Case study: The use of topical negative pressure therapy in the management of peristomal pyoderma gangrenosum

Improving function in the patient with an ileo-anal pouch

Case study: The long road to recovery of a patient with an open abdomen and multiple fistulae

Life Membership awarded to Susan Dunne
Discover your research potential!

With the Elinor Kyte Research Grant

Do you have an idea about how to improve patient outcomes?
Do you have a burning passion to know more about an unexplored area of stoma care?

Then discover your research potential with the Elinor Kyte Research Grant. ConvaTec is pleased to sponsor an individual or group STN investigation into an aspect of stoma management or patient care. The project does not need to be product specific. Five thousand dollars is available for projects spanning 1-2 years.

Turn your idea into a reality.

Enquire today
Tel: 1800 006 609
email: connection.au@convatec.com

Congratulations to Ian Whitely, current grant holder. Ian’s research results ‘A qualitative interpretation of the relevance of colostomy irrigation’ were presented at Tripartite 2011.

Contact ConvaTec to discover
• Heritage • Innovation • Inspiration
AASTN Code of Ethics

- The stomal therapy nurse must at all times maintain the highest standards of nursing care and professional conduct.
- The stomal therapy nurse will provide needed services to persons irrespective of their race, colour, creed, sex, sexual preference, age and political or social status.
- The stomal therapy nurse must respect the beliefs, values and customs of the individual and maintain his/her right to privacy by maintaining confidentiality, sharing with others only information relevant to that person’s care.
- The stomal therapy nurse will not participate in unethical practice.
- The stomal therapy nurse must maintain competency by keeping abreast of new developments in the theory and practice of stoma care and related fields.
- The stomal therapy nurse will participate actively in professional, inter-professional and community endeavours in order to meet the highest professional standards.
- No full member shall be in the employment of a company or self-employed in the manufacture or sale of products, prostheses or pharmaceuticals where it could be perceived that the use or selling of products, prostheses or pharmaceuticals could disadvantage or contradict the personal preference of clients or be construed to result in unethical conflict of interest.

Published four times a year by

CAMBRIDGE
PUBLISHING
a division of Cambridge Media

10 Walters Drive, Osborne Park WA 6017
Web www.cambridgemedia.com.au
Copy Editor Rachel Hoare
Graphic Designer Sarah Horton

Advertising enquiries to
Simon Henriques, Cambridge Publishing
Tel (08) 6314 5222 Fax (08) 6312 5299
Email simonh@cambridgemedia.com.au

Disclaimer The opinions expressed in the Journal of Stomal Therapy Australia are those of the authors and not necessarily those of the Australian Association of Stomal Therapy Nurses Inc., the editor or the editorial board.
EXECUTIVE COMMITTEE

President Elaine Lambie
Allamanda Private Hospital
29 Spendlove Street, Southport, QLD 4215
Tel (07) 5532 6444
Mobile 0439 655 402
Email elainelambie@healthscope.com.au

V/President Helma Riddell
Murrumbidgee Local Health District
PO Box 159, Wagga Wagga, NSW 2650
Tel (02) 6938 6487
Mobile 0427 460 024
Email hermannariddell@gsahs.health.nsw.gov.au

Treasurer Vanessa Rhodes
Royal Hobart Hospital
48 Liverpool Street, Hobart, TAS 7000
Tel (03) 6222 8283
Mobile 0409 807 827
Email joco79f5@bigpond.net.au

Secretary Leigh Davies
Silver Chain Nursing Association
6 Sundercombe Street, Osborne Park, WA 6017
Tel (08) 9242 0242
Mobile 0417 385 533
Email gencahir@internode.on.net

Membership Coordinator Robyn Simcock
PO Box 153, Floreat, WA 6014
Mobile 0417 677 970
Email rnsimcock@bigpond.com

Editor Theresa Winston
Fraser Coast Health Service, Hervey Bay Hospital,
PO Box 592, Hervey Bay, QLD 4655
Tel 0438 738 074 (w)
Email theresawinston@gmail.com

Committee Jill Fairhall
John Hunter Hospital, Newcastle Private Hospital
Lookout Road, New Lambton, NSW 2305
Tel (02) 4921 3000
Email jill.fairhall@hnehealth.nsw.gov.au

Debra D’Sylva
Silver Chain Nursing Association
6 Sundercombe Street, Osborne Park, WA 6017
Tel (08) 9242 0242
Mobile 0410 222 048
Email debiedsilva@hotmail.com

Genevieve Cahir
Northern Hospital, 185 Cooper Street
Epping, VIC 3076
Tel (03) 8405 8597
Mobile 0417 385 533
Email gencahir@internode.on.net

Education Subcommittee Fiona Bolton
64 Carlisle Street, Ethelton, SA 5015
Mobile 0418 266 680
Email fiona.bolton65@optusnet.com.au

WCET ID Brenda Sando
The Sunshine Coast Private Hospital
Sal Lingard Drive, Buderim, QLD 4556
Tel (07) 5403 3481
Email brenda.sando@uchalth.com.au

CPD & Credentialling Officer Sue Delany
Launceston General Hospital
Charles Street, Launceston, TAS 7250
Email sue.delany@dhrs.tas.gov.au

Website Genevieve Cahir
Northern Hospital, 185 Cooper Street, Epping VIC 3076
Tel (03) 8405 8597
Mobile 0417 385 533
Email gencahir@internode.on.net

Public Officer Carol Stott
Stomal Therapy Department, Dickinson 2 North,
Prince of Wales Hospital, Barker St, Randwick, NSW 2031
Tel (02) 9382 3869
Email carol.stott@sesiah.health.nsw.gov.au

SPAP Member Diana Hayes
CNC/Stomal Therapy, Western Hospital
Gordon Street, Footscray, VIC 3011
Tel (03) 8345 6553
Mobile 0428 441 793
Email diana.hayes@wh.org.au

SPAP Member Joanne Campbell
CNC Stomal Therapy, Sir Charles Gairdner Hospital,
Verdun Street, Nedlands, WA 6009
Tel (08) 9346 3333 pager 4311 ext 4368
Email jo.campbell@health.wa.gov.au

AASTN STATE REPRESENTATIVES

ACT Vicky Browne
The Canberra Hospital
PO Box 11, Woden, ACT, 2606
Tel (02) 6244 2236
Email vicky.browne@act.gov.au

NSW Jenny Rex
CNC, Royal Prince Alfred Hospital
Missenden Road, Camperdown, NSW 2050
Tel (02) 9515 8990
Email jenny.rex@cs.nsw.gov.au

NT Donna Fisher
Stomal Therapist / Wound CNC
Royal Darwin Hospital,
PO Box 41326, Casuarina, NT 0811
Tel (08) 8922 6195
Email Donna.Fisher@nt.gov.au

QLD Emma Vernon
The Prince Charles Hospital
Rode Rd, Chermside, Brisbane, QLD 4032
Tel (07) 3139 5433
Email emma.vernon@health.qld.gov.au

SA Lynda Staruchowicz
Stomal Therapy Department, Royal Adelaide Hospital,
North Terrace, Adelaide, SA 5000
Tel (08) 8222 4000 page 1224
Email lynda.staruchowicz@health.sa.gov.au

TAS Andrea Hicks
Mersey Community Hospital
Bass Highway, Latrobe, TAS 7307
Tel (03) 6426 5620
Mobile 0409 924 496
Email andrea.hicks@dhhs.tas.gov.au

VIC Patricia McKenzie
5 Royal Place, South Morang, VIC 3752
Tel 1300 33 44 55
Mobile 0406 334 850
Email pmckenzie@rdns.com.au

WA Leigh Davies
Silver Chain Nursing Association
6 Sundercombe Street, Osborne Park, WA 6017
Tel (08) 9242 0242 (w)
Mobile 0410 222 386
Email Ldavies@silverchain.org.au
President’s report

Elaine Lambie

CONGRATULATIONS TO THE OUTGOING PRESIDENT AND EXECUTIVE MEMBERS

In my first report as national President, I would like to congratulate the retiring President, Sharmaine Peterson and the Executive members for the wonderful work they have done over the last two and a quarter years. I would especially like to thank them for the extra few months they served, due to the AGM being held at the conference with the Tripartite Colorectal Meeting in Cairns. Their commitment has been very much appreciated. Also, a special thank you to Theresa Winston for continuing as Editor for JSTA.

I would like to also acknowledge Helen Nodrum and the Victorian branch for the outstanding work and commitment given to the Conference and the organisation with the Tripartite team. The programme at the Conference and Tripartite was excellent. The social activities were also very enjoyable. It is exciting to know the Tripartite colorectal surgeons stated they would like to have future joint conferences. It is a privilege to be associated with such caring, hard-working people.

A FEW WORDS ABOUT ME

I did my Stomal Therapy Certificate at PAH, Brisbane, in 1992. I have worked at Allamanda Private Hospital, Southport on the Gold Coast, since 1987. Allamanda is now part of the Healthscope group. Our practice includes wound care and continence, as well as ostomy care. Over the years I have been assisting at the Gold Coast Ostomy Association in a voluntary capacity, but this year I have commenced four hours a week as an organised out-patients service. I was President of the Queensland branch of the AASTN for eight years.

My hopes for my term are:

• To maintain and encourage the highest level of stomal care for our ostomy patients, referring to the values, purpose and vision of the AASTN.

• Encourage participation in Stomal Therapy Week, both in the hospital and community, to bring more awareness to our speciality and the needs of our ostomy patients.

• Increase AASTN membership.

I look forward to being your elected representative and will, to the best of my ability, keep everyone informed and up to date.

The Executive values your ideas, feedback and comments, so please contact us; our details are listed on page 2.

PICO™

Simplified Negative Pressure Wound Therapy

• Application in a few minutes
• Minimal training required
• Discreet & quiet

• May allow early patient discharge*
• No additional costs
• Single use only, fully disposable

*Reference: OR DOF/012. A prospective, open, non comparative, multi-centre study to evaluate the functionality and dressing performance of a new negative pressure enhanced dressing in acute wounds.

Smith & Nephew Pty Ltd Healthcare Division
Australia 315 Ferntree Gully Road (PO Box 242), Mount Waverley 3149, Victoria Australia

New Zealand
621 Rosebank Road Avondale (PO Box 442), Auckland 1140 New Zealand
Over the last year the JSTA has published a range of articles from reflective journals and case studies relating to wounds and stomas, to information on credentialling and the all-important professional development points. I would like to take this opportunity to thank everyone who has submitted an article; not only does it make my role as editor much easier when they are flowing in, but it is motivating to know that so many of you are prepared to make the time in busy schedules to write up and share your experiences. I would also like to thank the peer reviewers who give up their time to review the articles.

At the end of 2010, the Executive was approached by CINAHL®, the Cumulative Index to Nursing and Allied Health Literature, to include articles from the JSTA in their index. Having the abstracts available in the CINAHL® database will mean JSTA articles are viewed by a greater number of people extending beyond those that are members of the AASTN and receiving the journal as part of their membership. As it is the abstracts that are available on CINAHL® it is important that anyone submitting an article for publication includes an abstract.

Since March 2010, Cambridge Media has been able to supply reports on the number of articles they have received and the number of articles that have had a peer review. This is a great way for us to keep track of articles and for peer reviewers to know how many articles they are reviewing each year. Since March last year, 16 articles have been submitted through the Cambridge Media website. Data is only captured for articles submitted directly through the Cambridge Media website and I would encourage anyone who is thinking of submitting an article to use this website rather than emailing the article directly to the Editor. Information on how to access the website is in the JSTA or if you are having difficulty, please contact the Editor for help.

It is amazing to think that 12 months have passed since our last AGM. I thought this would be my final editorial, but I have agreed to extend my role as Editor for another two years. I look forward to working with the Executive of the AASTN over the next two years and if anyone has any ideas on what they would like to see in the JSTA or improvements that could be made, please do not hesitate to contact me.

This is a friendly reminder that your Continual professional Development Portfolio is due by close of business 31st December each year with supporting documentation. Do not send original copies of evidence please as these will not be returned. If you have already reached your 100 points feel free to submit at the beginning of October.

Thanks.
SIMPLIFIED WOUND CARE
One product, three actions

- Moist wound environment
- Continuous auto-debridement &
- Broad spectrum anti-bacterial activity

www.flaminalaustralia.com

Please tell your patients to always read the label and use only as directed. If their symptoms persist, tell them to see their doctor or health professional.
INTRODUCTION

Pyoderma gangrenosum (PG) is a very painful skin disorder with lesions that can occur on any part of the body. The pathogenesis of this condition remains obscure and the cause has been associated with immunosuppression and viral or bacterial infection.

The literature reports a large variety of topical and systemic treatments have been used to treat this condition. PG is a relatively uncommon disorder and PG should be suspected in the presence of any rapidly occurring, painful pustule that develops into an undermined ulcer with violaceous edges. When located in the peristomal area, the moist lesions can undermine the security of the ostomy appliance. There is no definitive diagnostic test for PG, although a biopsy may be obtained to rule out other conditions such as vasculitis. A diagnosis is dependent upon the clinical presentation, particularly when there is a rapid onset of the lesion, the appearance and the pain associated with the wound and the patient’s history of inflammatory bowel disease. Other people at risk may have rheumatoid arthritis, malignant cancers or diverticular disease.

This case study will demonstrate the use of negative pressure wound therapy in the treatment of peristomal PG. The purpose of this case study is to share this experience with other stomal therapy nurses, to enhance their knowledge of the technique used and show how this intervention can achieve a positive outcome for patients.

Vacuum-assisted closure (VAC™ therapy) is the application of topical negative pressure, as measured in mmHg. A foam dressing is used to fill the wound defect and this is covered with a semi-permeable film dressing. A suction tube is attached to the dressing and the exudate is drained into a canister when negative pressure therapy is applied.

THE PATIENT

Beryl is a 72-year-old lady who had undergone a total proctocolectomy with end ileostomy for Crohn’s disease a few years previously. She is visually impaired and, together with her supportive husband of 50 years, successfully manages her ileostomy using a Hollister convex, one-piece drainable pouch.

Teaching stoma care to Beryl and her husband was a challenging, but rewarding experience. I had not seen Beryl for some time and because we had built up such a rapport and trust over that period, she presented as an out-patient with a very painful peristomal ulcer under her base plate (Figure 1).

TREATMENT

Beryl was admitted to hospital for pain management and wound care. PG was the initial diagnosis based on the patient’s age, history of Crohn’s disease, the development and the appearance of the lesion, the degree of pain experienced and the location. Research has also shown that the possibility of minor trauma related to the increased pressure exerted on the peristomal skin from using a convex appliance may have exacerbated this condition.

Beryl stated that the area started as one small pustule, which had increased in size and was now very painful. The lesion had ragged edges and a bluish ‘halo’ in the peristomal tissue typical of PG.

A multidisciplinary approach was required and included a colorectal surgeon, infectious diseases consultant, gastroenterologist, dietitian and stomal therapy nurses. Treatment included surgical debridement and biopsy of the lesion, antibiotics, infliximab and VAC™ therapy.
The initial topical treatment was to apply Kenacomb ointment to the ulcers, cover the ointment with an alginate dressing and apply a thin hydrocolloid before putting on the appliance (Figures 2, 3 and 4). This treatment had worked well when used previously. Kenacomb ointment is useful for inflammatory dermatoses with bacterial and/or fungal infections.

Despite systemic hydrocortisone, further surgical debridement of the ulcer was required. There was extensive necrosis around the lateral edge, extending into the right flank. A very wide and deep excision to the fascia was performed and the specimen sent for histology as well as microbiology for suspected necrotising fasciitis.

At this stage, the infectious diseases consultant reviewed the patient and a 48-hour course of high-dose penicillin and lincomycin were given. This was ceased after 48 hours as the patient did not present clinically as necrotising fasciitis and the ulcer was probably still consistent with severe PG.

The following day, the gastroenterologist commenced IV Infliximab 240mg over a four-hour period. Infliximab is a type of antibody, which is effective in the treatment of PG by suppressing the inflammatory process that PG manifests.

Surgical debridement and biopsies were taken. The ulcer and peri-ulcer skin were injected with 1mg Celestone after high dose oral steroids seemed ineffective in halting the progression of ulceration. Histology confirmed PG (Figure 5).
Five days later, the ulcer remained unchanged, still extremely painful and the granulation tissue was not healthy. At this stage a colleague recommended vacuum-assisted wound closure or topical negative pressure wound therapy (Figure 7).

To maintain a good seal around the stoma, a Hollister Adapt seal and paste was applied. In this way the appliance was securely maintained and remained in situ until the dressing was changed three times per week.

The technique was to place the drape over the foam and the stoma in one piece. The drape was then cut at mucocutaneous junction. The Adapt seal was placed snugly around the stoma and Hollister paste applied to ensure a good seal prior to applying the pouch (Figure 8). The wound showed evidence of healing (Figures 9 and 10).

Negative pressure was maintained at 125mmHg continuous therapy and at each dressing change it was evident that the wound had decreased in size and was granulating well.

The purpose of applying topical negative pressure to the wound was to help promote wound healing by reducing oedema, promoting granulation tissue formation, increasing perfusion and by removing exudate and any infectious materials. To maintain the maximum benefit from negative pressure therapy, it was most important that the wound was debrided of all devitalised tissue and that the wound would be supplied by adequate circulation to support the healing process. The white foam was used as this dressing is a dense, open-pore foam with a high-tensile strength that is ideal for extremely painful wounds (Figure 8).
They said it couldn’t be done. So we did it.

For a long time now it was thought that foam dressings and hydrogel could never work optimally together. But HARTMANN scientists have actually developed a wound care innovation that everyone else thought just wasn’t possible.

Announcing NEW HydroTac – the world’s first “hydroactive” dressing that ingeniously combines absorbent foam with a hydrogel wound contact layer. The result – HydroTac both absorbs and donates moisture, creating the optimal moist wound healing environment, while being gentle on sensitive skin.

HydroTac’s unique net-shaped hydrogel wound contact layer has the benefit of our AquaClear technology, so it’s gentle and soothing on delicate skin, with an initial tack for easy application and removal. And the absorbent foam has a moisture permeable top film for enhanced fluid handling.

Experience the moist wound healing advantages of new hydroactive HydroTac:
- absorbs exudate quickly and effectively
- donates moisture to dry wounds
- reduces risk of maceration
- protects the wound from bacteria
- soothes painful wounds
- doesn’t dry out or stick to the wound bed
- ideal for skin tears and ulcers

To learn more about HARTMANN HydroTac call 1800 805 839 or visit www.hartmann.com.au

HARTMANN creates your wound care solutions
To maintain continuity whilst in hospital, the stomal therapists would change the dressings every Monday, Wednesday and Friday. This was to ensure continuity of wound care and provided Beryl with peace of mind.

It was so encouraging to see a marked improvement in the wound at each dressing change. The pain had decreased, the granulation tissue was healthy and the wound was decreasing in size. Beryl was discharged from hospital on day 24 with community nurses providing ongoing management with topical negative pressure wound therapy. When the negative pressure was no longer required, traditional dressings, namely, an alginate dressing covered by a thin hydrocolloid were the dressings of choice (Figures 11 and 12).

**CONCLUSION**

A collaborative team approach optimised an early diagnosis and commencement of appropriate treatment. The negative pressure wound therapy chosen minimised the patient’s length of stay in hospital and enabled her to be pain- and infection-free.

PG is complex and difficult to treat because it can mimic a soft-tissue bacterial or fungal infection\(^3\). Stomal therapy nurses need to be suspicious of any rapidly developing painful peristomal wound, for the disorder is frequently perceived to be ulceration as a result of leakage or localised pressure. This case study demonstrates the effectiveness of topical negative pressure therapy in the management of this painful disorder.

Beryl was a very different, independent and much happier person when she came back for a final check-up. Although this wound took over five months to heal, it was a very rewarding and challenging experience with a successful outcome (Figure 13).
REFERENCES


Visit the AASTN website
www.stomaltherapy.com

AASTN MEMBERSHIP RENEWALS AND RECEIPTS

The AASTN Executive Committee would like to notify and/or remind all members:

- Membership fees are due by 31 December of each year (AASTN Constitution 2003).
- Membership ceases if in arrears for 60 days, that is 1 March. (AASTN Constitution 2003).
- Please note from 2011 AASTN will implement the late fee charge ($20) for members who renew later than 1 April.
- Late fees DO NOT APPLY to new members applying after 30 March.
- AASTN’s preferred method of fee payment is by direct banking. Please consider this payment method. Your membership ID (MID) and surname should be included in the payment description for easy identification.
- From 2011 receipts will not be issued unless the request is indicated on the renewal form. The preferred format of issue will be via email. Please ensure your provided email address is current.

This notification by the Executive Committee has been prompted by the large number of AASTN members renewing late into the membership year, and increasing postage costs.

Thank you for your understanding and cooperation.

FUTURE ENVIRONMENTAL SERVICES.

PROVEN ODOUR CONTROL FOR:
CONTINENCE, WOUND, PALLIATIVE CARE, STOMA PATIENTS.

* Hos-gon - no-smells! Nursing Homes, Prevents odours which upset staff, relatives & residents.
* Hos-ology - no-smells! Oncology, Palliative Care, Fungating & Necrotic tissue.
* Hos-togetel - no-smells! Aged Care, Oncology, Palliative Care, Laboratories, Theatres.
* Hos-toma - no-gas! Prevents build up of gas, neutralising mal-odours at the same time.
* Hos-toma - lube! Prevents pancaking.

Contact us for Information, Literature, Starter Packs, Material Safety Data Sheets, or place an order.

FUTURE ENVIRONMENTAL SERVICES
(TOTALLY AUSTRALIAN OWNED) PO BOX 155, Caulfield South, VICTORIA. 3162 AUSTRALIA.
PHONE: 03 9569 2329, FAX: 03 9569 2319 E-mail: health@futenv.com.au Web: www.futenv.com.au
Improving function in the patient with an ileo-anal pouch

Lynda Staruchowicz • RN, BN, Grad Cert of STN, Grad Cert of Health (ACNP), MN (Continence), STN (Cred)

INTRODUCTION
Restorative proctocolectomy with ileo-anal pouch has become the standard surgical option for the treatment of mucosal ulcerative colitis and familial adenomatous polyposis. Despite this, however, controversies still exist regarding some of the crucial points of surgical technique and functional results are not always optimal. This article seeks to explore the literature available to accumulate knowledge to improve ways in which colorectal surgeons and stomal therapy nurses can assist in helping to improve function in their ileo-anal pouch patients. It assumes the reader has a sound knowledge of the surgery pertaining to the operation as these details are not included in the body of the text and may need to be sought elsewhere. Complications of pouch surgery and causes of pouch dysfunction are outlined, followed by a discussion of ways in which pouch function can be improved.

BACKGROUND
Outcomes for patients after restorative proctocolectomy with ileo-anal pouch are generally good, with 96% of 1156 patients followed up in one study saying they would have the operation again and 97.7% saying they would recommend the operation to others. It is reported that their quality of life is similar to the general population and that this is stable over time without any significant deterioration. Persistent urgency is a problem for about 5% of patients, continence is normal in another 70–80% and 5% have significant faecal leakage. In 50% of patients, overnight defaecation occurs. Many of these patients use antidiarrhoeal medication to attain satisfactory bowel frequency.

COMPLICATIONS
Complications in the pouch patient can be long- or short-term. In the immediate postoperative period, the most common cause of pouch failure is pelvic sepsis. Ischaemia of the reservoir is another uncommon cause of early postoperative pouch failure. Long-term complications in the pouch patient include those related to septic complications, which may result in the occurrence of pouch vaginal or pouch perineal fistula. The other complications of note are poor pouch function and mucosal inflammation of the pouch, commonly termed pouchitis. Anaemia is also a complication, which may be caused by vitamin B12 deficiency; but also more often by low serum levels of iron. Nurses managing the ileo-anal pouch patient need to be aware of these complications and endeavour to manage them in conjunction with the colorectal surgeon.

CAUSES OF POUCH DYSFUNCTION
Inflammatory causes of pouch dysfunction
Pouchitis
Pouchitis is an idiopathic, chronic inflammatory condition that may occur in the ileo-anal pouch in up to 60% of patients after ileal pouch anal anastomosis for ulcerative colitis. Conversely, pouchitis rarely occurs in patients who have had ileal pouch anal anastomosis for familial adenomatous polyposis. Investigators reason that this suggests an underlying genetic predisposition.

Pouchitis also typically does not occur until the diverting loop ileostomy is closed and faecal material flows through the pouch. This, coupled with the fact that pouchitis usually responds to antibiotic therapy suggests that bacterial antigens are involved in the inflammatory process.

A diagnosis of pouchitis should be made by pouch endoscopy and biopsy. Acute pouchitis is usually treated with metronidazole or ciprofloxacin for 10 to 14 days. If the patient should suffer frequent relapses or chronic pouchitis they may require long-term antibiotics.

Symptoms of pouchitis include increased stool frequency and liquidity, abdominal cramping, urgency and tenesmus and occasionally rectal bleeding or fever. Disease activity and pattern can vary widely as can individual response to antibiotic therapy. Probiotics may also be effective.

Cuffitis
Cuffitis is the inflammation of residual anorectal mucosa which remains in patients with a stapled anastomosis as opposed to a hand-sewn anastomosis after ileo-anal pouch formation. Approximately 20% of patients can suffer from symptoms of this problem. These are similar to proctitis and include burning, urgency and the passage of small, frequent amounts of blood-stained stool. Treatments used for cuffitis are as for proctitis and are usually effective and pouch revision is rarely required.

Crohn’s disease
It has been found that about 2–3% of patients diagnosed with ulcerative colitis preoperatively are found to have Crohn’s disease. Of these, some develop fistulas and others pouchitis but most of these patients generally reach the stage of pouch excision.
DOES THE SKIN AROUND YOUR STOMA SOMETIMES BECOME SLIGHTLY RED OR IRRITATED?

This is not normal...

Eakin® Cohesive® is the gold standard in skin care and protection. Eakin Cohesive will provide a complete seal around your stoma and prevent leakage and skin irritation. By preventing leakage Eakin Cohesive will make your pouch more secure and your skin more comfortable.

Take the Eakin Cohesive Healthy Skin Test

<table>
<thead>
<tr>
<th>Do you have:</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Slightly red or red skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sore skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Itchy skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irritated skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Weepy” skin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you ticked yes for any of the above please contact Omnigon Customer Service for more information and a free sample of Eakin Cohesive seals.

Your skin will thank you.
Specific infection
Cytomegalovirus and Clostridium difficile have also been found to cause pouch inflammation in a few cases. These should be excluded by a stool culture and antigen testing.

Mechanical causes of pouch dysfunction
Ileo-anal stricture
An ileo-anal stricture is a narrowing of the area at the anastomosis between the pouch and the anus. This also seems to occur more regularly in patients with stapled anastomosis, with some studies suggesting that 40% of these pouches can stenose. If stenosis results, repeated dilation under anaesthetic or the daily use of anal dilators may be needed. Poor outflow, resulting in poor function, is often the result and the use of a rectal catheter may be of benefit to these patients.

Weak sphincters
Weakness of the anal sphincter complex can cause frequent, small-volume incontinence and this is more common in women after vaginal delivery. Pelvic floor exercises may be useful to improve the function of these muscles, especially if combined with drugs to thicken the faecal output.

Small-volume pouch
A pouch may have been constructed in such a way as to hold an inadequate volume of stool. This will result in poor pouch function as high-stool frequency may result. Pouch revision may be required.

Other causes of pouch dysfunction
Pouch fistula
Pouch fistula is when an abnormal opening develops from one cavity and tracks through to another. Infection can affect the anastomosis between the pouch and the anus and work its way through to the exterior. In females, the most likely path of a fistula is between the pouch and the vagina, whereas in the male the infection pathway drains through the buttock wall. The end result of fistulation is leakage of faeces. This is generally managed by further surgery to correct the defect or formation of a temporary diverting loop ileostomy to allow healing of the fistula. If this does not take place, removal of the pouch may be inevitable. The use of a seton for drainage may also be tried.

Pelvic sepsis
Pelvic sepsis is a frequent, early postoperative complication occurring in about 5–10% of patients, severely enough to warrant drainage. About one-third of this group of patients at St Mark’s Hospital fail to overcome the problem and the end result is pouch removal.

Defaecatory frequency
Normal pouch function varies but typically patients following ileo-anal pouch surgery have four to eight bowel movements, or about 600–700ml of semi-formed stool per day. This may be managed with drugs such as loperamide or codeine to improve stool consistency and decrease problems with urgency and frequency. Loperamide is generally well-tolerated but should be titrated to the individual’s needs. Codeine may also be used with caution due to unwanted side effects of sedation as an issue for some people.

STRATEGIES TO IMPROVE POUCH FUNCTION
Pouch training and compliance
According to the literature, preoperatively ileo-anal pouch patients are advised that individual pouch compliance and training may take from between three months to one year. The end result should be that the pouch is largely continent and in control of their pouch.

Pouch training should be commenced two to three days postoperatively after ileostomy closure when the pouch starts functioning. Because the small bowel is used to form the pouch, it is initially not used to its new function as a reservoir and it needs time to develop compliance and fulfil its new role. Patients need to be reassured that the pouch works in the same way as the rectum and often this point needs to be reiterated.

Deferment of defaecation is used to build up the compliance of the new pouch reservoir. Patients should be advised to refrain from defaecation after the initial urge to do so and instead tighten the external anal sphincter muscles to “hold on”. The period of holding on starts off with a few seconds and is gradually increased to a few minutes over the following weeks. This should eventually be increased to holding on for over an hour after several months.

There are reports that consistent postponed emptying may contribute to poor function and should be avoided. Deferral for 30 to 90 minutes is ample and this is the time period advised.

The Medena catheter
In the event of problems with poor pouch function due to outflow obstruction caused, for example, by ileo-anal pouch anastomosis stricture, the use of the Medena catheter is recommended in the literature. A Medena catheter is a transparent flexible tube which has two drainage eyes situated at the top of the catheter. It is manufactured from polyvinyl chloride. This catheter is inserted into the pouch through the anus and its purpose is to assist in the drainage of faeces from the reservoir. It can also act as a channel for water if irrigation of the pouch is required to assist with emptying.

Patients may be educated to insert the Medena catheter themselves. They are advised to commence this at home only once they feel confident with the procedure. Regimes for catheterisation vary with each individual patient, some finding that using the catheter for the first evacuation in the morning and the last at night sufficient to maintain satisfactory emptying. Others use the catheter on a more regular basis to assist with evacuation.

Defaecation is used to build up the compliance of the new pouch reservoir. Patients should be advised to refrain from defaecation after the initial urge to do so and instead tighten the external anal sphincter muscles to “hold on”. The period of holding on starts off with a few seconds and is gradually increased to a few minutes over the following weeks. This should eventually be increased to holding on for over an hour after several months.

There are reports that consistent postponed emptying may contribute to poor function and should be avoided. Deferral for 30 to 90 minutes is ample and this is the time period advised.

The Medena catheter
In the event of problems with poor pouch function due to outflow obstruction caused, for example, by ileo-anal pouch anastomosis stricture, the use of the Medena catheter is recommended in the literature. A Medena catheter is a transparent flexible tube which has two drainage eyes situated at the top of the catheter. It is manufactured from polyvinyl chloride. This catheter is inserted into the pouch through the anus and its purpose is to assist in the drainage of faeces from the reservoir. It can also act as a channel for water if irrigation of the pouch is required to assist with emptying.

Patients may be educated to insert the Medena catheter themselves. They are advised to commence this at home only once they feel confident with the procedure. Regimes for catheterisation vary with each individual patient, some finding that using the catheter for the first evacuation in the morning and the last at night sufficient to maintain satisfactory emptying. Others use the catheter on a more regular basis to assist with evacuation.

Dilation of the pouch anal anastomosis
Dilation of the ileo-anal anastomosis can improve function for the patient with a stricture at this site. This can be done under general anaesthetic and then followed up by regular use of a Hegar dilator to maintain patency.
Pelvic floor muscle exercises

Weakness of the external anal sphincter can cause frequent, small-volume incontinence of stool. This is more common in women who have given birth vaginally.

Pelvic floor exercises are designed to improve muscle bulk and endurance of the anal sphincter complex. Results of pelvic floor training may take up to 12 weeks and patient compliance and dedication is required.

Biofeedback

Biofeedback can be used to improve pouch emptying difficulties in suitable patients. It is suggested that these difficulties may develop due to an inability to utilise the correct defaecatory muscles. Prior to surgery, some of the patients may have had a temporary ileostomy or diarrhoea and have somehow forgotten how to appropriately use these muscles. Biofeedback teaches the patient how to coordinate the muscles used in normal bowel emptying to work in the correct way to promote evacuation of faeces.

Diet

Dietary advice needs to be provided as a necessary basis to maintaining good pouch function. In the immediate postoperative period, small, regular meals consisting of low-fibre, soft foods should be encouraged. It is recommended to chew food well and add new foods one at a time.

Patients should be advised not to drink excessively with meals as this moves food through the small intestine too quickly. Chewing food slowly and avoiding swallowing air is recommended to avoid excessive flatus. Smoking, drinking fizzy drinks, using a straw or chewing gum may also produce this result as well.

The ability to discriminate between flatus and stool in the reservoir may take some time to develop, even several months. Thickening the faecal output from the pouch with starchy carbohydrate foods may be helpful and education into foods that produce this effect is required as is avoiding foods that have the opposite result.

Alcohol will produce an increased faecal output in most individuals, so moderate amounts are recommended. Fluid intake is essential and so, as for patients with an ileostomy, 1.5 to 2 litres is recommended per day. Extra salt needs to be added to the diet to compensate for electrolyte losses.

Other considerations

Anal skin care, blood tests to monitor anaemia, cancer testing and osteoporosis screening are all recommended follow up for ileo-anal pouch patients but these do not affect pouch function.

CONCLUSION

There are a number of strategies that can be employed to improve function in the ileo-anal pouch patient. Early postoperative training by deferment of defaecation is essential to develop compliance and maximise pouch function. Complications and problems must be accurately diagnosed and managed to effect optimal outcomes in this patient group.

REFERENCES

“My goal is to assist patients in attaining their optimum quality of life” Stomal Therapy Nurse

For Maria, a colostomy was the solution after a long battle with Crohn’s disease.

“Thanks to the colostomy I could do a lot more than previously. Of course there were problems at the start, physically as well as mentally. But the main thing is that I could carry on with my life. That’s really important.”

“SenSura is a big improvement compared to other products. I used to have leaks. Since I’ve been using SenSura, I haven’t had any.”

“The added quality [of life] it has given me is that I feel safer and don’t have to be so afraid of the pouch falling off or dirtying clothes.”

“I think everybody who has a stoma wants confidence and safety.”

The combination of evidence-based nursing and the SenSura® double-layer baseplate reduces incidence of leakage…

% of participants who never experienced leakage

At the end of the DialogueStudy, nearly 3 times as many participants answered that they never experienced leakage (output under the baseplate) than at the start.

- Reduce incidence of leakage
- Improve peristomal skin conditions
- Improve quality of life
Coloplast Care is a nurse directed program to make life easier for people with intimate healthcare needs, and the healthcare professionals that support them.

Benefits of the Care program for you and your patients
- Coloplast provides product samples and tools to assist patients in their transition from hospital to home
- Dedicated support for product and lifestyle questions
- Gives patients access to monthly wellness education newsletters addressing various lifestyle issues

To participate in the program
- Fax the nurse participation form to 03 9541 1155
- Email your request to care@coloplast.com
- Call a Coloplast Care Specialist on 1800 333 317

Ask your Territory Manager how to register patients in the program so they can experience Coloplast Care.
Case study

The long road to recovery of a patient with an open abdomen and multiple fistulae

Ian Whiteley • Clinical Nurse Consultant – Stomal Therapy & Wound Management

ABSTRACT

A 54-year-old male patient was transferred from a regional hospital with an open abdomen and multiple enterotomies. Topical negative pressure therapy was initially used to deal with the open abdomen. The failure of topical negative pressure therapy (vacuum-assisted closure; VAC®) to effectively contend with the challenges of the open abdomen and contain the fistulae effluent was followed by a more conservative approach using Eakin® fistula pouches. The Eakin® fistula pouch successfully managed the high-output fistulae and allowed the wound to contract from the base and edges. The open abdomen and fistulae were associated with significant morbidity due to fluid loss, electrolyte imbalance, sepsis and thrombosis. Eventually surgical repair of the fistulae and primary closure of the wound was undertaken. The length of stay was 164 days (approximately 5.5 months).

PATIENT HISTORY

The patient had a history of a perforated bowel of unknown aetiology and underwent a large bowel resection when seven days old. The patient and his mother, now in her 80s, are unsure of the pathology regarding this original surgery.

On this occasion, the patient was admitted to a regional hospital with a small bowel obstruction (SBO) from a volvulus secondary to adhesions. A laparotomy was performed at the regional hospital and the bowel was reported to be “friable”, resulting in multiple enterotomies leading to gross faecal contamination. The patient was then transferred to a major metropolitan teaching hospital intubated and with an open abdomen.

The extended period of hospital stay challenged the patient’s fragile mental state. He had a prior diagnosis of schizophrenia and had been prescribed a mood stabiliser (sodium valproate) and an antipsychotic (olanzapine). He was supported throughout his admission by the psychology and psychiatry teams.

WOUND ASSESSMENT AND THE HOSPITAL JOURNEY

The day following admission to the metropolitan teaching hospital, the patient was reviewed in the operating theatre where he underwent an abdominal washout and application of a vacuum-assisted closure (VAC®) open abdomen dressing. These dressings were changed in the operating theatre under general anaesthetic every few days, mostly due to painful skin caused by effluent leaking from the VAC® dressing. These frequent dressing changes enabled routine assessment of wound progress. On day 8 of the admission, Foley catheters were placed in two of the enterotomies in an attempt to control the effluent leaks.

Total parenteral nutrition (TPN) therapy was required to meet nutritional requirements with octreotide given as an adjuvant due to its proven ability to lessen healing time and reduce the complications associated with small bowel fistulae by decreasing output1. A proton pump inhibitor (pantoprazole) was prescribed for its proven action of decreasing the output from proximal gastrointestinal fistulae by decreasing pancreatic and gastric secretions2. Makhdoom et al.3 identify a range of factors likely to inhibit the spontaneous closure of fistulae and this patient displayed the following influencing variables: short fistula tracts; sepsis; transfer from another hospital; output >500ml/day; malnutrition and chronic duration of fistulae.

For this patient, the fistulae output was generally between 500ml and 800ml in 24 hours, but occasionally increased to as much as 2200ml. Fistulae with an output of greater than 500ml in 24 hours are described as “high output” and are most likely to originate from the small bowel1-3. After almost three months in hospital on nil by mouth, the patient was allowed to commence on two high-protein supplement drinks per day to give him the pleasure of ‘tasting some food’. The patient was trialled on a full fluid diet and the fistulae output immediately increased to 2200ml in 24 hours.

The patient was intubated and required long-term respiratory support and on day 11 of admission a tracheostomy was performed.

A month after admission the surgeon invited the stomal therapy nurse clinical nurse consultant (STN CNC) to come to the operating theatre to review the wound and become involved in the care of this patient. The STNs had been aware of the patient from weekly multidisciplinary meetings; however, they had never been asked to consult by the surgeon or the intensive care unit (ICU) staff and were led to believe that VAC® therapy was adequately managing the wound and controlling effluent.

At the initial examination by the STN in the operating theatre, there appeared to be four fistulae of varying sizes in the wound bed. The wound bed was granulating and the periwound skin was reddened and moist (Figure 1). The wound dimensions were not taken at this point due to operating theatre time constraints. The largest fistula in the distal end of the wound...
was most active, routinely producing 500–800ml of effluent per day.

At this time it was clear that VAC® therapy was ineffective. The peri-wound skin was denuded from the corrosive effluent draining from the fistulae and the constant negative pressure from the VAC® was causing the fistulae to mature. The STN contacted the clinical support team from KCI Medical to assist with a trial of the ABThera™ VAC® system, which has a larger collection chamber with a 1000ml capacity and thicker drainage tubing to facilitate the evacuation of more viscous wound contents. ABThera™ differs from the usual topical negative pressure therapy device as it provides continuous negative pressure to remove a high volume of exudate. This device is specifically designed for the early management of an open abdomen, but unfortunately was no more effective in this situation than standard VAC® therapy.

There was some difficulty applying the ABThera™ VAC® system as the previous applications of VAC® therapy had caused the paracolic gutters to become “stuck down”. The paracolic gutters are the depressions formed between the lateral margins of the ascending and descending colon and the posterolateral abdominal wall and it is these depressions into which the open abdominal VAC® drape are normally positioned. As mentioned earlier, the ABThera™ VAC® system was trialled as it has a larger collection chamber, larger lumen drainage tubing for higher volume drainage and provides continuous negative pressure.

The next day it was evident that the ABThera™ VAC® system was no more effective than the previous Info-VAC® system at managing this particular wound. The effluent was too viscous to be sucked through the non-adherent interface on the VAC® sponge, resulting in undermining the dressing, further leaks and peri-wound skin breakdown (Figures 2 and 3). Use of the ABThera™ VAC® was discontinued and the STN team took over the wound management using an Eakin® fistula pouch.

A comparison of Figures 1 and 3 reveals that VAC® therapy had been “splinting” the wound and drawing the edges inwards. Once VAC® therapy was ceased, the width of the wound increased significantly and the shape of the wound changed from oval to round. In Figure 3 the wound dimensions are 15cm long, 14cm wide and 4cm deep. The Eakin® fistula/wound pouch selected was the vertical pouch measuring 160mm wide x 245mm long and was selected as it suited the dimensions of the wound.

At this time the patient was transferred from the ICU to the colorectal unit and by giving analgesia prior to Eakin® fistula pouch changes there was no need for the patient to return to theatre. Opinions were sought from a number of colorectal surgeons with a unanimous decision that it would take some time to optimise the patient's health and allow the wound further time to contract before being able to return to theatre, repair the fistulae and close the abdominal wall defect. As the patient was no longer having regular anaesthetic for dressing changes, the STN team suggested removal of the tracheostomy.

The siloxane properties in Welland barrier film (WBF®) allowed the use of a non-irritating, non-toxic skin barrier that repels both water and chemical attack, such as stool enzymes, to prevent further periwound skin damage. Siloxane copolymers have also been reported to protect skin from adhesive trauma, to last up to 72 hours and to not leave residue on the skin[5], making them ideal in this situation. WBF® was used to prepare the periwound skin prior to the application of each Eakin® fistula/wound pouch.
Once the Eakin® fistula/wound pouch had been cut to size using a template, the off-cuts and Eakin Cohesive® seals were used to border the wound to create a physical barrier to prevent effluent coming in contact with the periwound skin. Eakin Cohesive® seals have a unique carbohydrate composition, which is slowly released to dilute harmful enzymes in the small bowel effluent, reducing their damaging effects on skin and they are also moisture-absorbent to protect the epidermis. Protecting the epidermis is vital in facilitating pouch adherence and improving patient comfort. The long wear time of the Eakin® fistula/wound pouch also made them a cost-effective choice. The wound bed was covered with Stomahesive® powder. Whilst this has no proven scientific basis, it did seem to offer some protection and encourage granulation. The wound pouch was bordered with Salts Secuplast® Hydro hydrocolloid strips to aid in securing the pouch edges into skin folds.

Figure 4 was taken three days after the application of the first Eakin® fistula/wound pouch and the improvement in the periwound skin is clearly evident and the patient’s pain level decreased significantly. Figure 5 shows the pouch immediately following application.

Figure 6 depicts the wound after having used Eakin® fistula/wound pouches for 49 days. This image was taken 17 days prior to the surgery that involved a laparotomy, small bowel resection and abdominal wall repair. At this time, the wound had decreased to 11cm long x 8cm wide (the depth by then was superficial). The periwound skin was intact, the base has granulated upwards and the wound edges had contracted around the fistulae. Note the Argyle™ yankauer sucker being used to suction effluent whilst the periwound skin is being prepared for application of the Eakin® fistula/wound pouch using the technique outlined above. Table 1 highlights the steps in changing the Eakin® fistula/wound pouch.

Table 1. Steps to change an Eakin® fistula/wound pouch.

<table>
<thead>
<tr>
<th>Step</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cut the new pouch using the template</td>
<td>Pouch needs to be ready to apply due to high fistula output</td>
</tr>
<tr>
<td>Place the pouch under the patient’s thigh</td>
<td>Warming the pouch aids with ‘moulding’ to the skin and adherence</td>
</tr>
<tr>
<td>Remove old pouch</td>
<td>Use remove wipes to aid in removal of residue or if removal is painful – clipping hair can also assist</td>
</tr>
<tr>
<td>Use a yankauer sucker to suction effluent (the aid of a second person is beneficial)</td>
<td>Keeps periwound skin clean and dry while applying new pouch</td>
</tr>
<tr>
<td>Prepare periwound skin with Welland barrier film (WBF®)</td>
<td>Repels chemicals in effluent and protects skin from adhesive trauma</td>
</tr>
<tr>
<td>Use the off-cuts from the new pouch to border the wound (the plastic inner lining must be peeled off)</td>
<td>Ensures a good seal and protection of periwound skin – alternatively use large seals</td>
</tr>
<tr>
<td>Dust the wound bed with Stomahesive® powder</td>
<td>May provide some protection to wound bed</td>
</tr>
<tr>
<td>Apply new pouch starting at the bottom (when using a large pouch, the aid of a second person is beneficial)</td>
<td>Second person can continue to use the yankauer sucker and aid with placement of the pouch</td>
</tr>
<tr>
<td>Mould the pouch to the skin and warm with hands</td>
<td>Aids in pouch adherence and increases wear time</td>
</tr>
<tr>
<td>Apply Secuplast® Hydro hydrocolloid strips to any creases or edges that are prone to lifting</td>
<td>Aids in pouch adherence at the edges and increases wear time</td>
</tr>
</tbody>
</table>

The Eakin® fistula/wound pouch was changed by the STN team twice a week over the 14 weeks between ceasing VAC® therapy and surgery. During this time the pouch only leaked once requiring the nursing staff to change it after hours. The days when the pouch was changed, the ward nursing staff and nursing students were encouraged to observe and assist. Due to the high output of the fistulae, pouch changes were difficult and an Argyle™ yankauer sucker connected to wall suction was used to suction effluent as the periwound skin was prepared and the new pouch was applied. The STN team continued to undertake all pouch changes to:

- ensure enough time was taken to correctly apply the pouch
- ensure supplies were used in the most cost-effective way
- provide education to the ward nurses and students
- assist the ward nurses to look after this patient with complex health care requirements
- enable routine monitoring of wound progress
- offer reassurance and continuity to the patient.
If you haven’t tried ConvaTec Mouldable Technology™ yet, now’s the time to change.

ConvaTec’s wafers change lives with:

- Built in Rebounding Memory Technology™ that helps the adhesive gently hug the stoma for a secure seal.
- Durahesive® Technology which absorbs effluent and swells to gently turtleneck and hug the stoma – for even greater leakage protection.
- and Flexible adhesive that moves with the patient to maintain a secure seal, to minimise leakage and maintain healthy skin!

Convex and flat mouldable wafers are available on ConvaTec SUR-FIT® plus, and Esteem synergy® appliances.

To learn more, call your ConvaTec Business Development Manager or telephone: Australia 1800 006 609  New Zealand: 0800 441 763
Over the ensuing period, the patient developed central venous line sepsis and occluded internal jugular vein, brachiocephalic vein and proximal subclavian vein, requiring treatment with intravenous heparin. This resulted in an intra-abdominal bleed five days later, with a collection measuring 15x14x11 cm. Intravenous heparin was ceased, the patient was transfused with six units of packed cells and two units of platelets and was returned to ICU for monitoring. The patient suffered a further septic event when a left subphrenic collection developed. This collection was initially drained in theatre and then again in radiology with the insertion of a pigtail-catheter. This catheter remained in position until the day prior to discharge. The patient also experienced bilateral pleural effusions which required draining.

Finally after 134 days in hospital (19 weeks), the patient underwent a laparotomy, small bowel resection to repair one fistula, primary repair of a second fistula and abdominal wall closure. Figure 7 shows the abdominal incision four weeks after surgery.

Bowel function was slow to return, TPN was weaned as an oral diet was introduced and TPN was finally ceased three days prior to discharge. Normal bowel function returned prior to discharge and the patient was continent, with 2–3 motions per day.

The STN made follow-up phone calls at two weeks and three months post-discharge. On the final follow-up call the patient was doing well, with 1–2 bowel motions per day; he continues to have regular physiotherapy, is back driving his car and feels life has returned to normal.

CONCLUSION

The complications of an open abdomen with gastrointestinal fistulae can be numerous and many were experienced by the patient depicted in this case study. A multidisciplinary approach did eventually achieve a pleasing result for this patient, who expressed gratitude for the hard work of the teams involved in his care.

A cautious and conservative approach gave this patient the physical and psychological reserves to cope with set-backs and a protracted hospital journey. It was rewarding and remarkable to see this patient walk out of hospital after 5.5 months.

REFERENCES

Cavilon™ Reassuring protection
now with a new look

15 years in development, more clinical evidence than any other moisture barrier or barrier film.*
Cavilon™ No Sting Barrier Film is the Gold Standard for uncompromising skin protection.

For a free sample or more information contact 3M on 1300 363 878 or visit www.cavilon.com.au

*3M Data on File
The following report is from the Coalition of National Nursing Organisations (CoNNO) meeting held in Melbourne on 1 April 2011. Presentations and issues discussed included:

CREDENTIALLING

As mentioned in the last CoNNO report published in JSTA (March 2011), CoNNO received funding from the Australian Department of Health and Ageing (DOHA) to undertake a project related to credentialling. CoNNO employed the services of Christine Ashley and Denise Ryan from Ashley Ryan and Associates, Health and Education Consultants to develop a credentialling framework that member organisations could utilise when developing a credentialling process, but which would also provide national consistency for credentialling.

The main focus of this meeting centred around the project context, key issues, credentialling definition, explanation of terms, workshop on the principles, workshop on the standards, and toolkit content. To follow is some background to this project:

- International context – increasing trend to/interest in credentialling.
- National context – national consistency in regulatory processes.
- Impetus for project – CoNNO members’ recognition of value for credentialling.
- Orderly development of specialist practice – CoNNO mandate and ICN platform.

Consultation process:

- Literature review – mid-January 2011.
- First draft of revised Principles (circulated to CoNNO member organisations for comments – 27 January).
- First draft of Standards, revised Principles (circulated 8–21 February).
- CoNNO Council meeting 1 March – agreement on revised Principles, definition and management of issues for Standards.
- Second draft of Standards – circulated 3 March.
- Third draft of Standards – circulated 15 March.
- Workshop 1 April.
- Final agreed Principles and Standards to CoNNO Council 13 May 2011.

The credentialling toolkit will include:

1. Principles and Standards.
2. Literature review.
3. Model credentialling programme:
   - A checklist template to review existing credentialling processes against the proposed framework.
   - A checklist (or possibly combined with the above) to set up a credentialling process for the first time.
   - Template for governance processes for credentialling, based on the CoNNO governance framework.
   - Template for selection processes for consumer/expert representative to sit on credentialling committees and related information for the potential consumer/expert representative.
   - Template for assessment of candidates.
   - Template for evaluation of the credentialling programme.

INVITED SPEAKER

Rosemary Bryant, Commonwealth Chief Nurse and Midwifery Officer gave a short overview of activities currently in progress which include:

- Area of Aged Care:
  - Nursing home teaching project
  - Funding models for nurse practitioners in aged care
- Consolidated nursing and midwifery education scholarships.
- Health reform.
- Rural Locum Scheme – this will allow rural nurses to take leave to perform CPD, whilst their position is filled by a locum.
- Reviewing nurse practitioner funding.
- Nurse practitioner/midwives access to Medicare and PBS.

CONNO COUNCIL

The CoNNO council elected Kim Ryan as Chairperson and Tracey Osmond as Deputy Chairperson.

MENTORSHP SURVEY

CoNNO recently conducted a mentoring survey. The main issues that member organisations raised as requiring support included: lobbying; professional standards; credentialling; and submission writing/grants/tenders.
AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY (APHRA) SENATE INQUIRY

At the time of the CoNNO meeting, there was a Senate inquiry into the administration of the health practitioner registration by APHRA, looking at some of the issues occurring from a national registration perspective. There have been numerous difficulties or anomalies with the transition to national registration, particularly with undergraduate students, international students, nurse practitioner candidates and their endorsement. The Senate Hearing for the inquiry will be held on 4 May 2011 and the final report including recommendations will be available via APHRA’s website.

GOVERNANCE STANDARDS

CoNNO is currently developing an online Governance Education Toolkit. This programme has been developed from funding provided by DOHA and should be completed by the end of the current financial year. Upon completing the online programme, individuals will be issued with a certificate, which can be used as supporting evidence for their CPD.

E-HEALTH

Jo Foster from Nursing Informatics Australia gave an overview of e-health initiatives including Health Care Identifiers: Individual Health Identifiers (IHI), Individual Health Professionals (IHP) and Individual Health Organisations (IHO). This initiative will run through Medicare and not be linked with registration.

The Personally Controlled Electronic Health Record (PCEHR) introduction in July 2012 will be managed by NEHTA. At this time it is GP-orientated. It involves a personally controlled health record for every individual in Australia. Initially, the individual will have control of their own health information record, input and access. Currently, there are many roundtable discussions going on; however, there is a need for more nurses to be involved. Any nurses interested should contact Jo Foster on j.foster@qut.edu.au

CONNO WEBSITE

The update of the CoNNO website has been completed. The council is interested in comments/feedback.

MEMBER ORGANISATION REPORTS AND MINUTES

Member organisation reports and a copy of the minutes of meetings can be accessed via the CoNNO website: www.conno.org.au

NEXT CONNO MEETING

The next meeting will be in Sydney on Friday 19 August 2011.

Lesley Everingham RN, STN (NSW)

Australian Council of Stoma Associations Inc. (ACSA)

ACSA Report

Norm Kelly • ACSA Secretary

The ACSA Executive has had an extremely busy year with a number of important matters that deserve mention in this report.

Firstly, our President Peter McQueen has been involved in voicing matters that affect ostomy associations and ostomates in general, leading up to the release of the SAS (Stoma Appliance Scheme) Review and dealing with the decisions that were made by that review. I am sure that your members are very aware of these changes, particularly the variations to products that are now available and the withdrawal of some products.

The makeup of the SAS Panel has been altered, with ACSA having representation but no voting position. The ACSA Vice-President Geoff Rhodes has been appointed to this position and with Geoff’s experience in dealing with government bodies we are in good hands.

ACSA also saw its member associations vote to resume full membership of the IOA (International Ostomy Association). The IOA has implemented some considerable changes which will see it become a regionally focused organisation better placed to provide assistance to disadvantaged ostomates in countries which do not provide the level of care and assistance that is needed. ACSA also continues to help some of these overseas ostomates in a number of countries through the Australia Fund with the supply of product donated by participating associations.

The reformation of the Asia Region of the IOA to include Australia, New Zealand and the South Pacific Islands was influential in ACSA changing its status to full membership. Peter McQueen will be attending the first meeting of the new Asia South Pacific Region in Iran this October.

The next significant event for ACSA will be our Annual General Meeting and Conference, which will be held in Sydney commencing on 11 October.

Regards to all.
In July I was privileged to be able to attend the joint AASTN and Tripartite Colorectal Conference in Cairns. I am sure that those of you who attended with me will agree it was a very special event, with us all being able to attend both the doctors’ and nurses’ lectures. In some cases, papers were given together by both disciplines, which enhanced the importance of both the doctors and AASTNs working as a team. There were over 1000 delegates with good plenary and concurrent sessions. An event like this does not come together without an enormous amount of planning and when that is done across a few continents it makes the job even harder. So it is with much admiration and awe that I compliment our AASTN Victorian colleagues as well as the colorectal surgeons who were part of the organising committee. It would be wonderful if both parties could join together in the future for another conference of this type and from the accolades that you were voiced, I won’t be surprised if this does happen. Well done to all the presenters and committee!

Thank you to the 60-plus people who attended the WCET Australian Biennial Members meeting, which was held during the conference. It was wonderful to have your support! During the meeting Fiona Bolton, chair of the 2012 WCET Congress being held in Adelaide 19-23 April, gave a progress report from the planning committee. Fiona told us the confirmed invited speakers are: Professor Keryln Carville – Australia, who will speak on wound and stoma care; Pat Black – UK, consultant, coloproctology and ET nurse; Dorothy Doughty – USA, ET, WOCN; Dr Gary Sibbald – Toronto, Canada, dermatologist and internist; Sandy Quigley – Boston, USA, CWOCN, CPNP specialising in paediatric nursing. All of these people have published widely and have had years of experience in their speciality. The preliminary programme includes a section on burns; the latest techniques in bowel surgery; wound and stoma care including bariatric care; professional development and education, research and practice innovation. The Saturday programme will focus on vascular, paediatrics, bowel/continence and dermatology – these will be concurrent streams. Of course, there will also be chosen abstract papers on all these topics. As well as the keynote speakers, other well-known speakers from Australia and overseas will be invited to talk. All in all, it is shaping up to be a conference you will not want to miss. Watch for the early bird registration so you can register. If you are a member then it will be even cheaper. The membership fee is a lot less than the conference savings for members, so join now at www.wcetn.org and click on new member.

I would like to take this opportunity to congratulate our colleague, Keryln Carville on being made a full Professor of Domiciliary Nursing at the Curtin University in Western Australia. Keryln received her PhD in stomal therapy a few years ago and so now is Professor Dr Keryln Carville. Thank you Keryln for the outstanding contribution you make to our chosen profession.

For those of you whose membership is due for renewal at the end of this year, now is a good time to register while the pound is still favourable with the Aussie dollar.

The closing date for the call for abstracts for the 2012 congress has been extended to 15 October, so you still have time to submit yours. After seeing the outline of the programme above, I am sure you will have an interesting situation on the topics listed you would like to share with your colleagues. Your paper will also be submitted to the AASTN and WCET journals for consideration for publication. If you are a relatively new STN, it is a great opportunity to present a paper where your friends can give you support and it also looks very good on your CV, as well as for CPD points and your nursing registration. Keep those abstracts rolling in; the review team are ready to read them!

Best wishes.

ELECTRONIC SUBMISSION OF MANUSCRIPTS TO THE JOURNAL

The Journal of Stomal Therapy Australia now requires all submissions to be made online

STEPS TO SUBMISSION AND PUBLICATION

- Go to the publisher’s website: www.cambridgemedia.com.au
- Click on Manuscript System.
- Login.
- Create an account if first time using the system. This will be retained for future enquiries and submissions.
- Enter your personal details: all fields must be completed.
- Confirm your details.

SUBMITTING AN ARTICLE

- Step 1 – Type the title, type of paper and abstract. Select publication – JSTA.
- Step 2 – Confirm author. Add co-author details (all fields) if applicable.
- Step 3 – Upload files. Only Word documents are accepted. Please ensure your document contains the required information and is formatted according to the author guidelines. Photos to be sent separately in jpeg format.
- Step 4 – Add any comments for the editor.
- Step 5 – Review your information then click submit.

Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review.

Peer review

Peer reviewers will be asked to review the manuscripts through the electronic process.
Life Membership awarded to Susan Dunne

At the recent Annual General Meeting of the AASTN, Susan Dunne was honoured with life membership. Susan has been, and still is, a dedicated and active member of the AASTN since completing the Stomal Therapy Nursing Course at Sydney Hospital in 1979. At that time she was employed in a multi-specialty surgical ward at St Vincent’s Hospital, Sydney. After completing the course, Susan established the Stomal Therapy Nursing Unit at St Vincent’s and was there until her retirement in 2009. At the time of her retirement, Susan was the Clinical Nurse Consultant for Stomal Therapy and Wound Management. Susan has always been dedicated to her job and has shown enthusiasm above and beyond the call of duty. She has been a valued and respected member of the St Vincent’s staff. Patients speak of her nursing care with fondness and with the highest praise as do the surgeons, physicians, nurses and allied staff. One stomal therapy nurse relates that when she did her clinical placement with Susan, the patients were from very diverse living standards. Susan looked after the upper-class from the more affluent areas of Sydney but also looked after homeless people who lived on the streets and the parks. Susan’s attitude and care was the same towards every patient irrespective of their social circumstances and the patients adored her because of this. Another colleague described Susan as St Vincent’s Hospital’s Mission Statement in action. At her retirement function at St Vincent’s, the Director of Nursing described Susan as a “Legend”.

Susan has been enthusiastic and involved with professional matters outside of the hospital. Over the past 30 years, she has been an active member of the AASTN and is highly regarded and respected locally, nationally and internationally. Susan has consistently held positions on the NSW State branch executive and the conference organising committees. She was Treasurer for the AASTN National Executive from 1984 to 1986. Susan has represented NSW on the AASTN Education and Professional Development Subcommittee, Tutor for the College of Nursing Graduate Certificate in Stomal Therapy Nursing and is currently involved in the rewriting of the course.

Susan’s activities have not been restricted to Australia. Susan has held numerous positions within the World Council of Enterostomal Therapists. She was the Australian International Delegate for 4 years, Chairperson of the Constitutional Committee from 1998 to 2002 and Treasurer for 3 terms from 2002 to 2008. This included an extraordinary third term of office in what is a very challenging and difficult role. As Treasurer, Susan facilitated great advances in streamlining the function of the WCET so that it is consistent with modern technology.

In 1984, the NSW Stomal Therapy Nursing Course transferred from Sydney Hospital to St Vincent’s Hospital. Susan was the course co-ordinator from 1987 to 1996 which included not only organising and giving lectures but also co-ordinating the clinical placements. This was all performed whilst maintaining a busy clinical workload. Susan was one of the key people instrumental in organising the transfer of the stomal therapy nursing course from hospital to the tertiary sector. Since 1997 she has been a writer, tutor and marker for the graduate certificate course in stomal therapy nursing run in the distance education mode by the College of Nursing in conjunction with the AASTN.

Susan has presented papers at national and international conferences and has had many articles published. She demonstrated advanced practice by becoming a credentialed Stomal Therapy Nurse.

Whilst retirement sees most people slowing down their activities, Susan remains active within the AASTN. Susan is currently Treasurer for the NSW branch, NSW representative on the AASTN Education and Professional Development Subcommittee, Tutor for the College of Nursing Graduate Certificate in Stomal Therapy Nursing and is currently involved in the rewriting of the course.

Susan is hard working, dedicated, selfless, extremely honest, and highly principled. She is recognised and looked up to as a role model and mentor. Susan always has something insightful and meaningful to contribute, and her participation on any committee ensures for a lively discussion. She has the ability to understand ‘the fine print’ and has an unswerving commitment to fairness and ethical procedures. Susan’s characteristics have won the admiration and respect of her colleagues’ world wide.

The bestowing of life membership to Susan not only recognises and acknowledges her consistent contribution to the AASTN and Stomal Therapy Nursing but also serves as a thank you and a tribute to Susan for her wonderful work.
Australian Capital Territory

Stomal therapy in the ACT has continued to grow as a speciality, with seven qualified STNs to date. I work full-time in the acute sector and the other STNs all have registered nursing roles with opportunities to practise as STNs part-time in the acute and community settings. The branch meetings are held five times per year at Phillip Health Centre, although attendance remains a problem due to the workloads outside the STN role for many members.

The AGM held on 7 June saw a change in some of the state Executive positions.

Office bearers

President: Kellie Burke; Vice-president: Judie Coulson; State Representative: Vicky Browne; Secretary: Lily Viekkanen; Treasurer: Therese Verdon

I am pleased to have Vicky Browne taking over the reins as State Representative. Clare Love is vacating the Secretary’s chair and Lily Viekkanen has agreed to take on this role. Judie Coulson is welcomed into the Vice-president’s role. I wish them all the best in their new roles.

The challenges for the rest of 2011 and into 2012 include succession planning, with a focus on the registered nurses who are enthusiastic and motivated about stomal therapy. I am hoping to encourage some nurses to obtain this postgraduate qualification.

We also continue to encourage participation in CPD and credentialling. I offer congratulations to our ‘adopted’ ACT member Kirsti Dixon for her successful credentialling. I know this has motivated me to attempt this in 2012.

Finally, we are focusing on the need for acute care beds and looking at the discharge planning processes. The possibility of implementing fast-track colorectal surgery is also being explored.

Thank you,

Kellie Burke

New South Wales

Our educational session at our second monthly meeting in June was titled “Pelvic exenteration stomas and conduits”, presented by Professor Michael Solomon, colorectal surgeon, RPAH. Ian Whitely, CNC, Concord Hospital will present on irrigation at our August meeting.

We welcome a new member to the AASTN NSW branch – Jennifer McCudden.

Many NSW branch members will attend and will be presenting at the Tripartite/AASTN Conference in Cairns in July. We are all looking forward to this conference for education and networking experience.

At the AGM, in Cairns, Susan Dunne will be awarded Life Membership into the AASTN. Susan has been, and still is, a dedicated and active member since completing the Stomal Therapy Nursing Course at Sydney Hospital in 1979. She then established the Stomal Therapy Nursing Unit at St Vincent’s Hospital and worked there till her retirement in 2009. Susan has always been dedicated to her job and has shown enthusiasm above and beyond the call of duty. She has held many state and national positions over the years. Congratulations to Susan on receiving this well-deserved award.

Remaining meetings for 2011 are Tuesdays 2 August and 4 October and Friday 2 December at RPAH. Please contact me for any further details.

Cheers,

Jenny Rex

Queensland

In 2011 our committee consisted of Jan Fields (President), Colleen Pope (Vice-President), Petra Prokop (Secretary), Maxine Wench (Treasurer), Shirley Jones (BOSVS), Ros Probert and Pat Sinasac (Education) and Emma Vernon (State Representative). Our meetings continued bimonthly with a good attendance at each meeting.

It has been a difficult year. The state flooded in January. Thankfully no STNs were directly affected. One of our company representatives did suffer extensive flood damage. Only last month she and her family are finally recovered, rebuilt and moved back into their home.

Nicole Bowden, one of our STNs, was in a tragic motor vehicle accident in November last year. She is currently receiving rehabilitation and we send our best wishes to her and her family.
A successful community ostomate education afternoon was held in Brisbane with great attendance. Many STNs volunteered to assist and present at the event.

Pat Walls and Brenda Sando were able to go to Phoenix for the WCET Conference. They presented a poster on “Evacuation system for colostomy irrigation”.

Clarrie Bond retired from Beenleigh Community Services after many years of service. We continue to wish her well for her future.

Brenda Sando retired for a few months. She is back in active duty at the Sunshine coast Private Hospital.

Theresa Winston has taken on JSTA Journal Editor for another year. The Queensland members thank her for her ongoing commitment to this difficult role.

Penny Dewinter and Michelle Carr are currently going through the nurse practitioners’ course. It’s wonderful to see AASTN members advance in this role.

I close this report by saying what a fabulous time we had at the Tripartite Colorectal Conference. The speakers, the collaboration between the AASTN and the colorectal doctors and the networking to be had was fantastic. Cairns was beautiful, the weather was just right and I know that we all enjoyed ourselves. I have enclosed a photo of most of the Queensland members that attended. We would like to thank the Victorian branch for organising the first conference of its kind. Well done.

Thank you,
Emma Vernon

South Australia

As I write this report I have only just finished unpacking my luggage after a short holiday in Cairns following the Colorectal Tripartite Conference. The conference was a great opportunity to explore new ideas and knowledge as well as meet colleagues both in the nursing and medical profession. Thank you to Helen Nodrum and the rest of the Victorian stomal therapy nurses team in conjunction with the assisting colorectal surgeons for putting together such a well-organised and interesting conference programme.

At the AASTN (SA branch) meeting in April, Joanne Perry, colorectal extended practice nurse at the Royal Adelaide Hospital, gave a presentation on her role supporting the colorectal cancer patients and surgeons. She is the first nurse in this state to fulfil this type of job and the stomal therapy nurses here were keen to hear about what Jo is employed to do. With the National Bowel Screening Programme picking up many new cancers, she has apparently been very busy.

At the most recent AASTN (SA branch) meeting on 29 June, Elizabeth English spoke about her recent trip to Africa and her work with the WCET. It sounded very interesting, assisting with the education of nurses and becoming involved with patients there who greatly benefited from the expert care they received.

Another item which has raised some discussion at recent branch meetings are the changes to the Stoma Product Assessment Scheme. A number of stomal therapy nurses feel that the new scheme warrants further consideration and discussion of this needed to be raised at the national level in Cairns, which was duly done.

Currently some fundraising events are being planned in this state with a film afternoon on the agenda for 30 July. Unfortunately, this is the same day as the football showdown between the Crows and Port Adelaide, so there may be some conflict of interests occurring. Hopefully there will be a good attendance as the movie sounds like it will be one which will appeal to a wide audience. A quilt, which was handmade and donated to the AASTN (SA branch), will also be raffled to assist with fundraising, along with a basket of goodies organised by the company representatives.

Stomal Therapy Week in June was marked with a flourish at Calvary Hospital with Fiona Bolton and Claire White erecting a stand to advertise the occasion. Below are pictures of the event taken to celebrate the week.

Now that the conference has finished, life will become more orderly for those of us in South Australia, although continuing preparations for the WCET congress in Adelaide in 2012 roll on. Hopefully the end product will be like the Cairns conference: something to extend our knowledge and improve our practice, resulting in benefits to our clients.

Lynda Staruchowicz

Tasmania

At the time of writing this, Tasmania has been experiencing lower than average temperatures and snow in places it doesn’t
usually snow. Luckily a number of our members got to enjoy the wonderful climate of Cairns.

Sue Delanty, on her return from Cairns, reports that she arrived two days prior to the conference for the AASTN E&PDs meeting and worked her fingers to the bone. The committee members have changed over the last few years and I am happy to report that nearly all, but not quite all, members are credentialled. I went out for dinner with the NSW girls on the Saturday night and had a great time getting to know these wonderful women with diverse roles in NSW. Thank you for your company. Now it is back to work as I have over 100 emails to check … Sigh!!

Teena Carydakis on her return reports that the Cairns Tripartite Conference was great, allowing national and international networking and learning among all participants. There was good representation from Tasmania with five stomal therapy nurses (two from the north, two from the south and one from the north-west), four colorectal surgeons (two from the north and two from the south) and one colorectal registrar from Launceston. The warm weather was fantastic to experience, given Tassie’s severe cold snap. Unfortunately a camera malfunction meant no photos!!

Thankfully one of our surgeons had a functioning camera!

The North/North-West Journal Club meeting was recently held at ETC Bakery. Carolynne Partridge presented a PowerPoint presentation on erectile dysfunction, Sue Delanty presented a talk on the Dialogue Study results, Teena Carydakis presented a PowerPoint presentation on mentorship and Andre Gall of Coloplast presented Coloplast Care. All were very informative presentations, which generated an open discussion on each of the topics. As always, a big thank you to Andre and Coloplast for their continued support of this event.

On behalf of the AASTN Tasmanian branch members, congratulations to one our members: Angela Locke and husband Sam on the safe arrival of baby daughter Millie Grace. We wish you all the very best. On 26 August we will be holding a PEG tube seminar for nurses, a topic that generates a lot of interest from many areas of health care. Speaking on the day will be Margot Hickman, a local dietician and pharmacist and gastroenterologist, Professor Shan Rajendra. Thank you to Robyn Wortel and Kimberly-Clark for their assistance and sponsorship.

Congratulations to the AASTN Victorian branch, organisers of the conference, which was a great success and enjoyed by all that attended. The 2013 Tasmanian conference planning is well under way and we hope that we can be as successful.

On behalf of all the Tassie STNs, kindest regards,

Andrea Hicks
meetings were held and this also gave presenters a chance to rehearse their talks and get feedback from their peers.

A number of members of the Victorian branch have completed the CPD and are working their way through the credentialling process. This gives this rest of us the impetus we need to start the process ourselves.

Achievements over the year

Diana Hayes, clinical nurse consultant in stomal therapy at Western Health, was recognised for her research into patients having surgery on the small bowel and not receiving the full benefits from their slow-release medications, resulting in effects of fluid loss and dehydration. Diana was honoured by the state government, with the Award of Excellence in Nursing Practice.

RDNS stomal therapy nurse consultant completed a five-year project, in association with the AASTN, in translating the English versions of the AASTN education leaflets, into five different languages. The languages are Greek, Macedonian, Italian, Chinese and Vietnamese. These are now available on the AASTN website, via the RDNS link. This makes them available all over Australia.

Congratulations to all the contributors to this year’s activities.

We anticipate a successful conference in Cairns and look forward to being involved in the Tripartite Meeting with the colorectal surgeons from the United Kingdom, America, Australia and New Zealand.

Let’s strive for excellence in the next 12 months.

Patricia McKenzie

Western Australia

Firstly I would like to extend my thanks to the Victorian branch for their wonderful conference. Well done to all of you in the preparation and planning. I imagine it would not have been easy especially incorporating the colorectal surgeons conference.

The dinner dance was great and, of course, the venue and then there was the beautiful town of Cairns and their friendly folk. Thanks again.

We were fortunate to have a good number of Western Australian delegates, some of who actually presented: Jo Campbell and Nicole Walsh, to name a couple.

Little has happened since our return from the conference but the year’s planning for clinical updates and study days are already going ahead.

The report I submitted to the AGM was as follows for those that are interested.

The Western Australian branch has been active this year, with some extremely successful study days and changes within the association; enabling us as a group to promote and encourage other nurses to become actively involved.

The AGM 2010 introduced the new committee.

Office bearers

President: Carmel Boylan; Secretary: Shannon Tassell; State Representative: Leigh Davies; Treasurer: Rita McIlduff

Education Committee: Lorrie Grey, Sandy Hyde-Smith

Committee members: Deborah D’Silva, Brigid Keating, Mileva Basic, Lisa Richards, Kerlyn Carville

Web Coordinator: Karen McNamara

The biennial Stomal Therapy Nursing Education Programme was completed in 2010 by a group of 13 nurses from various working domains. The success of the course was due to the extensive work put in by:

Course facilitator: Lorrie Gray; Wound management: Kerlyn Carville & Liz Howse; Stomal therapy: Carmel Boylan; Continence: Shiree Walker

A close relationship with the Ostomy Association of WA continues, with STN representation at their meetings. The Madge Eyles Scholarship, sponsored by the Ostomy Association, was awarded to Megan Stein on completion of the STNEP.

A survey of WA ostomates and STNs was carried out, to assist in identifying problems in respect to product supplies, stomal therapy support and identification of ongoing needs.

A professional development day (PDD) and clinical updates continued throughout the year and were well-attended. The PDD was particularly popular and focused on the aged care sector, with the aim being to promote better management of stomas and wounds within those facilities. Areas for discussion included complex draining wounds, gastrostomy tube management and general wound care issues.

The STNs who completed their CPD in 2010 were:

Lorrie Gray, Deborah Sinclair, Carmel Boylan, Maggie Phillipson, Del Tenant, Pam Thompson, Nicole Walsh, Shiree Walker, Lynette Beelitz, Eileen Lim Joon, Marleen McLaughlin, Joanne Campbell and Liz Howse.

All in all it has been a successful year and we hope to continue to maintain all our successful relationships with the ostomates, the WA Ostomy Association and the product representatives in the year ahead.

Yours sincerely,

Leigh Davies
Guidelines for authors

The Editors and the Editorial Board of the Journal of Stomal Therapy Australia have specified guidelines for prospective authors to follow when compiling an article they wish to submit to the journal.

TERMS OF SUBMISSION

The Journal of Stomal Therapy Australia is a quarterly publication which aims to provide educational material to the membership and any other interested bodies. Accordingly, the Editor welcomes contributions which relate, clinically or professionally, to stomal therapy nursing. These can include scientific papers, case studies, reports or letters to the Editor. Contributions can be four lines or four pages long. If necessary, you can phone the Editor or write for advice on preparing your submission.

Accompanying each submission must be a letter signed by all authors and stating that the work has not previously been published and will not be published elsewhere. Once it is published, the article and its illustrations become the property of the journal, unless rights are reserved before publication.

All work is sub-edited to journal style. The editors reserve the right to modify the style and length of any article submitted, so that it conforms to journal format. Major changes to an article will be referred to the author for approval prior to publication. The Editor will provide assistance to first-time authors and may be contacted by email.

Authorship

All authors must make a substantial contribution to the manuscript and will be required to indicate their contribution. Participation solely in the acquisition of funding, the collection of data or supervision of such does not justify authorship. All participating authors must be acknowledged as such; proof of authorship may be requested by the editors. The first-named author is responsible for ensuring that any other authors have seen and approved the manuscript and are fully conversant with its contents. If the author wishes to reproduce copyrighted work, it is the responsibility of that author to obtain written permission from the copyright holder and to submit the original copy of that permission to the editor with the work as it is to be copied.

Conflict of interest: It is the responsibility of the submitting author to disclose to the Editor any significant financial interests they may have in products mentioned in their manuscript. Conflicts of interest should also be disclosed within the manuscript before the References section.

Ethics

Investigations in human and animal subjects must conform to accepted ethical standards. Authors must certify that the research protocol was approved by a suitably constituted ethics committee of the institution within which the work was carried out and that it conforms to the Statement on Human Experimentation or the Statement on Animal Experimentation by the NHMRC.

MANUSCRIPT TYPE

The journal publishes articles of interest to readers from the areas of stomal therapy nursing. Submitted work may take any of the following forms:

Discussion: Presentation of information from more than one viewpoint (for example, for and against) and usually ending with a recommendation or opinion, based on the evidence presented.

Literature review: Narrative – describes and evaluates the current knowledge of a subject, identifies gaps or inconsistencies and includes critical evaluation with recommendations for future research. Systematic – describes planned analysis and evaluation of all available research studies on a particular clinical issue, conducted in accordance with scientific principles and may include recommendations for future research.

Research report: Presentation of study results in an ordered fashion, based on common practice. Research reports are expected to follow the uniform requirements for manuscripts submitted to biomedical journals, as published in the New England Journal of Medicine, Vol. 336, No. 4, 1997.

Case study: Combination of recount (retelling of events as they occurred) and information report (classification and description of something). Can be presented in different ways to give a cohesive account.

Exposition (incl letter to the Editor): Putting forward a particular viewpoint/justification of a particular argument.

Narrative: An informing and/or entertaining account of a happening in the world (for example, conference report).

PREPARATION OF MANUSCRIPTS

Manuscripts are to be no more than 4000 words and include an abstract of no more than 250 words. Use double spacing with Times Roman 12 font and margins 2.5cm. Title page to include title of manuscript, author’s names, qualifications and affiliations, corresponding author’s details including email address and contact phone number, total word count and up to five keywords. Include title of work on the abstract page and first page of introduction. Include key points on what is already known on the topic and what your manuscript contributes. Define abbreviations in the summary and on first mention in the text. Avoid abbreviations unless terms are used repeatedly and abbreviating them will enhance clarity. Additionally, photograph(s) of the author(s) must be included in the submission and should be in jpeg format.

Tables and figures are to be presented on separate pages, one per page. Tables should be clearly typed, showing columns and lines. Number tables consecutively using Arabic numerals in the order of their first citation in the text and supply a brief title for each. Place explanatory matter in footnotes, not in the heading. Explain in footnotes all non-standard abbreviations used in each table.

Figures must be submitted on separate pages. Photographs of the highest quality may be included in the submission and should be in jpeg format. Legends for any figures supplied must be typed in sequence on a separate page(s). Illustrations and figures
must be clear, well-drawn and large enough to be legible when reproduced. Titles of illustrations should be supplied on a separate piece of paper, not in the figure or illustration. Each figure must include its place, its number and the orientation of figure. Patients or other individual subjects should not be identifiable from photos unless they have given written permission for their identity to be disclosed; this must be supplied.

Referencing guidelines

The referencing format is based on the Vancouver style, the main feature of which is the use of numbers at the point of reference so as not to interfere with the flow of words. Each number corresponds to a single reference provided in the reference list at the end and, once assigned a number, a reference retains that number throughout the text, even if cited more than once. If more than one work is quoted in a reference, each work must be assigned a number. That is, at any point in the text, the reference may be one or several numbers.

Following are examples of references from different sources:

- **Journal article** (list all authors up to six; above six, use first author only, followed by *et al.*).

- **Book**

- **Edited book**

- **Chapter in an edited book**

- **Website**

- **Unpublished paper presented at a meeting**

**SUBMISSION OF MANUSCRIPTS**

Manuscripts are only accepted as an electronic submission with an attachment as a Word document. All tables, figures and photographs are to be included in the one attachment. The manuscript must be accompanied by a covering letter indicating that the manuscript has not been submitted elsewhere and transferring copyright to the Journal.

Manuscripts are submitted electronically:

- Go to the publisher’s website: www.cambridgemeedia.com.au
- Click on Manuscript System.
- Login.
- Create and account if first time using the system – this will be retained for future enquiries and submissions.
- Enter your personal details – *JSTA* requires all fields to be completed.
- Confirm your details.

Follow the steps for submitting an article

- **Step 1** – Type the title, type of paper and abstract. *JSTA* requires an abstract for all submissions. Select publication – *JSTA*.
- **Step 2** – Confirm author. Add co-author details (all fields) if applicable.
- **Step 3** – Upload files. Only Word documents are accepted by *JSTA*. Please ensure your document contains the required information and is formatted according to the author guidelines.
- **Step 4** – Add any comments for the editor.
- **Step 5** – Review your information then click submit.

Once submitted, the manuscript is reviewed by the editor and, if acceptable, sent for peer review. You will be notified by email once your manuscript has been selected for peer review.

**PEER-REVIEW PROCESS**

All manuscripts are initially reviewed by the Editorial Board and those deemed unsuitable (insufficient originality, serious scientific or methodological flaws, or a message that is too specialised or of limited interest to a general medical audience) are returned to the author(s), usually within four weeks. If the manuscript does not conform to the submission guidelines, the author will be asked to amend prior to peer review.

All manuscripts are reviewed by content and writing peers for relevance, construction, flow, style and grammar. All reviewers spend considerable time in reviewing the manuscripts and providing feedback to the authors. The length of time of the publication process can vary and depends on the quality of the work submitted. Several revisions may be required to bring the manuscript to a standard acceptable for publication. The Editorial team undertake the final review and often have different questions for the author/s to consider. When time permits, proofs of articles about to be published will be sent to the corresponding author for review. This requires rapid response; if such a response is not forthcoming, the article will be published irrespective of the author’s reply. Providing facsimile numbers facilitates this process. The final decision about publication is made by the Editor.

The peer-review process is managed online. Decisions are communicated by email to the corresponding author. Authors without email are contacted by phone, fax or post. Submitted manuscripts are acknowledged by email.

**PUBLICATION DEADLINES**

All materials for publication must be in the hands of the Editor by the following dates for 2011–2012. Please note that due to the editorial review process there is no guarantee of when accepted papers will be published.

- 17 October for the December 2011 issue.
- 20 January for the March 2012 issue.
Moderma Flex
1 Piece Closed Pouch

Skin Barrier:
• Gentle on skin when removing
• No residue left on skin

Flexibility:
• Conforms to your body shape
• Greater flexibility & security

AF300 Filter
• Does not block if comes into contact with liquid output
• Reduces pouch ballooning and pancaking

Contact Hollister for samples:
Australia: 1800 219 179
New Zealand: 0800 167 866