such as polyphenols, phytates, or calcium) that are part of some foods or drinks such as tea, coffee, whole grains, legumes and milk or dairy products can decrease the amount of non-heme iron absorbed at a meal. Calcium can also decrease the amount heme-iron absorbed at a meal. However, for healthy individuals who consume a varied diet that conforms to the Dietary Guidelines for Americans, the amount of iron inhibition from these substances is usually not of concern.
- Vegetarian diets are low in heme iron, but careful meal planning can help increase the amount of iron absorbed.
- Some other factors (such as taking antacids beyond the recommended dose or medicine used to treat peptic ulcer disease and acid reflux) can reduce the amount of acid in the stomach and the iron absorbed and cause iron deficiency.

How much iron do I need?

If you have already been diagnosed with iron deficiency, talk to your doctor or healthcare provider about treatment. For healthy individuals, the Recommended Dietary Allowance (RDA) for iron is listed in the following table.

Recommended Dietary Allowance (RDA) for

iron by age and sex.

| Age/Group | Life Stage | Iron (mg/day) |
|-----------------|-------------|---------------|
| Infants | 0–6 months | 0.27* |
| | 7–12 months | 11 |
| Children | 1–3 years | 7 |
| | 4–8 years | 10 |
| Males | 9–13 years | 8 |
| | 14–18 years | 11 |
| | 19–30 years | 8 |
| | 31–50 years | 8 |
| | 51–70 years | 8 |
| | >70 years | 8 |
| Females | 9–13 years | 8 |
| | 14–18 years | 15 |
| | 19–30 years | 18 |
| | 31–50 years | 18 |
| | 51–70 years | 8 |
| | >70 years | 8 |
| Pregnant Women | 14–18 years | 27 |
| | 19–30 years | 27 |
| | 31–50 years | 27 |
| Lactating Women | 14–18 years | 10 |
| | 19–30 years | 9 |
| | 31–50 years | 9 |

Dietary Sources of Iron

Food Sources of Iron ranked by milligrams of iron per standard amount; also calories in the standard amount. (All amounts listed provide 10% or more of the Recommended Dietary Allowance (RDA) for teenage and adult females, which is 18 mg/day.)

| Food, Standard Amount | Iron (mg) | Calories |
|---|-------------|------------|
| Clams, canned, drained, 3 oz | 23.8 | 126 |
| *Fortified dry cereals (various), about 1 oz | 1.8 to 21.1 | 54 to 127 |
| Cooked oysters, cooked, 3 oz | 10.2 | 116 |
| Organ meats (liver, giblets), cooked, 3 oz ^a | 5.2 to 9.9 | 134 to 235 |
| *Fortified instant cooked | 4.9 to | Varies |

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| | | Varies |
|---|-----|--------|
| *Soybeans, mature, cooked, ½ cup | 4.4 | 149 |
| *Pumpkin and squash seed kernels, roasted, 1 oz | 4.2 | 148 |
| *White beans, canned, ½ cup | 3.9 | 153 |
| *Blackstrap molasses, 1 Tbsp | 3.5 | 47 |
| *Lentils, cooked, ½ cup | 3.3 | 115 |
| *Spinach, cooked from fresh, ½ cup | 3.2 | 21 |
| Beef, chuck, blade roast, cooked, 3 oz | 3.1 | 215 |
| Beef, bottom round, cooked, 3 oz | 2.8 | 182 |
| *Kidney beans, cooked, ½ cup | 2.6 | 112 |
| Sardines, canned in oil, drained, 3 oz | 2.5 | 177 |
| Beef, rib, cooked, 3 oz | 2.4 | 195 |
| *Chickpeas, cooked, ½ cup | 2.4 | 134 |
| Duck, meat only, roasted, 3 oz | 2.3 | 171 |
| Lamb, shoulder, cooked, 3 oz | 2.3 | 237 |
| *Prune juice, ¾ cup | 2.3 | 136 |
| Shrimp, canned, 3 oz | 2.3 | 102 |
| *Cowpeas, cooked, ½ cup | 2.2 | 100 |
| Ground beef, 15% fat, cooked, 3 oz | 2.2 | 212 |
| *Tomato puree, ½ cup | 2.2 | 48 |
| *Lima beans, cooked, ½ cup | 2.2 | 108 |
| *Soybeans, green, cooked, ½ cup | 2.2 | 127 |
| *Navy beans, cooked, ½ cup | 2.1 | 127 |
| *Refried beans, ½ cup | 2.1 | 118 |
| Beef, top sirloin, cooked, 3 oz | 2.0 | 156 |
| *Tomato paste, ¼ cup | 2.0 | 54 |