PRESIDENT - Sam Wilson
478-477-8337
PROGRAMS - Mary Leonard
478-745-3866

Next Meeting

Our next support group meeting is **Sunday, January 22, 3:00 p.m.,** at the **Coliseum Medical Center** in Macon off of Coliseum Drive. The entrance is at 350 Hospital Drive which is up the hill from the entrance to the Macon Coliseum.

INSIDE

THE OSTOMY RUMBLE

PUBLICATION OF THE OSTOMY SUPPORT GROUP OF MIDDLE GEORGIA

Happy New Year wishes to and from our group. We seldom discuss the reality that we have improved the lives of hundreds of ostomates through our activities. We want to keep doing this. This Sunday we would like to take suggestions to improve the way we function in the present somewhat restrictive environment. We need more people to support and more input and referrals from the medical community. The operative question is "How?". We would also appreciate knowing of speakers our members have heard who might be of interest to our group. Please bring your ideas. This is your group. It needs you !

OUR MEETINGS

All meetings of the Ostomy Support Group are open to everyone with an interest in ostomy care: ostomates, their spouses, families, and friends. We meet regularly on the fourth Sunday of the month, except November and December. On the first Saturday in December we have a Christmas Party. The meetings start at 3:00 p.m., except for special occasions when the time will be announced.

MORAL SUPPORT	**SHARING**	**INFORMATION**
FREE PARKING	**FELLOWSHIP**	**MUTUAL AID**

OUR MISSION

We are a volunteer charitable group affiliated with the UNITED OSTOMY ASSOCIATIONS OF AMERICA (UOAA), which is a national organization composed of numerous support groups similar to ours. We maintain a visitor program in which we visit with persons and their families, at their request, to discuss life with an ostomy and address the many concerns they may have. All of our visitors have ostomies and have been through this change in lifestyle quite successfully with pleasant, happy, and thankful attitudes. An ostomy can be a very good substitute for natural human plumbing and is certainly preferable to continued catastrophic illness.

Next Support Group meeting on 22 January 3:00 P.M.

O S G M G . O R G

SOME OSTOMY HISTORY

Have you ever been asked when ostomy operations were first performed? Have you ever wondered how long they have been around? Here are some interesting facts brought to us by the Austin, Texas, ostomy group.

Colostomy: In the early 18th Century, a French surgeon, Alexis Litre, recorded a suggestion for a colostomy after an infant patient died of an imperforate anus. During 1750-1770, an English surgeon and a French surgeon recorded various surgeries done to correct bowel obstructions. There is an account of an iliac colostomy constructed on an infant in France in 1793. The surgery was successful and the patient lived forty-five years. Records tell of a lumbar colostomy placed on a patient's side in 1839. Dr. Miles of England was the first surgeon to combine abdomino-perineal resection of the rectum and end colostomy in 1908. Years passed before a Dr. Paley opened the colostomy and sewed it to the skin to avoid retraction of the stoma. Since that time much progress has been made by the surgeons as to the location and size of stomas which in turn resulted in appliances which are more comfortable and secure.

Ileostomy: It was more than a hundred years after colostomy surgery was performed that several English doctors operated to remove obstructions of the small bowel. In 1913, Dr. J.Y. Brown was the first physician in America to do an end ileostomy. His technique was used for many years. In 1951, Dr. Frank Lahey placed the ileostomy stoma on the right side instead of the midline incision. Dr. Rupert Turnbull improved the process with the construction of a longer stoma which helped reduce the dysfuction problem.

Urinary Diversion: The oldest form of urinary diversion, used for hundreds of years, was the insertion of a catheter into the bladder through an incision in the lower abdominal wall. Infections and stone formations were big problems because the body rejected the catheter since it was a foreign object. A tube directly into a kidney was another procedure used. In 1940, to prevent urine flow onto the abdominal skin, the surgeons connected the ureters to the colon. These operations were called ureterosigmoid ostomies. In 1950, Dr. E.M. Bricker devised the ileal conduit. This successful procedure reduced or eliminated many post-operative complications previously associated with urinary diversions.

Adhesions and Other Pains

Forward By *ReRoute,* Evansville, IN

An ileostomate may sometimes suffer from pain that can't be traced to blockage and may be told that adhesions are responsible; the actual cause may instead be a spasm. Adhesions are tough, string-like fibrous bands, often in the small intestine. They may form spontaneously but are more common after surgery, where disturbances caused by tissue manipulation may lead to healing in the form of fibrous tissue ... hence adhesions.

Some people form them more easily than others. Adhesions may grow to interfere with the normal motion of the intestine causing a blockage or obstruction with food, liquid or even air unable to pass the blocked area. Severe bloating, abdominal pain, vomiting and constipation are symptoms of blockage and present a serious situation requiring medical attention and possible immediate surgery to cut the obstructive adhesive bands.

Abdominal pain, though, doesn't always mean adhesions are blocking the intestines. A frequent cause for such pain is a spasm of muscles responsible for peristalsis—the rhythmic muscular contractions that propel the bolus through the intestines. Muscle spasms in the calf are referred to as a "charley horse"; spasms in the intestines are essentially the same thing but assume the name "irritable intestine" or "irritable bowel".

Even ostomates who function without colons are not immune from painful intestinal spasms—in the small intestine.

Stress and Intestinal Gas

Edited by Bobbie Brewer, UOAA UP-DATE

Stress is the cause of one of the most common gastrointestinal complaints. Flatulence occurs in people during stressful situations. When people are under stress, breathing is deeper and one sighs more, encouraging a greater than normal intake of air. Dr. Richter, a gastroenterologist at Massachusetts General Hospital, states that the average person belches about 14 times a day (*GI Series Newsletter*, Vol. 1, No. 4). The person with a flatulence problem does not belch more often. However, they may experience the sensation of needing to belch and get little relief from doing so. Here are some ways to relieve gas:

Avoid heavy, fatty meals, especially during stressful situations.

Reduce the quantity of food consumed at one sitting. Eat small low-fat meals about every three hours.

Avoid drinking beverages out of cans or bottles. Avoid drinking through a straw.

Avoid foods and beverages you personally cannot tolerate.

Avoid any practice that causes intake of air, such as chewing gum, smoking and blended foods that contain a lot of air.

Drink at least 8 glasses of water a day.

With the advice of your doctor and/or WOC Nurse (ostomy nurse), experiment with foods in your diet to achieve adequate bowel regularity.

Avoid eating too many fiber foods in one meal. Gradually add fiber foods in your diet to prevent excessive intestinal gas.

Avoid skipping meals. An empty bowel encourages small and gassy stool. Poor digestion can often exaggerate the symptoms associated with flatulence. Digestion enzymes aid in food assimilation and chemical digestion. Enzyme supplements should always be taken immediately before or after eating. Food coats the stomach and helps prevent gastric juices and acids from destroying the enzyme action.

United Ostomy Associations of America, Inc.

Next Support Group meeting on 22 January , 3:00 P.M.

American Cancer Society®

2017 Meeting Dates

JAN	22, 2017
FEB	26, 2017
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Too Much of a Good Thing

(taken in part from an article by Sharon Williams, RNET) Edited by Bobbie Brewer, UOAA UPDATE

Many accessory items have been developed to take care of specific needs. Ostomates should determine which items are best for their ostomy management...remember there can be too much of a good thing. Here are a few hints to remember to help achieve a successful ostomy management system.

Keep it simple. Do not use extra adhesive or other skin-care products, etc., unless absolutely necessary. Sometimes, extra products actually interfere with pouch adhesion or create skin problems. Plain water is still the best cleaning agent for skin around the stoma.

Do not continue to use therapeutic products after the problem has been solved. As an example: *Kenalog* spray and *Mycostatin* powder should not be used routinely when changing the pouching system. These products are prescribed for particular skin problems. *Kenalog* is usually recommended for its anti-inflammatory effects and symptomatic relief of the discomfort associated with skin irritation. However, continued and prolonged use of *Kenalog* after the problem is resolved may lead to thinning of the outer layer of skin, thus making it more susceptible to irritations. *Mycostatin* powder is useful for yeast infection. However, using *Mycostatin* after the infection clears serves no purpose.

Seek Advice. See your physician or WOC Nurse (ostomy nurse) if you find yourself a victim of this syndrome. They can provide assistance in selecting the most appropriate and economical ostomy management system for your needs.

When you should call the doctor

You should call the doctor or ostomy nurse if you have:

- Cramps lasting more than 2 or 3 hours
- Continuous nausea or vomiting
- Bad or unusual odor lasting more than a week (This may be a sign of infection.)
- Unusual change in your stoma size or color
- Blockage at the stoma (obstruction) and/or the inner part of the stoma coming out (prolapse)
- A lot of bleeding from the stoma opening (or a moderate amount in the pouch that you notice several times when emptying it) (NOTE: Eating beets will cause some red discoloration.)
- Injury to the stoma
- A cut in the stoma
- Continuous bleeding where the stoma meets the skin
- Bad skin irritation or deep ulcers (sores)
- Watery output lasting more than 5 or 6 hours

Anything unusual going on with your ostomy

A stoma can become narrowed with time, usually over many years. This narrowing or tightness of the stoma is called stenosis and it may cause obstruction (blockage). Stenosis may also be caused by injury from irrigation or a short-term poor blood supply right after surgery. It can usually be corrected with a minor operation if it becomes a problem.

OUR DUES ARE DUE FOR THE 2017 YEAR. IT IS ONLY $12 FOR ALL OF THE BENEFITS

Problems that can happen with a stoma:

Most stoma problems happen during the first year after surgery.

Stoma retraction: Retraction happens when the height of the stoma goes down to the skin level or below the skin level. Retraction may happen soon after surgery because the colon does not become active soon enough. Retraction may also happen because of weight gain. The pouching system must be changed to match the change in stoma shape.

Peristomal hernia: Peristomal hernias occur when part of the bowel (colon) bulges into the area around the stoma. Hernias are most obvious during times when there is pressure on the abdomen. For example, the hernia may be more obvious when sitting, coughing, or straining. Hernias may make it difficult to create a proper pouch seal or to irrigate. The hernia may be managed with a hernia belt. Changes may also need to be made to the pouching system to create a proper seal. Surgery may also be done in some people.

Prolapse: A prolapse means the bowel becomes longer and protrudes out of the stoma and above the abdomen surface. The stomal prolapse may be caused by increased abdominal pressure. Surgery may be done to fix the prolapse in some people.

Stenosis: A stenosis is a narrowing or tightening of the stoma at or below the skin level. The stenosis may be mild or severe. A mild stenosis can cause noise as stool and gas is passed. Severe stenosis can cause obstruction (blockage) of stool. If the stoma is mild, a caregiver may enlarge it by stretching it with his finger. If the stenosis is severe, surgery is usually needed.

Urostomy Fact Sheet

Urostomy (Urinary Diversion): A surgically created opening in the abdominal wall through which urine passes. A urostomy may be performed when the bladder is either not functioning or has to be removed. There are several different types of surgeries, but the most common are ileal conduit and colonic conduit.

You are unique, so be sure to consult your doctor or WOC nurse before trying products or methods that are mentioned in this newsletter.

Friends of Ostomates Worldwide F.O.W. - U.S.A.

Visit our web site at osgmg.org

DOES YOUR STOMA HURT?

By Victor Alterescu, ET, via Chicago's New Outlook, Green Bay Area's and Joplin,MO newsletters

Quite often people tell me their stomas hurt. This surprises me a great deal since stomas don't have any sensation. You could cut, burn, do virtually anything to the stoma, and you would not feel a thing. That's hard to believe but true. Stomas do not have receptors for pain.

Visit our web site at osgmg.org

Crohn's Disease

Crohn's disease (sometimes referred to as regional enteritis) is a chronic, episodic, inflammatory condition of the gastrointestinal tract (GIT) characterized by transmural inflammation (affecting the entire wall of the involved bowel) and skip lesions (areas of inflammation with areas of normal lining between).

Crohn's disease is a type of inflammatory bowel disease (IBD) and can affect any part of the gastrointestinal tract from mouth to anus. The degree of symptoms of Crohn's disease can vary between affected individuals. The main symptoms are abdominal pain, diarrhea (which may be bloody) or constipation, weight loss, skin rashes, arthritis, and inflammation of the eyes.

The disease was named after American gastroenterologist Burrill Bernard Crohn in 1932. Crohn, with two colleagues, described a series of patients with inflammation of the terminal ileum, the area most commonly affected by the illness. Crohn's disease affects between 400,000 and 600,000 people in North America and estimates for Northern Europe have ranged from 27 to 48 per 100,000 people. Crohn's disease often develops in the teenage years, though even younger people can be at increased risk. There may be a genetic component to susceptibility with highest risk among siblings, affecting males and females equally.

Although the cause of Crohn's disease is unknown, it is believed to be an autoimmune disease that is genetically linked. The condition occurs when the immune system contributes to damage of the gastrointestinal tract by causing inflammation.

Unlike the other major type of IBD, ulcerative colitis, there is no known medical or surgical cure for Crohn's disease. Instead, a number of medical treatments are utilized with the goal of putting and keeping the disease in remission. These include steroid medications, immunomodulators (such as azathioprine and methotrexate), and newer biological medications, such as infliximab.

Ileostomy Fact Sheet

Ileostomy: A surgically created opening in the abdominal wall through which digested food passes. The end of the ileum (the lowest part of the small intestine) is brought through the abdominal wall to form a stoma. An ileostomy may be performed when a disease or injured colon cannot be treated successfully with medicine.

United Ostomy Associations of America, Inc.

KNOW ABOUT BLOCKAGE

By Henry C. Finch, MD, Edited by B. Brewer,

The small and large intestines are as different in function as are the arm and the leg. The primary function of the small intestine is to take nutrition from digested foods. The function of the large intestine is to absorb water out of the food residue. Consequently, there is a difference in the discharge from an ileostomy, a colostomy or a rectum. The discharge from the small intestine, which functions on liquid material and moves contents forward quickly, is liquid and soft. In the large intestine, the contents are changed from liquid to solid, through the process of absorbing water. The movement through the colon is much less rapid, and the discharge is solid or even hard. Movement through the large intestine frequently takes from 36 to 48 hours. Movement of the food mass through the small intestines is never more than a few hours. Thus, when anything blocks the forward motion of the contents of the small intestine, an immediate chain of events is set up. There is pain, then cramping. Later, if there is no forward motion, a backward motion of fluid causing vomiting. The most frequent cause of the onset of this chain of events is blockage at the ileostomy stoma. Usually, this is precipitated by undigested food; a bean, pea, peanut, stringy vegetables, shrimp, lobster, coconut, raw vegetables or similar food.

The best way to handle a blockage is not to allow it to occur in the first place. This is done by chewing foods well and drinking plenty of water. However, if symptoms of blockage occur, notify your doctor and follow his/her advice. As blockages may arise from causes other than undigested food particles, observe the following two cautions:

1) Do not take any laxatives without your doctor‘s specific order; any laxative may cause additional complications and pain.

2) Do not take any medication for pain without your doctor‘s specific order. Pain medication may mask a symptom that the doctor needs to know about. Urostomates must be sure to take particular precautions in order to prevent blockages. Where the ileum or colon are joined after a segment is removed to make the conduit, a stricture can occur which is not as extendible as the normal intestines. Some symptoms of a blockage can be relieved with a glass of white grape juice or a tablespoon of mineral oil. It can work wonders sometimes, even to the extent of loosening the blockage enough to pass.

Colostomy Warning

In some cases of colostomy, skin irritation or infection can result from stool that leaks under the bag. A hernia can develop around a colostomy, and the bowel may become narrow. Taking good care of your stoma and eating a balanced diet can help you avoid these problems.

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Membership Application
Ostomy Support Group of Middle Georgia (OSGMG)
OSGMG Contact 478-477-8337

Membership in the Ostomy Support Group of Middle Georgia includes receiving the monthly newsletter, visitor training, regular chapter meetings on the fourth Sunday of each month excluding November and December, and other activities of the group. Dues and donations are tax deductible. (Please print legibly)

Name _____

Address _____

City _____ **State** _____ **Zip Code**_____

Phone Number _____**E-Mail Address** _____

____ Permanent Colostomy _____Temporary Colostomy _____ Ileostomy ____ Urostomy

____ Continent Pouch or J Pouch ____Medical ____Spouse ____ Other

____ I would like to be a member and enclose $12.00 dues.

____ I would like to receive the newsletter but cannot afford dues at this time.

____ I do ____do not give permission to use my name in the newsletter.

____ I am enclosing a donation for the chapter in the amount of $_____ .

Make checks payable to OSGMG and mail to OSGMG PO Box 945 Macon, GA 31202

OSTOMY SUPPORT GROUP OF MIDDLE GEORGIA
PO Box 945
Macon, GA 31202