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• The stomal therapy nurse will not participate in unethical practice.

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Work and play

Sharmaine Peterson

37TH AASTN CONFERENCE

I have just returned from 3 weeks in Perth, where I attended the 37th AASTN Conference. There were some excellent speakers, both national and international. The numerous trade displays were kept busy during the breaks and there were many opportunities to network with colleagues. I would like to congratulate the Western Australian stomal therapy nurses for the fantastic work they did and for the variety of the programme, which had topics for all to enjoy.

While in WA, I stayed with friends for 2 weeks. We drove to Denham and had 3 very relaxing days relaxing and sightseeing. At Monkey Mia, I was lucky enough to feed the dolphins. We also went on a 3-hour quad bike ride around Denham, along bush and beach tracks – there were a few scary patches, but it was great fun.

SURPLUS SUPPLIES

I have spoken to Bruce Harvey, a member of ACSA. He has organised supplies to be sent to Jakarta and Bogor in Indonesia, to Nepal, to the Philippines and is at present is gathering information about Fiji. Funding for this comes from ACSA and some of the companies. If you have excess stock, you can contact him at harvey.bruce@bigpond.com

CPD AND CREDENTIALING

Information about this can be obtained from Sue Delanty – her email address is in the journal. If you attend a conference, seminar or workshop, copy the certificate as evidence of attendance.

THANK YOU

As the new President, I would like to thank all existing members for their commitment to our association and also welcome new members. Thank you also to the South Australian branch for the nomination, encouragement and confidence in my abilities. I hope I can prove worthy of their trust.

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Taking the journal forward

Theresa Winston

Hello! I’m the newly elected editor of the AASTN journal, thanks to my Queensland colleagues, and am looking forward to the challenge of the next 2 years.

I live in the coastal city of Hervey Bay, Queensland, which is about 3.5 hours north of Brisbane. I work for Queensland Health’s Fraser Coast Health Service, which includes two hospitals, Hervey Bay Hospital and Maryborough Hospital, 40km apart. I have been nursing for 38 years, in a variety of roles, in England and Australia, but only completed my Graduate Certificate in Stomal Therapy in 2005. I am therefore a relative newcomer and still have a lot to learn! I’m an endorsed Nurse Practitioner, having completed my Master of Nursing Science (Nurse Practitioner) in the area of wound management and stomal therapy at the end of 2008. For the last 9 years my substantive position has been Nurse Unit Manager (NUM) of a 28 bed surgical unit, but over the last year I’ve been establishing the role of the NP.

I attended my first AASTN conference this year, in Perth, and found it a wonderful experience to meet and listen to other stomal therapists from around Australia and other countries. I believe a lot of us came away from the conference realising how lucky we and our ostomates are compared to those in China, Indonesia, South Africa and Iran. For those not fortunate enough to attend the conference, with permission from the speakers, some of the talks on the ‘global perspective’ are published in this journal. I have to apologise to those people who submitted articles and photographs for this journal, that have not been published. They will be published in the next journal. It was amazing to actually have too many articles for my first journal as editor, but please keep them coming in. I would like to thank all those authors who have contributed to this journal.

Working as a stomal therapist in an organisation where there had not previously been a stomal therapist has meant starting from scratch as far as policies, protocols etc go. Working in a rural area and not able to attend the state stomal therapy nurse meetings, it can be difficult to get information on best practice. I would like to see this journal become a resource tool to enable new stomal therapists to have some baselines for developing protocols/guidelines in their practice. Julia Thompson (Associate Professor, Practice Development Facilitator, St Vincent’s Private Hospital, Sydney) suggested that we have a regular feature in the journal where we ask readers to send to the editor their work practices and any tools/care pathways used. Julia and I will collate these and publish the consensus. Areas we’re thinking about include preoperative assessment, site marking, postoperative assessment, and management of mucocutaneous separation. The feature will be titled *What is the consensus*... Consensus means “An opinion or position reached by a group as a whole”. Any comments or suggestions would be welcome.

I would also like to have a small area in the journal with a profile of a stomal therapist. Each state could recommend someone; it would be another way of getting to know our fellow colleagues. The questions for the profile would be:

- What do you like best about your job?
- Can you share a funny experience about your job?
- What was your first job?
- What do you like to do in your spare time?
- What’s the most interesting place you have visited?

I look forward to undertaking this role and encourage readers to submit articles and ideas so we can all keep on sharing and learning from each others’ experiences.

AASTN OVERSEAS TRAVEL GRANT

The Australian Association of Stomal Therapy Nurses Overseas Travel Grant is open to applications in the year 2009. The grant to the value of $2,000 is awarded biennially to assist an active AASTN Full Member to travel overseas in order to participate in research, conferences or other worthy projects.

**SELECTION CRITERIA AND GUIDELINES**

The applicant is to submit to the AASTN Secretary by 31 October 2009:

- A completed official application form, which is to be obtained from the Secretary.
- A letter of endorsement from the candidate’s State Branch verifying their status as a Full Member active within the Branch.
- A letter of endorsement from the candidate’s employer verifying the candidate’s commitment to excellence in the field of stomal therapy nursing.
- A current curriculum vitae.
- A commitment by the candidate to continue working for at least 6 months after their return. A medical certificate must be supplied to the AASTN Executive if the applicant is unable to fulfil this contract due to illness or other circumstances.

In addition, the successful candidate will submit to the AASTN Executive a report for publication that acknowledges the award within 3 months of their return.

The project must be commenced within 2 years of the award. Receipt of a grant automatically excludes members from re-applying for 5 years. The successful candidate will be notified within 6 weeks following the closing date.
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Parastomal hernias revisited, including a cost-effectiveness analysis: is an ounce of prevention worth a pound of cure?

Assoc Prof Julia M Thompson RN STN PhD •
Practice Development Facilitator, St Vincent’s Private Hospital, Sydney NSW

ABSTRACT

During stoma creation, an opening is made to allow the intestine to be advanced to the skin. If this defect enlarges, a parastomal hernia can develop; the incidence rate is about 30%. There are three parastomal hernia subtypes – subcutaneous, intrastomal and interstitial. Some hernias are asymptomatic, but others cause discomfort, aching, pain, nausea, appliance leakage, anxiety, distress and psychological problems. Possible complications include intermittent bowel obstruction, incarceration, strangulation, perforation and exacerbation of back and respiratory problems. Risk factors include abnormal collagen metabolism, age, infection, obesity, smoking, muscle strain, raised intra-abdominal pressure, and previous hernia.

Diagnosis involves a clinical examination with the patient lying and standing, a careful history and sometimes radiological studies. Management is usually conservative. Surgical repair has a high recurrence rate and is usually avoided unless there is a severe complication. There is evidence to support use of a prevention programme, including abdominal exercises and support garments together with education to reduce excess weight, stop smoking, avoid lifting heavy weights. A cost-effectiveness analysis demonstrates that the preventive programme is worthy when compared with the costs of having a parastomal hernia or trying to surgically remove it.

INCIDENCE

The incidence of parastomal hernias is high but data vary greatly due to the non-standardisation of methods used in the studies. Carne et al.’s meta-analysis concluded that parastomal hernias affect 4-48.1% of end colostomies, up to 30.8% of loop colostomies, 1.8-28.3% of end ileostomies and up to 6.2% of loop ileostomies. This averages out to about 28.35% of all surgery; however, this does not include urostomies which are also able to be affected by parastomal hernias, although the incidence seems
to be lower. A review of 16,470 on the American United Ostomy Association Register revealed a 30% incidence over all types of stomas.

Devlin outlined various subtypes of parastomal hernias and, although there is no published data on relative numbers, this classification assists with the description of hernias detected on CT. These were subcutaneous (hernia sac lies in the subcutaneous plane – Figure 1), intrastomal (hernia sac penetrates into a spout ileostomy – Figure 2), and interstitial (hernia sac lies within layers of abdominal wall – Figure 3).

**DIAGNOSIS**

Diagnosis of a parastomal hernia involves a clinical examination, a careful history and sometimes radiological studies. For the clinical examination, the stoma should be digitally examined with the patient standing and by performing Valsalva’s manoeuvre. If a hernia is present, this will reveal an enlarged fascial ring and an inability to maintain increased intraperitoneal pressure during the manoeuvre. When standing upright, the hernia is more prominent but when supine it will usually reduce (Photo 1). Many people develop a bulge around their stoma (Photo 2), which is not actually a hernia because there is no sac and no protrusion of abdominal contents; therefore there is nothing to reduce.

If the patient’s history suggests a hernia but it cannot be proven clinically, ask a doctor to organise a CT scan with oral contrast or an upper GIT x-ray such as small bowel series or retrograde contrast study to visualise the loops of bowel.

**SYMPTOMS**

Most parastomal hernias present as an asymptomatic swelling or bulge near to or around the stoma. Some cause mild discomfort or a dull ache or a dragging/heavy sensation which may restrict activity. Some are associated with nausea related to the stretching of the bowel mesentery as it protrudes through the defect. The natural history is a gradual enlargement of the hernia and stoma aperture (Rubin & Bailey cited in Kane et al.).

**COMPLICATIONS**

Further to the basic symptoms, there are a few possible complications that can occur in patients with parastomal hernias. These include the following:

- **Intermittent obstruction** – where the bowel is inactive during periods of physical activity and then the stoma works when the person is resting.

- **Infection** – as the overlying skin is stretched, the subcutaneous tissue atrophies and the skin at the apex becomes ischaemic and susceptible to ulceration and infection. This is compounded by leaking appliances.

- **Incarceration** – the intestine is trapped in the hernia sac.

- **Strangulation** – the trapped intestine becomes twisted and its blood supply is cut off or twisted around adhesions at lateral margins of the hernia sac.

- **Perforated bowel** – this is due to pressure build-up proximal to the obstruction.

- **Ineffective irrigation** – where a previously effective irrigation technique may stop working. Furthermore, fluid trapped in the hernia sac may cause perforation.

- **Back pain** – this can be due to the failure of abdominal wall muscles to counter-balance back muscles and help maintain posture. The pain should be alleviated when the hernia is repaired.

- **Respiratory problems** – these may be exacerbated. As the hernia defect widens, the diaphragm loses synergy with the abdominal wall, thereby compromising expulsive functions such as in coughing and micturition.

It should also be noted that anxiety, distress and psychological problems can arise from this rapidly changing body image, including embarrassment, resentment and even fear that the bulge could be a tumour.

**RISK FACTORS**

Risk factors for developing a hernia may be intrinsic or extrinsic and include the following.

**Abnormal collagen metabolism**

Genetically determined abnormal collagen metabolism, causing weakness in muscles. Acquired collagen defects are ascribed to cigarette smoking or nutritional deficiencies, including obesity and people with malignancies.

**Age**

McGrath et al. cite a prospective review over 22 years by Londono-Schimmer et al. (1994) who found hernias more likely in elderly and Mylonakis et al. (2001) who found 22% of people over 60 years old developed hernias compared with 4.8% in those under 60 years old. This may be related to thinning of the rectus abdominus muscle and increasing subcutaneous fat (Kanehisa et al. 2004 cited in McGrath et al.).
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¹ A study of 16,470 ostomates registered with the A.U.O.A. revealed a 30% incidence of herniation.

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Compiled by Julia Thompson, who has been a practising acute care nurse for nearly 40 years and specialised in Stomal Therapy for 30. She has also taken her academic studies through to a PhD and is an Assoc. Prof. of Nursing.

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Wound infection

Bucknall\textsuperscript{13} demonstrated a link between infection and incisional hernias and Ahrendt \textit{et al.}\textsuperscript{12} showed that sepsis inhibits collagen synthesis and decreases fibroblast concentration, thus contributing to tissue degeneration. Wound failure can also be related to corticosteroids and malignancy and contribute to weakened muscles and thus to hernia formation.

Obesity

Obesity predisposes infection. Avascularity decreases oxygen, impeding phagocytosis by neutrophils\textsuperscript{10}. In obese people, abdominal surgery takes longer, increasing exposure to contaminants. There is increased tension on fascial edges at time of wound closure and an increased risk of fluid collections in adipose tissue further adds to this increased tension\textsuperscript{13}. Using engineering theory, De Ruiter and Bijnens (cited in Carne \textit{et al.}\textsuperscript{4}) concluded that obese patients (i.e. with a large abdominal wall radius) with large openings (loop stomas and colostomies) should theoretically be at higher risk of hernias.

Smoking

With other factors held constant, smokers have a 4-fold higher risk of developing incisional hernias. Animal studies show nicotine inhibits cell repair and smoking inhibits synthesis of subcutaneous collagen. Long-term smoking cessation studies are needed to determine whether smoking cessation may reduce incisional herniation\textsuperscript{14}.

Strain

Abdominal wall hernias occur when tissue structure and function are lost at the load-bearing muscle, tendon and fascial layer. Raised pressure can contribute to this failure, such as in COAD, prostatism, chronic constipation, ascites. Mechanical strain like coughing and weight lifting, can induce secondary changes in tissue fibroblast function within load bearing tissues, and chronic loading induces pathologic changes in structural tissue cellular and molecular function\textsuperscript{1}.

Emergency surgery

Emergency surgery is proposed as a risk factor by some, but McGrath \textit{et al.}\textsuperscript{10} found it is not supported by Del Pino \textit{et al.}'s\textsuperscript{15} prospective study over 19 years where 59% of the 1758 stomas were emergencies (peritonitis/obstructions/haemorrhage) but only 3% had hernias.

Previous hernia repair

Secondary fascial pathology occurs when fascial planes are replaced with scar tissue\textsuperscript{1}. Newer techniques and introduction of synthetic prosthetic mesh materials have reduced recurrence rates (mesh implantation appear best) to about 22%, and other complications (strictures and infection) to 20%\textsuperscript{16}. However, repairing a hernia may increase incidence of other complications as well as exposing the patient to the many general hazards of another anaesthetic and surgical procedure.

Location of the stoma

Sjodahl\textsuperscript{17} found that stomas should be through the rectus abdominus muscle and not lateral to it. However, Carne \textit{et al.}'s\textsuperscript{4} systematic review found that the incidence of hernias was not affected by the location of the stoma (whether through or lateral to rectus abdominus), the trephine size (surgical opening), fascial fixation (fixation to abdominal wall) nor the closure of lateral space.

Gray \textit{et al.}'s\textsuperscript{5} review concluded that available data does not support a relationship between a hernia and the location of abdominal wall trephine (because studies in the series were too small and there are no randomised controlled studies), nor between a hernia and a stoma created using intraperitoneal or extraperitoneal technique, nor due to preoperative consultation /siting by stomal therapy nurse.

MANAGEMENT

The best treatment for parastomal hernia is to remove the stoma, but the individual then risks a further hernia in the old stoma site. Surgical repair has a high recurrence rate and is generally avoided. Indications for surgery include obstruction, strangulation, or extreme difficulty gaining a seal. Relative indications for surgical repair include recurrent pain and cosmesis. However, most hernias can be managed conservatively using support devices, exercises and education.

Surgical treatments

Israelsson\textsuperscript{18} reviews several types of surgical treatment – but none are very successful. They include local tissue repair, which has a reported recurrence of 46-100%; however, this published data is not statistically significant due to small sample sizes. Stoma relocation is another method which is considered better than local repair and better when the stoma is moved to the other side of the abdomen. Repair with mesh is another method, including intraperitoneal (limited series published with reasonable results but no long-term results concerning complications), preperitoneal (i.e. in plane between rectus muscle and posterior fascia/peritoneum – very small series, good repair but reports of complications) and fascial overlay mesh repair (most common method, reasonable results. Infection not common but if it occurs may require removal of mesh). Finally, there is laparoscopic repair – there are a few published papers, usually single cases, and no reports of recurrences, but follow-up is short.

Surgical prevention

The only randomised study to demonstrate reduced incidence of hernias is one in which “a large-pore mesh with a reduced polypropylene content and a high proportion of absorbable material placed in a sublay position at the primary operation”, but there is no long-term follow up yet\textsuperscript{18}.

Non-surgical prevention

This is a very exciting development that involves simple interventions promoted by the stomal therapy nurse. Thompson & Traine\textsuperscript{19} examined two groups for incidence of parastomal hernia development. Group 1 was a retrospective study of those
with a stoma formed between 1 August 2001 and 31 July 2002. Group 2 was a prospective study from 1 August 2002 to 31 July 2003. These received discharge instructions not to lift heavy objects, and at 3 months were instructed about simple abdominal exercises and encouraged to wear support belts or girdles when lifting. The incidence of hernias in Group 1 was 33%. In Group 2 it was 15% and 56% had developed their parastomal hernias within 6 months of surgery.

Detailed instruction for the exercises is found in their paper and on the website www.stomasupportgarments.com. Clinicians are encouraged to use the information from this website, but if anything is to be reproduced (e.g. exercise sheets), permission is required.

Another work regarding non-surgical intervention, Gray et al.’s review, was published before Thompson & Trainor’s work. It concluded that there are really no proper published nursing studies about hernia prevention and management, just expert opinion and clinical experience about:

- Changes in pouching systems – changes need to accommodate changes in the size and shape of stoma and surrounds.
- Patient education about obstruction and incarceration – seek medical attention if stoma changes colour or there is severe unremitting pain.
- Follow-up visits – there is a need to schedule regular follow-up visits so the stomal therapy nurse can monitor progress of the hernia.
- Irrigation problems – if is any difficulty in introducing fluid or prolonged or incomplete evacuation, then the person should stop the irrigation procedure.
- Dietary education – education regarding regulation of diet and fluid intake should be offered to ensure a soft, pasty stool and prevent constipation.
- Hernia support belt – a hernia support belt should be used in selected cases. The belt should be applied whilst the hernia is reduced, i.e. when the patient is supine. A support belt should be fitted with just a slight tension in this position and therefore provide firmer support as the patient stands and the hernia attempts to promote outwards. A range of styles, fabrics and widths are available and consideration should be given to the location and size of hernia as well as size of patient.

**Appliance changes**

Generally, it should be noted that the changing stoma size, shape and parastomal contours may require a change of appliances to one with increased adhesive area, or one with added tapes or borders (e.g. hydroframes), and/or one with a more flexible baseplate. Seals or paste may be needed as the parastomal area alternates between stretching and relaxing while the patient changes position and the hernia changes size.

Further, some people want a hole in the support belt so the bag is not restricted. To achieve non-restriction of the bag, it is important to have a belt made from a sufficiently flexible fabric and to have adequate adjustment rather than having a hole. People often have the garment too tight; it is just meant to support, not to constrict.

Unfortunately, if a hole is cut to accommodate the bag, then the hole needs to be quite large because it must take into account the adhesive area around the stoma, and also must allow feeding of the bag’s plastic through the hole so that the bag lies flat. If such a hole is cut, the support garment now mimics the situation that caused the hernia in the first place, so it cannot help prevent hernias; however, it may give some comfort and support. There is also a risk that if a support garment or belt has a hole and is too tight it may contribute to stomal prolapse (Figures 4-5). Some people advocate making a horizontal slit just under the level of the stoma to feed the bag through so the stoma is covered but most of the dependent part of the bag is not.

**Support garments: are they tools or toys?**

The incidence of parastomal hernias is high and the problems they cause can vary from mild inconvenience and embarrassment to life threatening proportions. There is now some evidence that wearing a support garment may prevent hernias, and they can certainly relieve discomfort. When deciding whether or not to recommend that a person wears a support garment, the following should be considered.

It is important that a person be measured correctly so the appropriate sized garment is used, not one that is too tight. The person should be lying flat on their back to allow the bulge/hernia to settle/reduce before measuring with a tailor’s tape so the tape can move over the abdomen easily. It is also important that the bulge/hernia is settled/reduced when the garment is placed over the area. Thus, if wearing a belt, the person ought to position it on the bed then lie on top of it before wrapping it around their abdomen. If wearing support pants, the person ought to pull them up to a level just below the bulge/hernia then either lie down or, if sitting, lean back and reduce the bulge/hernia then pull up the pants. Putting on a belt or pants when already in the standing position with the bulge/hernia prominent will not give proper support and is likely to be difficult because it will seem too small/tight. If the pants are so tight that they are difficult to pull up, then they are probably not the right size.
Cost analysis of non-surgical prevention

A letter published in *Ostomy Australia* states that support garments are too expensive and their availability through the ostomy associations should be restricted. However, sometimes it is wise to spend some money to prevent a bigger problem, hence the old saying “an ounce of prevention is worth a pound of cure”. Even before reading the letter, a cost-effectiveness analysis was undertaken to explore the relative costs of using the garments. The details are reproduced here and fall into several sections.

The cost of having a parastomal hernia

Not all the costs are measurable in dollars. The psychological costs can vary greatly, from negligible to incapacitating. They may result from embarrassment at further change in body image or due to leakages. There may be generalised anxiety and worry – is this new bulge another tumour?

In some people there will be social costs, including withdrawal from activities, leading to lost opportunities to socialise. Further, for psychological as well as for physical reasons, there may be discontinuation of exercises and activities that would otherwise contribute to general wellbeing.

There may be physical costs (see previous sections on symptoms and on complications). These range from discomfort and a pulling/dragging sensation, to back strain, bowel incarceration or strangulation. If a person needs treatment for their hernia, there is a risk of morbidity or death with each surgical procedure and anaesthetic required.

There may be monetary costs, including the need for new and different clothes to fit over and disguise the increasing abdominal contours. When leakages occur, there is not only the inconvenience and embarrassment but also the need for extra washing and often a need to trial new and different bags and equipment with various accessories to try to minimise leakages. There may be a need to take time off work to go to stoma nurse or hospital for assessments and treatments (conservative or surgical).

The Australian Government Department of Health and Ageing *Pricing Guidelines Stoma Appliance Scheme Consultation Paper* was used to try to gauge costs for extra appliances needed due to changes in size, shape, location of stoma and surrounding contours and also due to leakages. The costs for the simplest appliances (one-piece) were used; these are shown in Table 1.

Many people with a hernia also need accessories to help stop leakages. These are also expensive and general costs were obtained from the listings of the Stoma Appliance Scheme Schedule (January 2009) (Table 2).

It can be concluded that, overall, the cost of having a parastomal hernia can be considerable, especially when one considers that their natural history is to progressively increase in size and thereby progressively change the size and shape of the abdomen and the stoma. A glance at the tables shows that the cost of appliances and accessories varies greatly, so the following calculation is conservative. If the person has one leakage a week and it costs $7 to fully replace their appliance and accessories, then that works out at an annual $364 extra cost to the taxpayer funded scheme – and this can go on for years, maybe even worse if the person does not seek stomal therapy advice.

So far the only benefit of having a parastomal hernia, that this author has discovered, is that it is easier to reverse a loop ileostomy with a hernia [personal communication with colorectal surgeon] and, in that situation, the surgeon would repair the hernia when reversing the ileostomy.

### Table 1. Cost of simple appliance

<table>
<thead>
<tr>
<th>Type of one-piece appliance</th>
<th>Price per bag (range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Closed</td>
<td>$2.31 – $3.45</td>
</tr>
<tr>
<td>Drainable</td>
<td>$5.51 – $7.95</td>
</tr>
<tr>
<td>Urostomy</td>
<td>$3.92 – $9.04</td>
</tr>
</tbody>
</table>

### Table 2. Cost of accessory

<table>
<thead>
<tr>
<th>Accessory</th>
<th>Average cost per unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belt</td>
<td>$5.57</td>
</tr>
<tr>
<td>Barrier wipe</td>
<td>$1</td>
</tr>
<tr>
<td>Seal</td>
<td>$4.22</td>
</tr>
<tr>
<td>Paste</td>
<td>$10.72 per tube</td>
</tr>
<tr>
<td>Frames</td>
<td>$1.36</td>
</tr>
<tr>
<td>Tapes</td>
<td>$1.10 – $12 per roll</td>
</tr>
</tbody>
</table>

The benefits of the prevention programme run by Thompson & Trainor described earlier in this paper.

The monetary costs for the support garments are derived from the Stoma Appliance Scheme listings, January 2009 (Table 3). Other monetary costs include those incurred due to three or four visits to the stomal therapy nurse in the first year to educate and monitor progress, and then visits annually thereafter. This may involve time off work for the ostomate, and the cost of the nurse’s time which varies according to the level of appointment and type of institution. Although the patient does not usually actually pay the nurse, someone does! It could well be argued that the stoma nurse ought to be seeing the patients anyway. The other cost is the patient’s time to perform the exercises daily.
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- 15 x 20 cm

URGO MEDICAL
Heal and care
The benefits of having a parastomal hernia surgically repaired can include improvement in comfort, appearance and morale, having appliances adhere, and improvement in back and respiratory problems. Of course the major benefit in the person who had an incarcerated or obstructed bowel is that the operation can be lifesaving, and in that instance the monetary cost is certainly justified, even if the hernia recurs.

CONCLUSION

In conclusion, parastomal hernias are common – having one can condemn a person to a poor quality of life and, if complicated, can (rarely) be life-threatening. Having a hernia repaired can be very costly and recurrence rates are high, but literature suggests that surgeons are trying hard to develop preventive and reparative procedures with mesh.

There is now some evidence that a simple prevention programme involving education, support garments, simple exercises, sensible diet and avoiding heavy lifting and smoking may prevent parastomal hernia development in a significant percentage of those with stomas. The cost of this prevention programme is small compared with treatment or living with a parastomal hernia. This author believes that in this instance “an ounce of prevention is truly worth a pound of cure”.

The challenge – are you, as a stomal therapy nurse, trying hard enough to educate patients about avoidance of risk factors and use of simple measures to help prevent these hernias occurring?

ACKNOWLEDGEMENT

Thanks to Tim Ainsworth of Omnigon for his encouragement and to Sharon Toscano of Omnigon for clerical support. Thanks to Joe Kraus, Art Director at The Red Pill, South Yarra for turning my scribbles into lovely diagrams.

REFERENCES


<table>
<thead>
<tr>
<th>Table 3. Cost of support garment.</th>
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</thead>
<tbody>
<tr>
<td>Garment</td>
</tr>
<tr>
<td>-----------------</td>
</tr>
<tr>
<td>Support pants</td>
</tr>
<tr>
<td>Support belts</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 4. Cost of repair.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item</td>
</tr>
<tr>
<td>Simple repair of hernia</td>
</tr>
<tr>
<td>Repair complex hernia</td>
</tr>
<tr>
<td>Refashioning stoma</td>
</tr>
<tr>
<td>Anaesthetic* &lt;70 years for 2-hour operation</td>
</tr>
<tr>
<td>Anaesthetic* &lt;70 years for 1-hour operation</td>
</tr>
<tr>
<td>Admission for 1-5 nights @ $719/night</td>
</tr>
<tr>
<td>Cost of theatre for a band 6 operation</td>
</tr>
</tbody>
</table>

* Anaesthetic depends on length of procedure, complexity of anaesthetic and age of patient.
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The purpose of this presentation is to provide an overview of the Australian Association of Stomal Therapy Nurses Incorporated (AASTN Inc.) is the national association representing stomal therapy nurses (STNs) in Australia. The association aims to provide support and leadership to STNs in their endeavour to provide quality nursing practice. The association has many key elements or tools to ensure it is able to meet its objectives.

The purpose of this presentation is to provide an overview of the association, outline the current Executive structure, mention some achievements and introduce some issues for consideration in the future. Further, to consider whether stomal therapy nursing in Australia is recognised as a true nursing specialty.

INTRODUCTION

The Australian Association of Stomal Therapy Nurses Incorporated (AASTN Inc.) is the national association representing stomal therapy nurses (STNs) in Australia. The association aims to provide support and leadership to STNs in their endeavour to provide quality nursing practice. The association has many key elements or tools to ensure it is able to meet its objectives.

The purpose of this presentation is to provide an overview of the association, outline the current Executive structure, mention some achievements and introduce some issues for consideration in the future. Further, to consider whether stomal therapy nursing in Australia is recognised as a true nursing specialty.

BACKGROUND

Built from strong foundations:
looking back at significant dates for the association

27 March 1971 saw the inaugural meeting held at the Sydney Hospital. It was initially established as an association for registered nurses interested in stomal therapy. In the same year the first constitution was adopted (a new constitution was adopted in 2003) and a policy manual commenced. October 1971 saw the first stomal therapy nursing course conducted at the Royal Melbourne Hospital Victoria; by 1976 training programmes were held in most states.

24 March 1972 saw the first scientific meeting and Annual General Meeting held at Royal Children’s Hospital in Melbourne. In 1973 the first newsletter first published; in 1987 this became the Journal of Stomal Therapy Nursing Australia.

In 1977 certificates were presented to full members and in 1996 the association was incorporated. A national stomal therapy week declared in 1986 beginning after the second Sunday in June. In 1991 the Standards of stomal therapy nursing practice were developed (and were last reviewed in 2007). In 2001 the position of membership secretary was formalised, greatly assisting the association. In 1999 a webpage link was established, followed in 2001 when the domain name was registered.

THE AASTN TODAY

Current membership
Total membership stands at 568 – 400 full members, 100 associate members, 45 commercial members, 11 life members, 5 retired members, 7 honorary member and 23 journal subscriptions.

Clinical practice
Roles and positions may vary within clinical practice and in some settings may also include wound, continence or breast care nursing. STNs practise in a variety of settings across both acute hospital and community settings. Differences exist between major metropolitan institutions compared to regional, rural and remote area nursing. Further classifications may vary, particularly between states, related to the title of registered nurses – division 1, clinical nurse specialist or clinical nurse consultant.

Challenges

STNs face constant pressure on limited resources in the health sector. Multiple roles stretch individuals maintaining evidence of CPD and expertise in all specialties. Opportunities to provide evidence of workload require a national and consistent approach to data collection to enable benchmarking. Nursing ratios have not been established to support STNs.

Opportunities

The association administers five scholarships – an overseas travel grant, the AASTN research grant, the Elinor Kyte research grant, the Smith & Nephew education scholarship and the CSSANZ scholarship.

Currently stomal therapy nursing courses are conducted in South Australia, Western Australia, New South Wales and Victoria. Experienced STNs are encouraged to complete CPD – credentialing has been developed and administered by the association as preparation when providing clinical placement, support and preceptorship for students completing recognised courses.

Structure of the AASTN

The national Executive Committee comprises members from the states and territories; positions are held for 2-year terms, with half of the positions rotated annually. Around eight meetings are held each year to progress the business of the association. Meetings are held via national teleconference, with some meetings held via Skype with varying success. The 2008 Annual General Meeting of the association was the first to be held using technology via national televideo link. Whilst the AGM was successful, it did require significant technical expertise and a lot of resources.

Life members are nominated in recognition of excellence in stomal therapy nursing practice at a state, national and international level. The AASTN has clearly documented statements such as: Values, Purpose and Vision, and Code of Ethics. Members are divided into state and territory branches.

The Education and Professional Development (E&PD) Subcommittee of the association comprises a Chairperson (Fiona Bolton) and two representatives from each state. Meetings are usually held in March (1 day) and October (2 days).

Just a few of the achievements of the subcommittee include the following. The AASTN Standards document has been published and was developed from the framework of the National
Competency Standards for the Advanced Registered Nurse. CPD, credentialing and recredentialing for the specialty have been established – the strength of this process is held in high regard and recognised by other nursing organisations. The Stomal Therapy Australian Research Tool (START) database is a standardised national data collection tool for STNs and, importantly, it is available at no cost to members of the AASTN. It was developed with IT support from Convatec and input from key STNs. Contact the E&PD chairperson to obtain the database.

The subcommittee has developed many tools and documents that support the association and members. An example of being responsive to issues is a recent document to assist new members having completed stomal therapy courses overseas. You can find the documents on the website or contact your state representative on the committee.

The AASTN conference
2009 was the 37th Conference of the association. The conference was held annually until 2007 and is now held every second year (biennial). It provides an important opportunity for registered nurses interested in stomal therapy nursing to attend. The conference also gives us an opportunity to network with colleagues, update our knowledge, highlight the latest research and case studies and observe the latest products and technology and meet with industry.

The conference also provides a venue for several meetings of the association and, of vital importance, the AGM. However, with an off-conference year in 2008, the AGM was held via national tele-video link for the first time. The time required to coordinate a national teleconference as well as cost and access to specific technical expertise are ongoing issues for consideration.

Recognition as a nursing specialty
Is the specialty of stomal therapy recognised by nursing registration boards? Consider the registration renewal form – it is a concern why there is no designated tick box for stomal therapy nursing. Nevertheless, STNs can be confident that they are respected by our peers and colleagues and actively participate in multidisciplinary teams. STNs are valued by patients and clients and are aware of their gratitude in often difficult and challenging situations.

An expert nurse
As a STN, consider whether you meet the criteria and definition of an expert nurse in your practice. An expert nurse was defined so eloquently by the National Nursing Organisations document as:

A person with specialised skills and knowledge, who is an authority in their chosen field of practice and who demonstrates the features of: lateral thinking; challenging; autonomy; a research focus; extensive knowledge; acting as a consultant; viewing situations globally; and demonstrating leadership; vision and innovation in their practice.¹

Building effective relationships
Coalition of National Nursing Organisations (CoNNo)
The AASTN is a member of the CoNNo. Lesley Everingham (NSW) and Wendy Sansom (VIC), both members of the E&PD Subcommittee, are our representatives for CoNNo. Information and updates are included in the journal and CoNNo meeting minutes are on the CoNNo website.

World Council of Enterostomal Therapist (WCET)
The AASTN and WCET have formed a strong relationship over many years. Australia has significant WCET membership, both at Executive and general membership. Currently we have reciprocal journal opportunities. Brenda Sando is currently the Australian international delegate.

Australian Council of Stoma Associations (ACSA)
ACSA has stated that one of its aims is to foster and further develop relationship between our associations. We currently have reciprocal journal reports. Further, ACSA and the AASTN both acknowledge the support needed for persons with a stoma and particularly for new members. ACSA represents 22 ostomy associations with around 35,000 members, approximately 8,000 new members each year. About half are temporary stomas, with an overall increase of 1,000 each year.

Colorectal Surgical Society of Australia & New Zealand (CSSANZ)
CSSANZ is keen to foster and further develop effective relationships between our associations. Evidence of this is the provision of a scholarship awarded annually to a STN having completed a stomal therapy course within the previous 3 years. The AASTN has also been approached with an invitation to collaborate in the Tripartite 2011 Conference to be held in July in Cairns. CSSANZ has a strong commitment to the development of multidisciplinary care.

Commonwealth Department of Health and Aging
In Australia we are fortunate to have the support of the Stoma Appliance Scheme. Currently the scheme spends around $70m. As STNs our expertise contributes to ensuring the efficient use of stoma supplies. This is further dependent on there being adequate STN resources to provide vital initial and ongoing support to people with a stoma. The federal government department values our input as evidence by the fact that the AASTN has three representatives on the Stoma Product Assessment Panel (SPAP). For further information related to the stoma appliance scheme and more specifically the stoma appliances that are available, go to the website. Currently there are around 17 spreadsheet pages of products.

THE FUTURE
Communication tools for the 21st century: the AASTN website and journal
As well as email and communication with the state representatives, the website provides up-to-date information and facilitates effective communication with our members. It is responsive and quick to update and is accessed frequently, as evidenced by the number of hits. The website aims to be relevant, topical and useful and we have employed the technical expertise of Phil Morton to ensure this. Other organisations have also commented positively on our website. With Mary Ryan completing her term we look forward to a new website coordinator to join the Executive.

Regular reports as well as articles are published in the Journal – for its ongoing success we always need contributions, so please contact the editor with your contributions.

Issues for further discussion
Some of these issues were communicated to the state representatives prior to the AGM to facilitate effective and informed discussion.
• Suggest a meeting for the E&PD Subcommittee and AGM in March of the-off conference year.

• Consider taking up the invitation from CSSANZ to participate in some way with the Colorectal Tripartite Conference in 2011.

• Look forward to the first nurse practitioner in stomal therapy.

• Develop evidenced-based best practice clinical guidelines to promote a consistent approach to stomal therapy nursing care.

Our focus remains quality care across the continuum of care. Take a moment to consider what you think the qualities of a STN are. Perhaps the following quote from a patient says it all:

I did wonder where on Earth I was headed early in all of this, but your positive, bright, optimistic and professional attitude gave me much confidence...

CONCLUSION: AUSTRALIA IN REVIEW

The AASTN represents STNs in Australia and provides support and leadership in the specialty. The association has been established on strong foundations as noted in its history of significant dates. The current membership consists of 400 full members. The Executive structure includes representatives from each state and territory. The E&PD Subcommittee of the association provides and supports excellent professional development opportunities for members.

The association continues to maintain effective relationships with key organisations including WCET, ACSA, CSSANZ and the Commonwealth Department of Health & Aging. The journal and website provide effective communication tools members as well as the public domain.

Some issues for consideration in the future have been identified and will be addressed by the new Executive team members. Stomal therapy nursing in Australia is a truly unique and intimate clinical role. We encourage members to actively participate and contribute to the AASTN at a both a state and national level.

REFERENCE


Leanne has been a stomal therapy nurse for many years, and has been active in her local and national committees. Leanne was the previous President of AASTN and she has recently retired from her long-standing position at Ballarat in Victoria.

Stomal therapy in New Zealand

Sue Wolynecwicz STN CNS • Chairperson New Zealand Nurses Organisation, Stomal Therapy Section Capital and Coast Health, Wellington Hospital, NZ

As a general overview of stomal therapy in New Zealand (NZ), statistics are necessary to give an indication of how small NZ is in comparison to the other countries represented at the conference. We have a population of 4.3 million people and 38 million sheep.

Our health/hospital system comprises of 21 district health boards (DHBs); 15 of these are in the North Island and 6 are in the South Island. Throughout these DHBs there are approximately 45-50 practicing stomal therapy nurses.

Our national stomal therapy section is attached to the New Zealand Nurses Organisation (NZNO). This is our governing body, providing professional and financial support. Our national committee comprises four stomal therapy nurses (STNs) from the North Island and two from the South Island. We meet 3-4 times a year and organise conferences every 2 years; we had our last conference in 2008. We have approximately 100 members and produce a journal 3 times a year. We have a website via the NZNO with contact details of STNs practicing in New Zealand, links to other stomal therapy sites and information about upcoming conferences.

Stomal therapy training is not available in New Zealand so this is done through Australia. While it is recognised by the Nursing Council (NZ), it is not recognised by the universities. Throughout the DHBs there are differing titles. Some are STNs (those who have completed postgraduate studies in stomal therapy) and others are ostomy nurses (those who are working in stomal therapy but have not yet completed their study in stomal therapy). Some are hospital-based, some only community-based and some a mix of both hospital and community. This leads to some disparities between DHBs with pay rates and entitlements. We have one area that is privatised.

Some of the current challenges in stomal therapy being faced in New Zealand today, and I am sure in other countries, are:

• Ageing population with co-morbidities.

• A trend of annual increases in new stoma volumes.

• Some areas have long delays for reversal surgery, affecting budget planning.

• Budget restraints.

• Differences between DHBs for supply of ostomy products despite all being governed by the same Ministry of Health.

We have become very creative with bag management as patient entitlements to supplies is limited. The STN is not only responsible for the prescription of the product but also for ensuring distribution and overseeing the invoices and budgets.

It is also worth discussing the incidence of colorectal cancer in New Zealand as it is the second most common cause of death in men and women. It is the most common cancer and NZ has one of the highest death rates from this disease in the developed world. There are approximately 1700 deaths and 2700 new diagnoses each year. Inequalities exist between Maori and non-Maori due to the often late presentation of Maori to the health service. While the numbers are not high, they have a poorer survival and higher mortality rate than non-Maori because of their late presentation. A pilot colorectal screening programme is due to start in 2009 with the aim for full national screening before 2014.

To conclude, there are positive areas of development for stomal therapy nursing in New Zealand. The first one is that there has been national scoping within DHBs to bring the STN title/position into alignment. Secondly, there has been the development of colorectal specialist nurse roles. These roles
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span the continuum of care, coordinating and navigating the patient during their journey and came about as gaps and/or duplications were identified by the Cancer Control Strategy [Ministry of Health, 2003].

Sue works for Capital and Coast Health, Wellington Hospital, NZ as a CNS stomal therapy nurse. She has been a committee member for the National stomal therapy section since 2005 and the chairperson since 2007. Sue has worked as a district nurse in continence and stomal therapy for several years.

The stomal therapy/wound care nurse in Indonesia

Julie McCaughan • Consultant – Clinical Improvement, Siloam Hospitals Group, Indonesia

This story is one of courage and hope that has seen the development of a professional stomal therapy nursing body in Indonesia. Throughout my involvement in this journey since 2005, I have been privileged and fortunate to have had the un-ending support of my Australian STN colleagues, particularly Carmen George, the National Executive members of the AASTN, ACSA and WA State Branch members of the AASTN. Busy yet tireless colleagues donated their time and own resources to support this effort and, as a result, I am proud to share with you the results.

STATISTICAL COMPARISONS

Comparative statistics (Table 1) between Australia and Indonesia are like a glimpse into the future. I choose to look at these figures to identify not what we don’t have in Indonesia, but instead where we are heading and how we as professional nurses can project change requirements for our patient management. In summary, we can see from the statistics that:

- Although life expectancy is lower than in Australia, the number of elderly is much higher than in Australia – therefore in Indonesia we need to seek proactive management strategies to manage the needs of the elderly.
- Literacy and education remains low and therefore the challenge of ensuring understanding in prevention, treatment, management and follow-up is limited.
- There are less nurses available in Indonesia, yet the population is 10 times that of Australia. There is one prime difference, however; all nurses in Indonesia work full-time whereas Australian statistics reveal that up to 40% of the nursing workforce in different specialty areas is now working part-time.
- Internet users remain low which means that, in this growing world of IT technology, the positive impact that such technology could bring is still limited.
- In Indonesia there are less hospital beds available and community nursing is likely to be the way of the future.

The future for Indonesia is not dim. Such statistics and current trends (nursing and doctor shortages / increased IT and education knowledge) help us to plan for future growth. For example, a savvy stomal therapy nurse will seek a wider network of doctor support than immediate catchment, will understand better the need to have different levels of education ‘pitch’ due to the many varying levels of education and literacy levels, and will be proactive in determining a wider variety of teaching and education methods as a result of existing patient knowledge and capability.

THE DEVELOPMENT OF STOMAL THERAPY NURSING IN INDONESIA – FOLLOWING IN FOOTSTEPS

The history of the WCET, AASTN and InETNA, the Indonesian stomal therapy nurses organisation, reveal some startling similarities in development pathways.

The WCET started out in 1958 Dr Rupert Turnbull, a colorectal surgeon at the Cleveland Clinic, recruited Norma N Gill, a former patient and ileostomate, to assist in rehabilitating his ostomy patients. By 1961 a formal education programme had been established. The WCET was formally founded on 18 May 1978, representing 15 countries and 20 appliance manufacturers.

The AASTN started out 27 March 1971 when the inaugural meeting was held and convened by Professor Edward Hughes,

Table 1. Comparative statistics.

<table>
<thead>
<tr>
<th></th>
<th>Indonesia</th>
<th>Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geography and demographics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Land area (km²)</td>
<td>1,919,455</td>
<td>7,682,300</td>
</tr>
<tr>
<td>Population</td>
<td>238,301,000</td>
<td>21,728,000</td>
</tr>
<tr>
<td>Population density</td>
<td>129.36</td>
<td>2.77</td>
</tr>
<tr>
<td>Population aged 65+</td>
<td>13,764.81</td>
<td>2,835.03</td>
</tr>
<tr>
<td>Life expectancy at birth (years)</td>
<td>70.46</td>
<td>81.53</td>
</tr>
<tr>
<td>Literacy (%)</td>
<td>90.4</td>
<td>99</td>
</tr>
<tr>
<td>Tertiary enrolment (%)</td>
<td>14.6</td>
<td>63.3</td>
</tr>
<tr>
<td>Internet users</td>
<td>33,276,620 (14%)</td>
<td>17,023,580 (78%)</td>
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<table>
<thead>
<tr>
<th>Healthcare statistics</th>
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<tr>
<td>No. hospitals</td>
<td>1,234</td>
<td>1,332</td>
</tr>
<tr>
<td>– public/military hospitals (%)</td>
<td>50</td>
<td>55</td>
</tr>
<tr>
<td>– private hospitals (%)</td>
<td>50</td>
<td>45</td>
</tr>
<tr>
<td>No. nursing / midwifery personnel</td>
<td>179,959</td>
<td>187,837</td>
</tr>
<tr>
<td>No. physicians per 10,000 people</td>
<td>1.3</td>
<td>25</td>
</tr>
<tr>
<td>No. qualified STNs (registered)</td>
<td>52†</td>
<td>430‡</td>
</tr>
</tbody>
</table>

† As of April 2009
‡ Full and life
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a surgeon from Royal Melbourne Hospital. Elinor Kyte (nurse) was the first President of the then AAST and the first scientific meeting was held in 1972. The name was changed to the AASTN in 1984 and the association was incorporated in 1996.

InETNA comprised of eight dedicated nurses who received training in Australia, Malaysia, Singapore and Hong Kong over the course of 10 years (1995-2005), and then came together to form InETNA. They were assisted by Dr Benni Phillipi, a digestive surgeon, and Dr Melissa Liaw from the Indonesian Cancer Foundation. InETNA was formally formed on 15 July 2005. Like the WCET and stomal therapy in Australia, the support and guidance of surgeons and organisations has been instrumental in supporting this specialty’s development in Indonesia.

BARRIERS FOR STOMAL THERAPY / WOUND CARE NURSES IN INDONESIA

These barriers are not new and include the following:

• Inadequate training and education, resulting in:
  – A lack of available recognised specialty training,
  – Bureaucratic systems which prevent the development and acknowledgement of programmes,
  – A lack of available funding,
  – 95% nurses being diploma trained; non-accredited universities are operational.
  – Minimal critical thinking and analysis in initial training as well as minimal encouragement in hospitals.

• A negative organisation culture consisting of:
  – Nurses continuing to be seen as ‘hand maidens’, with minimal doctor partnership.
  – A high blame culture within organisations.
  – A resistance to change by all disciplines, including nurses.
  – 30% of time being spent on administrative duties.

• The cost of treatment to patients, resulting in:
  – Inadequate/inappropriate management.
  – Late treatment being sought.

Building blocks to our solutions

Building blocks include:

• An education programme – 20 nurses attended the inaugural programme in 2007 and a further 14 nurses were trained 2008. They receive support and mentoring from Australia. There are eight nurses on the current 2009 programme – that’s a 400% increase in STN numbers in 2 years.

• Nurse initiated wound care clinics – patients can self-refer or be referred by doctors.

• Education – A congress is planned for 2010.

A FINAL THANK YOU TO AUSTRALIA

I wish to thank the AASTN WA Branch for their support in sponsoring and hosting two Indonesian colleagues from Siloam Hospitals to attend the recent conference in Perth and spend 2 wonderful weeks in a variety of both community and clinical settings. The nurses have returned full of vigour and excitement of what they can achieve and they continue to marvel at the strong partnerships witnessed between doctors and nurses in the stomal therapy and wound care profession.

Thank you to the AASTN members who have supported and assisted us along the way. We look forward to continuing relationships between the Indonesian and Australian groups.

Julie has been a stomal therapy nurse for a number of years, and has been instrumental in leading the AASTN towards new horizons. She served on the National Executive as President before taking up her current post in Indonesia.

China’s evolution

Ms Huo Xiaorong • Chief Nurse, Jiangsu Province, Nanjing, China

Jiangsu province is located in East China and has a population today of nearly 80 million. It is one of the most developed provinces, full of culture and civilization. There are many interesting places in Jiangsu, such as the capital city Nanjing which has a history going back over 2,500 years. The Dr Sun Yat-sen Mausoleum, found in Zhongshan Mountain National Park situated on the eastern outskirts of Nanjing and Suzhou, located in the centre of the Yangtze delta, is world-famous for its delicate, graceful and elegant typical royal gardens.

There are hundreds of public hospitals in Jiangsu. In Nanjing more than 10 hospitals have over 10,000 beds; the number of outpatients seen in these hospitals is 3,000-5,000 a day.

The nursing association of our province where I work is paying more attention to a training programme for clinical nursing specialists (CNSs). A CNS is a clinical expert who is a person with a higher level and specialty of nursing knowledge and skills in certain fields (domains). The areas included in the training programme are ICU, diabetes, cancer, emergency, midwifery, dialysis and stomal therapy nurses (ET).

These specialist CNSs are needed to foster leadership in clinical fields (in order to raise the quality of nursing care), and to manage human resources, different levels and different staff. They use their own knowledge and skills to provide a specialist nursing service and to educate patients and society. They provide information and suggestions for peers to insure nursing equality and enhance nursing research in their field.

There are nearly 100,000 RNs in Jiangsu, yet in 2006 there were only seven ET nurses (China in total had 98 ETs). The number of patients with stomas and wounds is increasing each year; many of them are still living in a state of self-management, ashamed and unwilling to communicate with others. Most are eager to acquire knowledge and professional help. Therefore we are in much need of more ET nurses.

In 2006, I got the opportunity to attend the 4th congress of the Asian Society of Stoma Rehabilitation in Seoul, South Korea. I was so happy to meet Mrs Michele Li again and to meet Mrs Louise Forest-Lalande. With their encouragement and kind support, we planned to set up an ET programme.
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On 8 October 2007, the Nanjing ET programme held its opening ceremony at the Nanjing Medical University. The programme is undertaken by our Province Nursing Association and Nursing College of Nanjing Medical University. The first training course occurred at the same time. Many thanks go to our distinguished guests – the president of WCET, Elizabeth English, Louise Forest and Dr Yu Dehong – who attended our ceremony. We were also honoured to have some leaders from the provincial health authority and Nanjing Medical University.

There were 12 students in the first course, including six from Jiangsu; the other students were from Shanghai, Shandong, Tianjin, Sichuan, Anhui and Henan. The teachers were outstanding ET nurses from different countries such as Australia, Canada and Hong Kong; others were experts from big hospitals and medical universities in Jiangsu. We appointed seven big general hospitals as our teaching hospitals, in which seven ET nurses instructed our students. The curriculum consisted of 12 weeks (full-time), including 6 weeks of class-teaching and 6 weeks of clinical practice. All students worked hard, successfully finishing the course, and received their certificates from the WCET. Today they apply their knowledge and skills gained in our ET programme into practical work in their hospitals; they are very enthusiastic to serve ostomy patients.

In June 2008, as the director of the ET school, I introduced our programme to many peers at the 17th Biennial Congress of the WCET. In September 2008 we held the second course which was completed successfully in February 2009.

However, we still face some constant problems. The number of nursing staff is insufficient for the number of beds. Some ET nurses are change nurses, and are unable to fulfil the role of the CNS. Lastly, some hospital managers do not pay enough attention to CNSs. Eventually, some hospital managers do not pay enough attention to CNSs.

On 12 May 2008 an earthquake took place in Sichuan Province, a big disaster in China. Many nurses joined the rescue medical teams going to Sichuan where they treated many patients with wounds. It was acknowledged at this time by everyone who helped that more ET nurses are required who can give more professional care to patients with injuries.

Xiaorong is Chief Nurse, Jiangsu Province, Nanjing, China. She established the Enterostomal Therapy Nursing Education Programme in 2007 and has since coordinated the education of 32 registered nurses in the art of stomal therapy nursing. Xiaorong has an exceptional vision for stomal therapy nursing in China.

After returning from Perth in 2006, the first ostomy training was given to my students and nurses at the university. I started running 5-day workshops in the university I work for. The subjects of these workshops were ostomy, wound and incontinence; 2 days was devoted to ostomy, 2 days to wounds and the remaining 1 day to incontinence. These are carried out three times a year.

There are only five ET nurses in Iran, and we invited all five of them to give lectures at these workshops throughout this time. In addition, since 2006 I have been giving lectures in 1-day workshops for the Iranian Ostomy Society for nurses in Tehran, which ended with training being given to these people. In 2006 I was sent to Shiraz, another large city in Iran, to check the quality of ostomy training workshops by the ostomy society. There I observed that a clinic was run by a combination of physicians and nurses. In Tehran, nurses alone are running these ostomy training workshops. It was a nice experience to visit the ostomy clinic in Shiraz.

I have been the secretary of many congresses in which I have tried to include ostomy and wound workshops. In 2007, I participated in a 9-month course in wound care run by the University of Toronto in Tehran Medical Science University. I succeeded in getting another certificate in wound care.

In the summer of 2007, five ET nurses prepared an 8-week course plan for the Ministry of Health, Hygiene and Treatment, which is supposed to be performed in hospitals having ostomy clinics run by ET nurses in near future. There is also going to be an 8-week ET training course in the university I work for. In April 2009 run by both Iranian and foreign trainers.

Fariba completed her stomal therapy nursing education in Perth (an 8-week course on ostomy, wound and incontinence) before returning to Iran to teach undergraduate nurses in 2006. She has been active in developing the first stomal therapy nursing education programme in Iran which is proposed for 2009. At the conference in Perth, she mentioned how happy she was to be back in WA again.

The meltdown in nursing

Ms Prilli d’E Stevens STN • Past WCET President & Life Member, South Africa

Thirty years ago, the world was introduced to the international stoma care nurse, at that time providing care for persons with intestinal stomas, and working mainly with others in the field of colorectal surgery. Obviously, the role has expanded and, in common with other health professionals, many hot issues regarding the way we are able to function have emerged. There is much common ground globally, but some issues are more pressing in some countries where the costs have risen dramatically and medical funding is drying up.

Key issues for discussion include the effects of global warming, especially the use of long distance flying for conference purposes, and government recognition of lifestyle-induced diseases and their drive to eradicate some of them including obesity, smoking-induced impairment and lack of exercise.

Iran – a new beginning

Fariba Nasiri Ziba MSc STN • Faculty Member of Iran University, Iran

In Tehran, the capital city of Iran, there are colorectal wards in the university hospitals, training hospitals and the private sector hospitals; however, they do not have ostomy clinics run by nurses, most of them are run by doctors. In our university, Iran Medical Science University, there is a clinic for ostomy and wound management in Hazrate Rassoul Hospital which is run by a nurse.
Technological advances come at a cost and medical aid programmes are in many cases inadequate to cover such costs. Patients perceive privatisation as a money making business to their detriment.

There is a shortage of skilled nurses and possibly an exploitation of many due to lack of doctors and subtle shifting of responsibilities. Nurses engaging in previously medical domains performing surgeries and endoscopic procedures are at the opposite end of the spectrum, where the advent of carers rather than trained nurses, and the lack of accountability from agency hired nurses, is a major concern.

Reimbursement and remuneration, as well as the potential refining of available products will change the face of stoma manufacturing industry. Many ETs are turning their service-related practices into a full-blown business to provide a full range of equipment as hospitals cut their commitment to chronic ostomates.

The role of genetics, colorectal surgical advances such as stenting, sacral nerve enervation and the current status of laparoscopic surgery, especially in low rectal carcinoma, are discussed. Problems of conception after ileoanal surgery and complications of opportunistic infection after the use of specific Crohn’s disease therapy are changing the management protocols for these conditions.

Hospital-acquired infection, including multi-drug-resistant Staphylococcus aureus, drug-resistant tuberculosis, SARS, bird flu and Ebola fever all put health professionals in a potentially dangerous environment in which to work.

The shortage of nurses is the biggest hot topic, and a need to train, recognise and remunerate those doing the work is vital if we are to ensure that ET nursing will continue – the need is still there!

Prilli worked with the pioneers of stomal therapy at Barts in the 1960s and pioneered stomal therapy in South Africa in 1973 at Groote Schuur Hospital, Capetown from 1973-2005. Prilli was part of the pioneering international group of the WCET in 1978, President WCET 1980-1994 and Chairperson of WCET Education Committee from 1984-1990. Prilli has been awarded an honorary Life Member of the WCET. She has educated in stomal therapy nursing nationally and internationally.

**Australian Association of Stomal Therapy Nurses Inc. Education and Professional Development Subcommittee**

**POSITION STATEMENT**

**Scope of nursing practice for stomal therapy nurses**

It is recognised that stomal therapy nurses practise in a variety of settings and must operate in accordance with their scope of practice as determined by their relevant state registering body.

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To learn more about how the Skin Friendly Moli range can help reduce incontinence related skin problems, call 1300 720 983.

1 Source: J Junkin, J Solakof, J Mouw, Obstet. Gynecol. Obstetrics, Nov. 2007; 14(1): 260-269. 2 Applicable for MoliCare® Premium, MoliCare® Comfort and MoliForm only. 3 Applicable for MoliCare® Premium and MoliCare Comfort.
AASTN Education and Professional Development Subcommittee

Chairperson’s report – AGM March 2009

Fiona Bolton • Chairperson

In opening my report, I would like to acknowledge the outgoing Chairperson of this committee, Cynthia Smyth, AASTN Life member, for her tremendous efforts over the last 20 plus years on the committee. More than 10 of these years has been as Chairperson of the Education and Professional Development Subcommittee. Cynthia has been the guiding force in many initiatives of the AASTN Inc, most noticeably the implementation of the credentialing process, bringing the AASTN Inc. into prominence as an innovative and progressive association of nurses who support their members through this process. Secondly, following on from the credentialing process, was Continuing Professional Development. Cynthia managed both the CPD and credentialing portfolios for many years before handing over to our current Credentialing Officer Sue Delanty. Thirdly was the review of the AASTN Inc. Standards adapted from the Competencies of Advanced Nursing Practice.

Last year the committee met over a weekend in October in Melbourne rather than at the usual Country Women’s Association in Adelaide. Whilst the Richmond Hill Boutique Hotel was a cost-effective, well-organised venue to hold our meeting, we have decided to return to Adelaide for practical purposes for the next 2 years as there will be four Adelaide AASTN members attending the October meetings.

Last year was the first year without a national conference and we trialled omitting the usual March meeting but found we had to play catch up in October. The committee relies heavily on small group work to maintain deadlines, and the important and essential work this committee generates can not be undervalued. For this reason, the committee will continue to meet in March in the off-conference year at the most cost-effective venue to be decided in consultation with the National Executive.

CPD AND CREDENTIALING

Sue Delanty from Tasmania continues to play a pivotal role as Credentialing Officer. We do ask that all members participating in the CPD process follow the established guidelines by maintaining a time schedule and sending in copies of certificates and other supporting documents to justify your CPD. Sending in the written points portfolio is not enough. We ask that all state branches clarify this to their members on a regular basis to facilitate Sue in her position. The points portfolio was reviewed last October, which will facilitate all members to achieve CPD status.

We are pleased to announce 84 participated in CPD in 2008. Congratulations to those that took up the challenge. A further six members have participated in the credentialing process in 2008. These members are Jane Kulas, Tracie Beattie, Teena Cornwall, Caroline Harrison, Anna Plummer and Lynda Staruchowicz. Well done. Three members participated in the credentialing process – Jan Denyer, Jenny Davenport and Debbie Franklin. Fiona Bolton participated in the second round of recredentialing.

After lengthy discussion in October we are pleased to report that the AASTN recredentialing process will be increased from 3 years to 5 years. This reflects the high standard of professional work our members achieve, participation within the AASTN and dedication to their role as stomal therapy nurses. As long as the CPD continues annually they will maintain their credentialed status for 5 years. New certificates reflecting the new dates will be distributed by the state representatives. Please see your state rep to collect your certificate.

START DATABASE

The AASTN Education and Professional Development Subcommittee has evaluated the effectiveness of the AASTN Inc START database which was developed in consultation and with the assistance of ConvaTec. As Wendy Sansom demonstrated at the recent conference in Perth, it is an easy, readily accessible document to use. Please contact Sue Delanty (Tasmania), Wendy Sansom, (Victoria) or myself in South Australia for a copy. We thank ConvaTec for their tremendous input and dedication to our vision of a database unique to stomal therapy nursing.

SCOPE OF PRACTICE

The AASTN Education and Professional Development Subcommittee has received a number of enquiries regarding the scope of practice of a stomal therapy nurse. To prevent self-limiting criteria, the committee has developed the following statement:

It is recognised that stomal therapy nurses practise in a variety of settings and must operate in accordance with their scope of practice as determined by their relevant state registering body.

This was advertised in the March edition of the Journal of Stomal Therapy Australia.

COALITION OF NATIONAL NURSING ORGANISATIONS

Lesley Everingham and Wendy Sansom continue as our representatives on the Coalition of National Nursing Organisations who meet twice a year to discuss issues faced by nursing organisations and act as a medium to update us on relevant issues. Biannual reports are published in the JSTA.

AASTN WEBSITE

Lorrie Gray is the committee website liaison, ensuring documents are placed on the website in a timely manner. Please notify myself if you notice any discrepancies or if you have any ideas regarding our documentation format.

OVERSEAS TRAINED STNS

The committee has recently reviewed the criteria for membership of overseas trained STNs. The criteria will be soon available on the AASTN website.
ARCHIVIST

Julie Hoyle in SA has retired as Archivist of the AASTN. Wendy Humphreys (South Australia) will become the next AASTN Archivist and the committee hopes to focus some time in October on what is required to be kept, scanned or discarded as guidelines for the Archivist to follow.

EDUCATION PROGRAMMES

The Royal Adelaide Hospital Stomal Therapy Nursing Education Programme was reviewed last October and endorsed for a further 2 years. Congratulations to Merle Boeree, course coordinator, for her continued efforts in training new STNs who will hopefully become involved in AASTN activities.

CHANGES IN COMMITTEE MEMBERSHIP

Carmen George (South Australia) has resigned from the committee last October. Lisa Kimpton has been elected as her replacement. Donna Griffith (Western Australia) has also resigned. Sandy Hyde-Smith has been elected as her replacement. Pat Sinasac has been elected to replace Cynthia Smyth in Queensland.

WCET report

Hullo to my STN colleagues!

What a wonderful conference our Western Australian colleagues put on for us in March! Their organisation of the conference was, as always, of a very high calibre and the papers presented were also of a very high standard. It was great to catch up with other STNs who often we only meet at conferences – it is always great to swap stories with them or simply ask for their advice on a problem which may have been bugging you for sometime. In our chosen field of nursing we often work autonomously, and it is good to set up a network of colleagues with whom you feel confident to ask their opinion with a difficult problem. Conferences are a good way to cement these relationships as well as keeping up to date with the latest treatment, technology or simply the reinforcement of treatments you may be using.

The next stomal therapy conference is being held in Phoenix, Arizona in June 2010. At the conference in Perth, 83 people either renewed their membership or took out new memberships to the World Council of Enterostomal Therapists. This was a great response to our membership drive and I thank all those who took advantage of the opportunity to do this. I will keep you informed of when the Phoenix conference information is on the WCET website so you can submit an abstract if you wish or to register online for the conference. It will be a great conference as it is a joint venture with the Wound, Ostomy, Continence Nurses group from America. Members of WCET receive discount membership for the conference, which is usually a greater amount of discount than the membership fee, so for all of you who have haven’t joined yet, here is an incentive to enable you to take advantage of cheaper conference registration.

Don’t forget to check out the WCET website at WCETN.org for information from Liz English our president – I will also update you with new information when it becomes available.

More conferences to come

Brenda Sando CNC STN • The Wesley Hospital, Brisbane QLD

Hullo to my STN colleagues!

What a wonderful conference our Western Australian colleagues put on for us in March! Their organisation of the conference was, as always, of a very high calibre and the papers presented were also of a very high standard. It was great to catch up with other STNs who often we only meet at conferences – it is always great to swap stories with them or simply ask for their advice on a problem which may have been bugging you for sometime. In our chosen field of nursing we often work autonomously, and it is good to set up a network of colleagues with whom you feel confident to ask their opinion with a difficult problem. Conferences are a good way to cement these relationships as well as keeping up to date with the latest treatment, technology or simply the reinforcement of treatments you may be using.

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Don’t forget to check out the WCET website at WCETN.org for information from Liz English our president – I will also update you with new information when it becomes available.
A partnership in progress continued

Peter McQueen • Vice President ACSA

As in the previous article, I would like to continue the theme of partnerships – we, as ostomates, and our associations need to work closely with our professional colleagues the stomal therapy nurses to achieve the best possible outcome, both for our long established ostomates and new members alike. Our positions should never be considered as a ‘them and us’ scenario, for we need to work as a team for the wellbeing of all concerned.

I have heard it said on many occasions that if you are going to have an ostomy, Australia is the place to be. Not only do we have access to an excellent range of appliances, but the support from our stomal therapy nurses and associations is second to none.

We in Australia tend to take things for granted and assume that the support we enjoy just happened, yet this is not so. We are fortunate that many dedicated and influential people have paved the way for us. The Stoma Appliance Scheme (SAS) began in its present form in 1974; some pharmaceuticals were available prior to then, but a full range of appliances became available to Australian ostomates free of charge from that time. As there was already a distribution network of sorts (associations that had started out as self-help and buying groups were accessing some appliances and supplying them to their members), a special act of parliament was introduced to enable associations to be reimbursed for the appliances supplied under the SAS plus a 2.5% levy to assist in the costs of administration. This scheme that began 35 years ago is now widely recognised as the best throughout the world. All of the stakeholders – ostomates, stomal therapy nurses and appliance companies – have a responsibility to ensure the scheme continues to operate in a cost-effective and efficient manner.

Later this year there will be another opportunity for the partnership to continue – 3 October is time to celebrate World Ostomy Day. This year the theme will be Reaching out, which signifies the part ostomates, ostomy associations, support groups and health professional organisations play in the rehabilitation of ostomates in the general community. Promoting World Ostomy Day activities is an ideal forum to let the general community know what needs and aspirations ostomates have.

The Coloplast Merit Award will once again be an integral part of World Ostomy Day. The aim of the award is to encourage enterprising initiatives of national ostomy associations to other member associations throughout the world. There will be three regional contests – Europe, the Americas, and Asia & the South Pacific. Entries will be accepted from member countries of IOA and the two prizes will be given per region – US$2500 and US$1000. There will also be three encouragement awards of US$500, not necessarily one for each region.

Activities to promote awareness may include educational programmes, seminars, support meetings and demonstrations/displays, electronic information networks, newspaper and magazine announcements/advertisements and articles. Other examples include publication of informative handout materials and brochures, audio and video announcements and films, personal visits and lobbying activities, official government proclamations and joint activities with allied agencies and professional health organisations.

As part of WOD2009 there will also be an international photographic competition sponsored by Hollister – the World Ostomy Day photo contest. The theme of this competition is to indicate that having a stoma does not stop ostomates leading a full and active life. For example, families on vacation, during work, sporting activities, spending time with children/grand children or volunteering in community organisations. There will be 20 prizes of US$250 awarded. Entries will be accepted from ostomates or non-ostomates but must show ostomates being involved in some activity or other. Entry forms and criteria for both competitions are available on the IOA website.

Ostomy associations throughout Australia would welcome involvement from our healthcare colleagues in celebrating World Ostomy Day 2009.

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.
• 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.
Australian Capital Territory

The AASTN ACT branch has lobbied ACT Health for many years for the establishment of a full-time stomal therapist position at the Canberra Hospital. This goal was realised this year with the development of two positions at the Canberra Hospital – CNC Stomal Therapy and CNC Wound Management. The ACT branch feels this is a great step forward and long overdue. The development of these positions has already seen the interest in stomal therapy increase, with one nurse from the hospital enrolled in an accredited stomal therapy course.

The stomal therapists in the community sector continue to remain busy with the outpatient clinics. The drop-in clinic at the ACT Stoma Association remains a popular way for the ostomates to access expert advice. One of the community stomal therapists attends the Association one morning per month. This initiative fosters a professional and productive relationship between the stomal therapists, ostomates and the Association.

The ACT branch continues to struggle with membership at times. The current members are looking at ways to increase the interest in stomal therapy and to therefore increase the numbers that attend meetings. One goal is to maintain and strengthen current links and to develop new relationships with the stomal therapists in surrounding rural areas.

For 2009 we will be looking at encouraging members to submit CPDs in order to become preceptors. We are also looking forward to developing our relationship with the ostomates and Association by participating in activities they have planned this year.

Kellie Burke

New South Wales

Many NSW members travelled to Perth for the conference which was enjoyed by all.

Ostomy NSW Ltd, one of the distributors of the Stoma Appliance Scheme, is helping to support new stomal therapy nurses in NSW by offering a yearly scholarship to the value of $5,000 to a nurse enrolled in the Graduate Certificate in Stomal Therapy Nursing commencing in July 2009. This can be given to up to three people to share. This is great news for NSW – we all need to support new stomal therapy nurses. I understand that the ostomy associations in other states also do this.

Sadly, Susan Dunne from St Vincent’s Hospital is retiring in April this year after 30 years doing stomal therapy nursing. Sue assures me that she will continue to be active in the AASTN, especially the NSW branch and the education and professional development committee. Sue will also continue to be involved with the College of Nursing and the Graduate Certificate in Stomal Therapy Nursing which is fantastic for all of us – we do not want to lose all of her expertise.

The NSW Branch still have bi-monthly meetings (April, June, August, October on the first Tuesday of the month and in December on the first Friday of the month). All of the meetings are held at Royal Prince Alfred Hospital at 17:45. For further information contact Carol Stott 0402 018790. Regards

Carol Stott

Northern Territory

It’s nearly the middle of the year already; stomal therapy in the NT still plods along at the same pace with a few stomas here and there, some complex (always a good thing to keep a stomal therapist happy), others rather normal. Actual stomal therapy positions in the NT still sit at three, with two specialising in wound management and one in continence.

I hope everyone had a great time at the conference and caught up with old friends and made some new ones too. Take care and stay safe. Cheers.

Jenni Byrnes

Queensland

Our AGM was held in March and the following officers elected

President 
Elaine Lambie (re-elected)

Vice president 
Penny DeWinter

Secretary 
Petra Prokop (re-elected)

Treasurer 
Maxine Wench (re-elected)

State rep 
Helleen Purdy (re-elected)

BOSVS 
Sherryl Waye (re-elected)

Education 
Ros Probert (re-elected)

Pat Sinasac

National treasurer 
Sarah Axman Friend

National editor 
Theresa Winston

A special thanks to the outgoing committee members Pat Walls and Cynthia Smyth. Our meetings continue second-monthly and we encourage any new members to attend. Sherryl Waye has been networking to review best practice in postoperative management for abdo perineal resections. We also hope to review stoma education in nursing homes and develop an education package. We have also commenced regular meetings with the stoma associations to improve communication and networking.

Queensland was well represented with 47 STNs attending the AASTN conference in Perth. The conference was very hectic, with excellent speakers covering a broad range of topics. There was a great chance to network and come away with renewed inspiration to improve our own practices. Prilli d’E Stevens, Paula Erwin-Toth and Elizabeth English presented a very powerful message about the role of the STN. Cheers.

Helleen Purdy

South Australia

South Australian stomal therapy nurses have made a brisk start to the new year. We held our AGM on 25 February and, resulting from that, we have elected new office bearers for 2009. Lisa Kimpton will be the new President, while Erica Taylor and Michelle Williams will be sharing the role of Secretary. Sue Handsworth was elected to the role of Treasurer and I, Lynda Staruchowicz, have become the new State Representative. The Stomal Therapy Nurses of South Australia wish to thank the outgoing members for all their hard work and commitment, particularly Barb Lewis who has ably filled the role of Treasurer for many years.
March brought the 37th AASTN National Conference in Perth, with our state having many members in attendance. Stomal therapy nurses from South Australian country centres as well as city members turned out in Perth for a fantastic conference. Congratulations and well done Perth for such a varied and exciting programme. I have every expectation that the Joint Conference in Cairns will have just as much to offer.

The Royal Adelaide Hospital has just completed the first module of the Certificate in Stomal Therapy Nursing, with 16 students attending. Students came from a variety of metropolitan and country hospitals and they were a bright and enthusiastic group. This module (ostomy resource person) is open to RNs and ENs and sets a basic understanding of ostomy care. RNs can choose to complete the course and become fully qualified stomal therapy nurses. This course is run over a 12-month period.

A glance at the branch meeting programme for 2009 reveals a busy year, with guest speakers planned for meeting nights and a quiz night later in the year, so I guess that rest of 2009 will continue as it has started.

Lynda Staruchowicz

Tasmania

Our committee members are:
President Sonia Hicks
Treasurer Carolynne Partridge
Secretary Tina Cornwall
Education/PD Sub Committee Sue Delanty
State Rep Tracey Beattie

We have had a great year working in stomal therapy and supporting each other as a group.

We have continued education at our meetings which are run via videolink around the State and are therefore supported very well. We have approximately six meetings per year and have a face-to-face meeting at the end of the year combined with a social Christmas luncheon. Further, the Tassie roadshows – taking education to outreach areas – has continued to be appreciated with great feedback. Education has been a focus personally as well, with many members stretching themselves and returning to university studies.

As a state we have utilised the valuable ConvaTec START database on a daily basis – thank you to ConvaTec, our own Sue Delanty and the other members of the Education and Professional Development Subcommittee for this innovative tool!

Nola Polmear has officially retired and resigned from the AASTN this year. Nola has been an enthusiastic, energetic and active member of the Tasmania branch for many years. She has been committed to the AASTN on a national level as well with her valuable contribution as member of the Education Subcommittee. She has written articles for the AASTN Journal and also presented at conferences. We congratulate Nola on a ‘fabulous’ career and thank her immensely for her dedication and vibrant approach to work and life!

The stomal therapy department in Hobart welcomes new stomal therapist Vanessa Rhodes to the team – she will be job sharing with Sonia Hicks. In Launceston at the LGH, Teena Cornwall has joined Sue Delanty, allowing Sue to reduce hours slightly this coming year. Sue continues to work hard, however, and has been very busy with the Education Committee with credentialing and sorting through CPDs this year with the largest number received thus far. Well done to all those committed STNs!

We had all been looking forward to the conference in Perth. Congratulations to the WA AASTN for organising such a full and fantastic conference. ‘Well done’ doesn’t seem enough, as we realise this isn’t a small event to get off the ground. So our hats go off to you all! We feel very lucky that we were able to represent Tasmania so well, both in numbers and with the presenters accepted as part of the programme – congratulations girls!

All the best for a successful year ahead, meeting challenges and learning each day. Kind regards.

Tracey Beattie

Victoria

I am pleased to submit this annual general Victorian branch report for the period 2008/09.

We boast a productive year, cohesive supportive membership and outstanding committee who have worked tirelessly in their resolve to provide education to our members and general nurses and a professional approach to the VIC branch business agenda.

Fifteen students successfully completed 2008 Mayfield Stomaltherapy Certificate course and we are pleased to report all are active within their workforce, mainly in relieving stomal therapy positions. Sixteen students have commenced the 2009 Mayfield Stomaltherapy Certificate course. We enjoy an excellent working relationship with Nina Vucic, course co-coordinator at Mayfield. Nina is an outstanding communicator and very professional in her commitment to the success of the course. We acknowledge her hard work throughout this past year.

We strongly value our country members and for this reason continue to organise seminar days each year. In August last year a very successful seminar was held over 2 days in Warrnambool, with over 30 in attendance. Our thanks go to Jenny Fox as liaison organiser. This year’s country venue is planned for Echuca region in either late August or September.

The branch continues to meet each second month. As previously reported, our meetings have a guest speaker or education focus. The topics covered over the last year include inflammatory bowel disease, nutrition in Crohn’s disease, clinical case presentations, VAC therapy in complex fistulae wounds, and presentation speaker skills. The remainder of branch activities is the responsibility of the committee who meet four times a year, with a significant amount of other business conducted through e-mail communication.

I would like to acknowledge the following branch members for their outstanding contribution to stomal therapy over the last few years – Leeanne White (completing a 2-year term as National President); Diana Hayes (completing 2-year term as Editor, National Journal); Mary Ryan (standing down from website coordinator role); and Celia Habelr (retiring as VIC branch treasurer, after many years in the role, but remaining as country representative on the branch committee).
We congratulate and thank Margaret Fraser on accepting her nomination as Secretary on the National Executive for the next 2 years and assure Marg of our support. Within the VIC branch committee, Caroline Harrison is taking a break as she goes on maternity leave, with her first baby due in April. Christine Curley is presently undergoing treatment for breast cancer and we all lend our support and thoughts to Chris for her continued strength and health. We welcome to the Committee Lynne Bryant, Stephen Demur, Patricia McKenzie and Ros Carmichael. Wendy Sansom and Jenny Davenport are our two representatives on the National Education Committee.

Meetings planned for 2009 include a clinical presentation in June, date and venue to be confirmed. Also, 5 August at Western Hospital (Footscray Campus), a September country conference June, date and venue to be confirmed. Also, 5 August at Western representatives on the National Education Committee.

Underpinning the success of VIC branch and all our activities are our trade company colleagues and friends. We benefit from and enjoy enormous support from the trade; they are always in attendance, always willing to help in any way either financially, through trade displays, sponsorship, suppers at meetings or just being present. Through this report we acknowledge their input and express sincere thanks.

The VIC branch is looking forward to hosting the next national conference in 2011. Preliminary planning has commenced and we have engaged a secretariat, Pamela Richards Consultancy, to ensure a smooth and seamless planning for all involved.

Finally, our thanks to the Perth committee for an excellent conference and their hospitality at the 39th National Conference.

Helen Nodrum

Western Australia

In March, Perth hosted the Australian Association of Stomal Therapy Nurses 37th Conference at the Burswood Entertainment Complex Convention Centre – the organising committee are pleased to announce it was a resounding success according to all the feedback received.

It commenced on Tuesday 10 March with a cocktail reception. On Wednesday the conference was officially opened by Ms Mary Jo Kroeber AM, a Founding Member of AASTN and WCET. This marked the beginning of 3 full days of information and entertainment. We were excited to host a number of guest speakers from both international and national backgrounds.

The first day introduced Stomal therapy – the global perspective. In these presentations the audience were given an insight into the challenges faced by our colleagues and patients in Africa, North America, Indonesia, China, Iran, New Zealand and Australia. It was humbling to hear of the plight of ostomates in less privileged countries and brought home how truly lucky we are to live in a developed country. Topics also covered were parastomal hernia, bariatric surgery and the paediatric patient. There was not a dry eye in the house following Debbie Strode’s presentation on mitochondrial cytopathy – a family story. We can only hope that future treatment will be discovered to assist patients with this condition.

Day 2 was again a full programme, with many sessions on wound management and the use of technology to facilitate communication with remote hospitals and health services in order to enhance patient care. It is indeed amazing how progress in technology has developed, and how health professionals have incorporated this into their practice. In Western Australia we service many remote areas and, without programmes like telehealth, Silver Chain’s ComCare and WoundsWest, this task would be almost impossible.

The second day workshops were popular and covered gastrostomy care, fistula management, lymphoedema and lipoedema, oedema assessment and management, and complex wound care. These topics are always a challenge for stomal therapy nurses and valuable tips were shared amongst the attendees.

The third and final day was no less interesting or informative, with the focus being on continence, complex stoma management and professional practice issues. The international speakers again shared their experiences and views on patient empowerment, stomal therapy nursing practice and current health concerns.

Having spoken to many of the attendees at the 3-day conference, there was an overwhelming feeling of unity and a pride in the developments being made within stomal therapy nursing practice. The variety of speakers ranged from the relatively new who were delivering their first paper to those experienced nurses who have done so many times; however, each presenter had an important contribution and are to be commended on their contribution to the programme. There is a great sense of commitment within stomal therapy nurses, a pride in our accomplishments and, above all, a desire to improve the lives of the patients in our care.

On a lighter note, the conference dinner was an opportunity to enjoy a great meal and have a great time on the dance floor. The band encouraged audience participation and the dance floor was never empty right up to the last note, with many requesting the music keep playing.

The conference closed with an excellent presentation of wonderful Western Australia produce from Tastes of WA and Vasse Felix wines. This was an excellent opportunity to wind down with colleagues after an extremely busy 3 days. Unfortunately, many had to rush off for flights or other commitments, but it was a wonderful way to complete the programme.

On behalf of the organising committee from Perth, I would like to offer our sincere thanks to all who participated in making the conference such a success. The content and delivery of all presentations was both professional and interesting. I believe, however, that the audience also has a huge impact on the success of such events, so thank you all for your time and comments. A special thanks to Robyn Simcock, conference secretariat, who remained calm and so very, very organised from start to finish. We would be lost without her expertise and calming influence. Many thanks for the many emails and letters of thanks we have received since the conference, it makes it all worthwhile. Wishing you all well.

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