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AASTN Code of Ethics

• The stomal therapy nurse must at all times maintain the highest standards of nursing care and professional conduct.

• The stomal therapy nurse will provide needed services to persons irrespective of their race, colour, creed, sex, sexual preference, age and political or social status.

• The stomal therapy nurse must respect the beliefs, values and customs of the individual and maintain his/her right to privacy by maintaining confidentiality, sharing with others only information relevant to that person’s care.

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

• The stomal therapy nurse must maintain competency by keeping abreast of new developments in the theory and practice of stoma care and related fields.

• The stomal therapy nurse will participate actively in professional, inter-professional and community endeavours in order to meet the highest professional standards.

• No full member shall be in the employ of a company or self employed in the manufacture or sale of products, prostheses or pharmaceuticals where it could be perceived that the use or selling of products prostheses or pharmaceuticals could disadvantage or contradict the personal preference of clients or be construed to result in unethical conflict of interest.

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A proud history and a bright future for the AASTN Inc

Leeanne White • RN STN

Welcome to the September issue of the Journal. Currently the Beijing Olympics are in progress, so the eyes of the world are on China. What an opening ceremony and just how amazing are the sporting achievements?

MY OWN MARATHON

I have just recently returned from 5 weeks away exploring far North Queensland and Cape York – a distance of 9,300 kms from Ballarat to Cape York and return. It is really amazing country; rough and spectacular scenery. Returning back to Victoria, it has been very cold with some most welcome rain; it has been a welcome break. I have also semi-retired from nursing after nearly 35 years.

SPECIAL EVENTS

I am looking forward to meeting with the Education & Professional Development Subcommittee in October in Melbourne for their 2 day workshop. Certificates for credentialling and CPD were sent to State representatives following the AGM in March this year. I am also looking forward to hearing reports from those members of the AASTN that attended the WCET conference in June.

PREPARATION FOR 2009

Just as an Olympic athlete prepares, I encourage the State branches to consider nominations for the next Executive positions and continue preparations for attending the 2009 conference in Perth.

Thanks to all members of the national Executive team and particularly Diana Hayes for her dedication and work in maintaining the excellent standard of the Journal. We have had a short but well earned break but will be holding regular teleconference meetings again.

THE FUTURE

One of our future aims is to promote the specialty of stomal therapy nursing to meet the growing demands in the future, in particular in response to the National Bowel Screening Programme.

Please note my new contact details:
Leeanne White, PO Box 445, Sebastopol VIC 3356
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This is a very exciting edition of the JSTA. We have some outstanding papers and articles of interest regarding our history in stomal therapy nursing. I particularly would like to thank Terry Carver from the Ileostomy Association of Victoria for his contribution showing how far we have come with stoma care appliances.

The Editor’s position will be up for election at the next AASTN conference in 2009. On that note, whilst receiving papers submitted for publication, it has become apparent that contributors are still having problems with referencing. The Guidelines for Authors has been updated to reflect the Vancouver system, both in-text and end-of-text, rather than the American Psychology Association (APA) system previously shown. The Vancouver system is used in journals as it allows the paper to be read without any interruption.

WHY DO WE NEED TO REFERENCE?

Referencing is used to show your readers that you have researched your subject and are acknowledging the work, ideas and research of others. It allows the readers to find an article or paper that has been referenced and shows that you have professional and academic respect. If your referencing confuses readers, they may lose interest and look for a more superior presentation.

EXAMPLES OF REFERENCING SYSTEMS

An example follows of the two systems. Please note that the information given in the two examples is totally abstract:

APA system (used in universities)

The number of people who are considered obese has rapidly increased over the past 10 years in Australia (Source, Year.). Jones has argued that, “the need for dietary education and counselling within schools is paramount” (2006, p.34.). Jones also purports that this view is shared by Monty (1998), Page (2000) and Gardner (2001).

The end-of-text referencing is alphabetical, starting with the surname of the chief author. So, even though Jones appeared second in the text, he may be halfway down the end-of-text reference list.

Vancouver system (used for medical journals)

The number of people who are considered obese has rapidly increased over the last 10 years in Australia 1. It has been argued that educating and counselling within schools is the key to improving our nation’s diet 2.

The end-of-text referencing then appears in numerical order, not alphabetical. Jones would be the second person to be referenced in the end-of-text list. He is not named within the text, so the flow of the paper is not interrupted. It also gives a much neater and cleaner appearance within the text. If Jones was quoted again from the same source, the number 1 would be used again. If more than one source is used for the same argument, then more than one number is used.

To add the in-text reference number/s simply go to Format – Font – Effects, check superscript and press okay. Insert the number/s and then go back and uncheck superscript. THEN add you coma, semi-colon or full stop after the number/s. This will save hours of work by the editor and publisher.

Plagiarism

One aspect of writing a paper that will never be accepted is plagiarism. This is academic theft of other people’s work and writings. No-one expects you to be an inventor or a philosopher, so using other people’s ideas is totally acceptable. However, presenting these ideas as your own is not.

FORMAT OF THE PAPER

How the paper is presented is also important, particularly when writing the Abstract and the Conclusion.

The abstract

The reason why papers have an abstract is to entice readers to actually read your paper and to get an overall view of what is being presented. It is a condensed version of the full manuscript, including the purpose and outcome. If you wish to learn more about abstract writing go to: http://www.ece.cmu.edu/~koopman/essays/abstract.html

The conclusion

The conclusion is another interesting and important aspect of the paper. This is not the place to introduce new information. The conclusion is there to bring the reader back to where they started and rounds off the paper in a logical and strategic manner, including recommendations for further research.

So, please keep those papers coming. It is a pleasure to read and publish them in our journal.
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**Probiotics**

Teena Cornwall • Level 2 RN STN, Launceston General Hospital, TAS

**ABSTRACT**

Probiotics are a class of good or friendly bacteria that, when introduced, can exert a positive effect on the gastrointestinal system. Even though the term bacteria is associated with germs and illness, there are a number of bacteria that aid the human body to maintain health and fight illness and disease. This paper examines what probiotics are and the impact they have on gastrointestinal disorders.

**WHAT ARE PROBIOTICS?**

Probiotics contain microbes that help form a better mixture among the bacteria living in the human intestine. As there are billions of bacteria living in the gastrointestinal system, some more desirable than others. The consumption of probiotics can increase the number of the better bacteria. Some examples include *Lactobacillus casei Shirota*, *Lactobacillus acidophilus*, *Bifidobacteria* and lactic acid bacteria. *L. casei Shirota, L. acidophilus* and *Bifidobacteria* play a role in maintaining the balance between beneficial and possible harmful bacteria, therefore promoting bowel health. Lactic acid bacteria consumption helps suppress production of harmful substances, regulates bowel movement, assists digestion and absorption and also stimulates the immune system.

One product, which is under trial internationally, is VSL#3. It is made up of *Lactobacillus*, *Bifidobacterium* and *Staphylococcus*. Other examples of products that contain beneficial bacteria include fermented milk drinks, yogurts and cranberry supplements. Probiotics are available in capsule, solution or powder form.

**THEIR IMPACT ON GASTROINTESTINAL DISORDERS**

**Diarrhoea**

Probiotic use can promote a positive effect for the treatment and prevention of diarrhoeal illness. The principal effect of probiotics is demonstrated by stabilisation of the gastrointestinal microflora. With a disturbance in the gut microecology, probiotic utilisation can provide a positive influence to viral, bacterial and antibiotic associated diarrhoea.

Viral diarrhoea is associated with infectious strains such as *Enterococcus faecium* and *Streptococcus faecium*. The incorporation of lactobacillus strains of probiotics as part of the treatment for viral diarrhoea has shown to be effective at reducing the length of time for acute infection. This is done by the probiotic lactobacillus providing protection to intestinal mucosa during the infectious stage of pathogens.

Gastritis is a common cause of bacterial diarrhoea. This is a disorder that usually does resolve spontaneously. Rehydration fluid is the most important form of treatment, but this does not always reduce the number of days of diarrhoea. Several probiotic preparations, including the Lactobacillus strains, have been studied and proven to be beneficial in shortening the duration of bacterial diarrhoea.

Diarrhoea can also be antibiotic-induced. The focus of antibiotics is to kill harmful bacteria. Sometimes this can result in a microbial imbalance disrupting the gut’s flora. As a result, excessive diarrhoea and intestinal disturbances can occur. Replacement into the gut’s flora with beneficial bacteria during and after antibiotic treatment is reported effective at reducing the disturbing effects of some antibiotic preparations.

In order for probiotics to be effective against gastrointestinal disturbances, they must be non-pathogenic and must act against pathogens by different mechanisms from antibiotics. Their onset should be fast acting and should be strong enough to survive amongst gastric content, including the antibiotic therapy. Examples of probiotic strains that have these properties include the lactobacillus species.

**Irritable bowel syndrome (IBS)**

Irritable bowel syndrome or disease (IBS) is a common disorder of the intestines that results in cramp-like pain, abdominal bloating and changes in bowel habits. The abdominal discomfort is associated with painful constipation or diarrhoea, the sensation of incomplete evacuation and passing of mucus. In some people, stool changes can alternate. IBS is a functional disorder; this is because on examination there is no sign of the disease.

Probiotics can exert a positive effect in the treatment of the symptoms of IBS. Through scientific clinical trials it was found that the utilisation of lactobacillus strain probiotics in IBS sufferers reduces symptoms of the disorder. The benefits include a reduction in abdominal cramping, bloating, flatus and constipation. It has also been found that IBS sufferers’ intestinal flora differs to that of non-sufferers; the faecal microflora of IBS patients holds lower numbers of lactobacilli and bifidobacteria. Thus, a probiotic that can not only reduce pathogenic bacteria but also foster growth of non-pathogenic bacteria would be proactive in preventing and managing IBS.
Inflammatory bowel disease

Inflammatory bowel disease is the general name which refers to chronic diseases that inflame the gastrointestinal system; ulcerative colitis and Crohn’s disease.

Ulcerative colitis is inflammation of the mucous membrane of the colon and rectum which can extend to the submucosa. The disease does not affect the muscle and serosal layers of the colon. The disease occurs commonly in the rectum first and extends to the sigmoid colon and, if left untreated, can affect the entire large bowel. As a result of this, surgical removal is then the only cure. The most prominent symptom of ulcerative colitis is diarrhoea that progressively becomes worse associated with blood in the stool, abdominal cramping, anaemia, weight loss and fatigue.

Crohn’s disease resembles ulcerative colitis because the first sign can be diarrhoea, anaemia and weight loss. Other symptoms include nausea and vomiting, painful cramping after eating and difficulty in food absorption. Crohn’s differs from ulcerative colitis because the inflammation is of the full thickness of the intestine. Intestinal perforation can result, leading to abscess, stricture or fistulae. Crohn’s disease can occur throughout the entire digestive tract.

Inflammatory bowel diseases such as ulcerative colitis and Crohn’s disease are serious gastrointestinal disorders that can lead to the surgical removal of the severely affected part of the colon. The cause of these conditions is not known. However, neither condition is contagious nor caused by certain foods or stress. One theory is that inflammatory bowel diseases occur from a combination of genetic and environmental factors. Infectious agents such as bacteria can cause the body to attack its own intestinal tissue. This can result in chronic inflammation.

Probiotics have been reported to benefit patients with inflammatory bowel diseases. Probiotics may protect the gastrointestinal lining from pathogenic bacteria invasion. Therefore, safeguarding the lining of the gut can result in keeping inflammation under control. This can mean symptom relief for patients suffering Crohn’s disease and ulcerative colitis.

International clinical trials have been conducted using the probiotic agent VSL#3 on patients with Crohn’s disease and ulcerative colitis in separate controlled trials. This probiotic mixture contains eight types of bacteria. It includes species of lactobacillus and Bifidobacteria. Researchers have reported that a higher percentage of patients involved experienced remission of their symptoms associated with their inflammatory bowel disease. Researchers suggest that probiotics may provide alternative management for people with inflammatory bowel diseases when no response is achieved from conventional treatment processes.

Helicobacter pylori infection

Helicobacter pylori infections colonise in the stomach. The presence of this pathogen is associated with gastric ulcer disease and gastric cancer.

H. pylori may not always be treated effectively with antibiotic therapy. Thus, the excessive use of antibiotic treatment can result in resistance, which can be problematic. The high levels of lactic acid contained in lactobacillus strains of probiotics can inhibit the growth of H. pylori. As a result, H. pylori colonies and associated inflammation with H. pylori gastric infection can be suppressed. This can raise new hopes for effective treatment as unwanted side effects from existing standard antibiotic treatment could be eliminated.

Neonatal enterocolitis

Probiotic supplements may be effective in the prevention of neonatal necrotising enterocolitis. Necrotising enterocolitis is a disease affecting the small and large bowel. This illness results from ischaemic processes occurring in the intestine secondary to respiratory distress, sepsis or hypotension. It is most common among premature neonates. The mucosal and submucosal layers of the small and large intestine that are primarily affected. The epithelial cells of the mucosal layer are targeted and, when left unprotected due to reduced blood supply from the ischaemic process, cannot produce mucus. This makes way for bacterial pathogens to invade and contribute to the life threatening condition.

International research has shown that probiotic strains such as Bifidobacterium are effective in reducing the development of necrotising enterocolitis. This probiotic, by mechanism of action – controlling the inflammatory process – has shown considerable effectiveness in reducing the onset of this disease.

Colon cancer

Cancer is caused by the mutation or activation of abnormal genes that regulate cell growth that the immune system cannot recognise and destroy. The endogenous flora and immune system play an important role in modulating carcinogenesis. It is argued that both can be influenced by probiotic therapy. The mechanisms by which probiotics may inhibit colon cancer are due to alterations to the:

- Metabolic activity of intestinal flora.
- Physiochemical conditions in the colon.
- Intestinal microflora, which limit the production of carcinogens.

Evidence is based largely on animal studies. In animal models of colorectal cancer, the incorporation of probiotic treatment, specifically lactic acid producing bacteria, appeared to prevent the induction of carcinogenic compounds. However, human participation will be necessary to confirm these findings.

Other epidemiologic investigations imply the consumption of fermented milk products may have some protective effect against colon cancer. One study in progress in Europe, Syncam, is a human trial which includes volunteer cancer patients as well as individuals considered high risk for developing the colorectal disease. It consists of a 3 month trial of adding a probiotic to their diet. The aim of this study is to determine if probiotics can effectively reduce the risk of colon cancer in Western society.
CONCLUSION
Evidence supports the concept that probiotics can benefit gastrointestinal disorders and their symptoms. As a result, the use of probiotics as therapeutic agents for gastrointestinal disorders is becoming more recognised. The most common strains of probiotics that have been studied include *L. acidophilus*, *L. casei* and *Bifidobacterium*. These probiotic microorganisms can be found in food supplements, yoghurts, fermented milk drinks or even in the form of capsules and powders.

With ongoing research and the need for further human clinical trials, a greater understanding may be reached as to the mechanism of action, properties of different strains, and applications for use. This could make way for exciting new methods of the treatment of gastrointestinal disorders.

REFERENCES

STOMA APPLIANCE SCHEME UPDATED SCHEDULES
Available from the Department of Health website
If the page does not show immediately, use the www.health.gov.au search system and you will find it by typing in: stoma appliance scheme

Colorectal Surgical Society of Australia and New Zealand (CSSANZ) Scholarship for Stomal Therapy Nurses

PURPOSE
To foster and further develop the relationship between the Australian Association of Stomal Therapy Nurses Inc (AASTN Inc) and CSSANZ, the CSSANZ will present a scholarship for a novice stoma therapy nurse (stoma therapy nursing education programme completed within the previous 3 years) to attend their annual Spring Meeting. This is an annual award and will be presented at the AASTN Inc Annual General Meeting.

AWARD VALUE
This scholarship will cover registration to the annual CSSANZ Spring Meeting, economy class airfare and $500 towards accommodation.

ELIGIBILITY CRITERIA
Applicants must:
- Be a full member of the AASTN Inc.
- Be currently registered in the State where they are working and utilising their stoma therapy nursing skills.
- Have completed an AASTN Inc recognised stoma therapy nursing education programme within the previous 3 years.
- Be able to attend the Spring Meeting in or outside Australia.

PROCESS
Submit an article suitable for publication in The Journal of Stomal Therapy Australia (JSTA). The article may be in the form of, but not limited to:
- A clinical case study
- Research project
- Book review not previously published in JSTA
- Educational poster or teaching tool
- Professional issue pertinent to either specialty

The article, plus a completed official application form with a copy of current nursing registration, must reach the national executive secretary by 15 May in the relevant year. Contact details for the national executive secretary can be found in the current JSTA. Application forms are available from the AASTN Inc executive secretary and AASTN Inc website www.stomaltherapy.com

All applications will be reviewed by the judging panel. A decision will be available and all applicants notified within six weeks. The judging panel will consist of:
- The Editor, JSTA (or delegate)
- Committee member of the AASTN Inc Education and Professional Development Subcommittee.
- Nominated member of the CSSANZ

Late applications will not be considered. The scholarship award is not transferable.

SELECTION CRITERIA
The decision of the judges is final and based on the following criteria:
- Presentation
- Originality
- Appropriateness to stoma therapy nursing and colorectal surgery
- Demonstrated integration of theory and practice
- Suitability for publication following the JSTA Guidelines for Authors found in current JSTA.
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CONCLUSION

This study* confirmed the very good acceptability and efficacy of a new lipido-colloid contact layer dressing in the treatment of EB skin lesions, notably in young patients, suffering from this disease.


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Stoma, wound and fistula management in gynaecological oncology patients

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Jennifer Duggan RN STN • CNC (Acting) Gynaecological Oncology, Royal Hospital for Women, Sydney NSW

ABSTRACT

Gynaecological cancer refers to any cancer arising from the genital and reproductive organs in women. This paper will concentrate on specific problems concerning stomas, wounds and fistulae management in gynaecological oncology patients.

INTRODUCTION

The diagnosis of cancer is a crisis for any woman, but in addition to the very real threat of death, women faced with a gynaecological malignancy often have concerns about femininity, motherhood, sexuality, and changes to their body image, which can be compounded by a problematic stoma, wound and fistulae management. There are no magical solutions to many of the problems encountered with stomas, wounds and fistulae in this patient group; this paper will endeavour to give management options that will help with the problems that you encounter.

STOMA FORMATION

Stoma formation with gynaecological malignancy can be performed as an emergency or elective procedure depending on the site of the malignancy, the spread to adjacent organs, and the stage of the cancer at presentation (Figure 1). Ovarian and cervical cancers are the main gynaecological malignancies that may require stoma formation.

Ovarian cancer

Patients with ovarian cancer often develop intestinal obstruction either at the time of initial diagnosis or more frequently in association with recurrent disease – the obstruction can be related to a mechanical blockage or to a paralytic ileus and occurs in 25–42% of women with advanced disease. A stoma may or may not be necessary depending on the site of the obstruction and the disease process (Figure 2).

The decision to surgically manage an obstruction in a patient with progressive disease or who is palliative needs to be carefully evaluated. Generally surgery would not be indicated with patients whose life expectancy is very short, as research has shown that the median survival time for patients who have undergone intestinal surgery for bowel obstruction is between 3-12 months. If the patient presents with a single obstruction or an obstruction confined to one area, it can often be resected.
or bypassed, but if there are multiple obstructions, resection of several segments of bowel would not be indicated and in this instance a stoma would be formed. This could be a colostomy, ileostomy or even a jejunostomy.

Cervical cancer and stomas
Total pelvic exenteration or variations of the procedure, for example anterior exenteration or posterior exenteration, is radical surgery that is carried out on women with recurrent cervical and occasionally endometrial cancer. There should be no preoperative evidence of extra-pelvic disease, no tumour fixed to the abdominal wall and no evidence of obstruction of the ureters. The surgery involves resection of all pelvic structures including the uterus, vagina, bladder, lower ureters, lymph structures, distal colon and rectum and pelvic peritoneum (Figure 3). The woman has a permanent colostomy and urinary diversion, either an ileal conduit or a continent urinary diversion, and often a reconstructed vagina.

Learning how to look after the stoma
Stomas are almost always permanent with gynaecology patients (Figure 5). It is important to involve family, friends and partners in the education process as disease progression may make it difficult for the woman to remain independent with stoma care. The aim of stomal therapy intervention is to enable the person or carers to manage the stoma. This would entail being able to change and empty the appliance and order the equipment needed to carry this out. This should be made as simple as possible. Some patients have to be persuaded to start looking after their stoma at a time when they are actually preparing themselves for dying. This can be quite confusing for them, and also makes the role of the stomal therapist quite difficult. Community nurses can assist with stoma care but are not available day and night to carry it out.

Problem stomas
Many patients have irradiated bowel which means that, even with a colostomy, the output is going to be very watery which
can add to the problems patients have to deal with. Some of the stomas are positioned where the patient has difficulty seeing them, others can be inverted and/or positioned within skin folds.

Other patients with a colostomy may have problems with impaction or constipation due to the large amounts of narcotics that they need to take for pain control. Serotonin antagonists such as ondansetron and tropisatron which are the anti-emetics used when patients are receiving chemotherapy can also lead to constipation. This also needs to be considered and a comprehensive laxative plan put in place so that the patient does not become faecally impacted which can impact considerably on a patient’s quality of life.

Appliance selection

This poor lady, as you can see, had a stoma that disappeared into her abdominal skin folds (Figure 6). She was a very determined lady who wanted to become independent with her stoma management as quickly as possible in order to return home. She managed her colostomy which had quite a fluid output by using a ‘flat bag’ that she changed every 24 hours, and emptied about 5 times per day. As you can see, the bag needed to be bent in two in order for her to place it around the stoma, and she had to do this in front of a mirror, a bit like inserting a Frisbee between abdominal folds. Unfortunately she could not use a bag with belt tabs, as none were flexible enough for her requirements. Nevertheless, she managed her situation quite well. If a patient can obtain 24 hours wear-time from a drainable bag, this is usually acceptable.

Inverted stoma and use of convexity

An inverted stoma can be a management problem, especially if the output is liquid (Figure 7). A regime needs to be worked out and an appliance found that would help to flatten out the abdominal plane. Convex appliances, whereby the face-plate curves outwards, are designed to apply some form of direct pressure to the immediate peristomal skin in order to promote a good seal between the stoma appliance and the skin. Differing depths of convexity and the addition of seals can increase this.

Applying seal, convex bag and belt

This lady applied the seal and then a one-piece convex drainable bag, and also used a belt for added security. She changed the appliance every 48 hours, which took less than 5 minutes and emptied the bag about 5 times per day (Figures 8-10).
Most stomas are manageable with modern stoma appliances. There are some instances, however, where even with the best will in the world, a ‘leak-free’ stoma is not possible and, in order for the woman to have any kind of quality of life, the stoma has to be sited in a different location (Figure 11).

WOUND MANAGEMENT IN GYNAEONCOLOGY

Issues related to wound management in this group of patients are often complex. A thorough holistic wound assessment needs to be carried out initially, and then at regular intervals to make sure that the best possible wound management plan is implemented 6,7. If the wound is a complex wound, we need to reduce the complexity in order that the patient can be discharged from hospital. This usually means community nurse input, ensuring that the dressing is comfortable, odour free, leak-free, not too painful and lasts, setting in place a dressing regime that works for at least 24 hours.

Pre-disposing factors for wound breakdown include: radiotherapy/chemotherapy; multiple surgeries; infection; obesity; emergency surgery; poor nutritional status; malignancy (poor blood supply); being immunocompromised; and a poor psychological state 8. When you look at this list, it’s a miracle that any of the wounds we see in this patient group heal at all, as many of the women that we see have multiple factors that delay or prevent wound healing. This is quite a long list, and I am sure that we can all add to it. For example, endometrial cancer is a more common gynaecological malignancy in the developed world 9 and one of the predisposing factors is obesity; this would also mean that these patients have a high incidence of diseases such as diabetes, which also impedes wound healing, and so the list goes on.
Fungating tumours

Cancerous/fungating wounds are difficult to manage and provide a considerable challenge to everyone involved in these women’s care (Figure 12). Fungating lesions occur as a result of cancerous infiltration of the epithelium, resulting in a protruding nodular and often grotesque growth which is prone to infection and malodourous exudate. Symptom control and appropriate psychological support are the main treatment goals aimed at improving quality of life.

Groin wound breakdown/lymphocysts

Malignant tumours of the vulva are a relatively uncommon gynaecological cancer but are very problematic to manage (Figure 13). The surgical treatment is radical excision of the local tumour accompanied by groin node dissection. Major complications occur in up to 50% of the postoperative population, mainly in the form of infection, which can lead to groin and perineal wound breakdown and lymphocyst formation. Treatment consists of systemic antibiotic therapy, ‘laying open’ the wound and debridement of non-viable tissue in order to allow infected fluid to drain. Regular dressings with an absorbent dressing product are indicated and, once the dressing can be attended daily, the patient can be discharged with community nursing support.

Fistula formation

Fistula formation is an unfortunate complication post surgery and radiotherapy (Figure 14). The symptoms of fistula formation are rapid and disconcerting for the patient. Vesicovaginal fistulas occur mainly after pelvic irradiation. Patients present with urinary leakage through the vagina, which can lead to marked excoriation. Rectovaginal, colovaginal and ileovaginal fistulas can also occur. Although fistulas are not usually painful, it can have an extremely negative impact on quality of life due to the drainage and accompanying odour. Patients can become very isolated, avoiding social encounters.

There are surgical treatment options such as stoma formation above the level of the fistula, but it needs to be remembered that it would be a palliative procedure and the focus is about quality of life. Treatment is symptomatic, taking into account pain control, output management, odour control, skin care and psychosocial issues.

Wound management strategies

Odour control is often the main problem encountered with many of these patients especially those with fungating wounds and fistulae. Management strategies for odour can be used topically, systemically or environmentally.

Topical odour management would include such things as carbon backed dressings, Metronidazole gel and occlusive dressings such as hydrocolloids and film dressings. Topical Metronidazole seems to work better if used in conjunction with systemic Metronidazole but its use should be carefully
evaluated, as some patients get quite nauseated. Stoma bags can be used on malodorous wounds as they are occlusive and also have the added benefit of containing the exudate. There are some continence pads which have a built-in deodorant and some women find them quite useful. Some of the newer silver products used in wound management have also been reported as having odour control properties. Environmental odour control includes such things as ‘double bagging’ used dressings, using deodorants and burning aromatherapy oils.

Thick zinc-based creams and similar creams such as pawpaw cream have been found to be quite useful in preventing and treating excoriated skin occurring as a result of fistulas and fungating wounds. Other wound products such as absorbent dressings like the calcium alginate dressings and hydrofibre dressings are used to absorb and therefore control exudate.

CONCLUSION

This paper has detailed some of the issues encountered by gynaecological oncology patients with regard to stomas, wounds and fistulae, and gives some ideas on how to deal with the problems that these women have. Strategies to treat these diverse issues need to be tailored to the individual and a suitable plan of care worked out which takes into account the patient’s wishes.

REFERENCES

A study to evaluate the effectiveness of daily TenderWet Active 24® dressings as a wound debridement agent

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ABSTRACT
Treating chronic or slow healing wounds is often time-consuming and expensive, and significantly affects the quality of patients’ lives. Improved knowledge on the effectiveness of different wound dressings has the potential to improve patient care outcomes and achieve significant healthcare cost savings. This study assessed the clinical performance and incidence of any undesirable wound changes associated with the use of TenderWet Active 24®.

Twenty two patients, with a total of 25 chronic venous leg ulcers, who met the selection criteria, were followed over a 7 day period. A range of outcome measures were evaluated over this period to see if TenderWet Active 24 was able to achieve, via autolytic debridement, a sustainable clean wound bed. To enable some comparison between dressings, the trial also recruited a further seven patients with venous leg ulcers who were having the more traditional dressing management of six hourly normal saline compresses. Results showed that TenderWet Active 24 was 84% effective in meeting its objective of achieving a sustainable clean wound via autolytic debridement within the 7 day duration of the study compared with only 29% in the normal saline group.

INTRODUCTION
Chronic or slow healing wounds are generally seen in the lower extremities and are largely due to arterial, venous, pressure or neuropathic aetiology. The management of these wounds remains a considerable challenge for nursing and medical clinicians.

These wounds are traditionally defined as those that fail to progress through an orderly and timely sequence of repair¹ and are generally categorised in clinical practice as wounds that have existed for a minimum of 4 weeks and are either static or deteriorating. They are affected by intrinsic factors such as infection, devitalised tissue, reduced oxygenation secondary to reduced blood flow, and an alteration in fibrinolytic activity ². Wound healing is impaired in the presence of bacterial contamination, poor blood supply and inadequate moisture content. The management of these chronic wounds remains a considerable challenge for nursing clinicians. Treatment of the wound is associated with significant cost and, in many cases, a reduction in the quality of life for patients. Effective wound bed preparation is therefore essential to reduce the rate of infection and facilitate the wound healing process.

For effective wound bed preparation, debridement must be an aggressive therapy with the end point being assessment of the efficacy of the process, namely the development of a sustainable clean wound bed. Debridement describes the removal of necrotic or foreign material from and around a wound to optimise wound healing ³. The following describes different methods used to debride a wound ⁴:

- **Surgical removal of debris** – a costly, generally effective method that requires patients to undergo a general anaesthetic.
- **Sharp removal** – a conservative method which involves a trained professional (nurse or doctor) removing devitalised tissue using scalpel, scissors and forceps, leaving a thin layer of necrotic tissue within the wound. It is only recommended that ‘expert’ practitioners attempt this technique as a high margin of error exists. Unless a policy or procedure governing this technique is available, it should be discouraged from general practice. After sharp debridement, a secondary debridement is usually required using an autolytic method.
- **Mechanical removal** – this uses physical forces to remove devitalised tissue. This method is indiscriminate as it removes both healthy and necrotic cells and is generally painful.
- **Chemical debridement** – this uses enzymes and other compounds to dissolve necrotic tissue.
- **Bio-surgical debridement** – this uses sterile maggots, a method not acceptable to all patients, to remove necrotic tissue and pathogenic bacteria.
• **Autolytic debridement** – this uses the body’s natural processes which are enhanced by providing a moist wound environment. It is more selective than other forms of debridement, causes little pain but takes the longest to work and is not appropriate for infected wounds.

There are no well designed randomised controlled trials that confirm whether particular method of debridement is superior for preparing the wound bed of difficult to heal wounds. Less robust studies indicate that modern dressings that promote moist wound environments, and reduce the rate of infection, facilitate the wound healing process. However, most of these studies have small sample sizes and are methodological flawed. No gold standard exists for the most effective dressing to manage chronic wounds.

Autolytic debridement using normal saline compresses every 4-6 hours enhances the natural phases of healing by providing a moist, warm environment to increase macrophage activity in removing necrotic and infected tissue. This practice has been in place for over 3 decades. The major disadvantages of this dressing technique are prolonged dressing times and patient discomfort. The average length of time taken to complete a dressing is 30 minutes, and this is changed four to six times a day. Dressing renewals cause pain and anxiety and sleep is disturbed due to dressing changes at 22:30 and 04:30hrs. Patients often require additional analgesia or Entonox™ gas (equal mixture of nitrous oxide and oxygen) for pain relief.

Further, poor application technique and application of dressings early or later than scheduled cause dressings to dry; this suspends the action of wound healing and can also result in a form of mechanical debridement. The frequency that the dressing is renewed also interrupts thermal requirements for wound healing and cell regeneration. Normal saline compress dressings have little or no effect or ability to control wound exudate, which in chronic wounds can hinder the wound from entering the proliferation stage. The excess exudate also can have damaging effects on surrounding skin and is an excellent host for bacteria. It has also been reported that topical application of normal saline can inhibit granulation.

TenderWet Active 24® is an innovative, moisture retentive, polyacrylate debridement system produced by Paul Hartmann Ptd Ltd. The dressing provides a moist warm environment incorporated with the unique properties of Ringers solution to actively debride wounds. The Ringers solution contains a mixture of electrolytes similar to natural body fluid; calcium ions participate in the intracellular regulatory process and potassium ions are required to transport CA⁺ enhancing cell regeneration. TenderWet Active 24 combines the actions of autolytic and mechanical debridement and can absorb large volumes of exudate without it seeping back on to the wound bed. It is an interactive wet therapy, i.e. the multi-layered pad will not dry out and therefore it provides a constant moist environment. The waterproof layer acts as a thermal regulator, keeping the wound warm. It is also claimed that the dressing is effective in controlling bio-film and bacterial burden which interfere with the ability of wounds to heal.

Three years’ clinical experience with TenderWet Active 24 in clinics and ambulatory care settings in Switzerland indicates good results can be achieved with chronic wounds. However, no independent randomised controlled clinical trials to examine the safety and efficacy of the dressing have been published. A number of non-refereed case studies available on the manufacturer’s website and a more recent trial sponsored by the manufacturer verify the efficacy of the dressing.

**PURPOSE OF STUDY & DESIGN CHANGE**

The original aim of the study was to compare the debridement rate (measured in time) and patient comfort between TenderWet Active 24 dressings (treatment group) and 6-hourly normal saline compresses (control group).

The study design was a two arm parallel group, open label randomised control trial that commenced in September 2005. Allocation to receive the treatment or the control was contained within sealed envelopes generated by means of permuted block randomisation. Between September 2005 and March 2006, 13 patients entered the trial; seven into the treatment group and six into the control group.

Shortly after trial commencement, an ‘access block’ within the hospital, where patients were unable to be transferred from the Emergency Department due to a lack of ward based beds, resulted in an unplanned significant change to the recruitment process. The anecdotal ‘success’ of daily TenderWet Active 24 dressings providing a clinically significant better outcome in a shorter timeframe resulted in increasing difficulty with recruiting and retaining patients in the study. Although initially supportive of the clinical trial, medical staff began to opt in favour of TenderWet Active 24 dressings as TenderWet Active 24 enabled early patient discharge with home nurse follow-up. At this time management of patients with chronic wounds needing debridement changed from hospital care to home care with clinic follow-up, effectively preventing randomising patients to either treatment group. Patients who did require admission to hospital were automatically prescribed TenderWet Active 24 and, after 24-48 hours of treatment, were often discharged to community care.

Without the ability to randomise patients to receive the alternative dressing, the study design changed in April 2006.
to an open prospective, observational, non-comparison cohort study. It was, however, considered important to continue with an objective, unbiased evaluation of the TenderWet Active 24 product because the safety and efficacy of the dressing has only been published in non-refereed case studies available on the manufacturer’s website. As a result, the study’s main aim was changed to monitoring the clinical performance and incidence of any product (TenderWet)-related undesirable wound change.

Outcome measures were modified to record:

- The rate of wound debridement and development of a sustainable wound bed. This was achieved by recording days to accomplish a clean wound and recording outcomes using photographic evidence and measurement of bacterial burden (the number of bacteria and bacterial burden found in wound fluid) at pre-determined time intervals.
- Product-related undesirable wound changes.
- Patient comfort. This was done by measuring the patients’ pain levels between and during dressing changes.
- Cost effectiveness of dressings, including nursing time, ease of application and exudate management.

**METHOD**

All patients with leg ulcers admitted to Fremantle Hospital, Western Australia, were assessed as soon as possible (within 12 hours of admission) for suitability for inclusion in the study. The study end point was time (in days) to achieve a sustainable clean wound bed suitable for grafting, or 7 days if this was not achieved.

**Inclusion criteria**

Patients were enrolled in the study if they:

- Had a chronic, slow/non-healing (defined as a wound that showed no progress towards healing within 4 weeks) venous or mixed leg ulcer(s).
- Had ulcers with a diameter of 3cm or greater.
- Were able to understand the purpose of the study and give informed consent.

**Exclusion criteria**

Patients were excluded if any of the following were present:

- Wounds less than 3cm in diameter (minimum TenderWet Active 24 dressing size).
- Severe systemic infection, e.g. osteomyelitis as an underlying cause of chronic wound healing delays.
- Arterial ulcers.
- Severe lymphoedema or conditions that produce excessive wound exudate that required more frequent primary and secondary dressing changes.
- Current immunosuppressive drug therapy.

The study was originally approved by the South Metropolitan Health Service Human Research Ethics Committee; the change to the research design was also approved by the Committee in April 2006. Informed written consent was obtained from all patients prior to entry into the study.

Patients with chronic leg ulcers vary in the number of wounds and the area of skin involved on an affected limb. It is not unusual for most of the lower leg to have wounds that part or fully cover the limb circumference with ‘islands’ of apparently healthy skin interspersed. Therefore the study counted all chronic wounds on a limb, regardless of the number of individual wounds, as one. When both limbs were involved, this counted as two separate wounds for the one patient. Once a patient was selected for a treatment, the patients’ wounds all received the same dressing until a sustainable clean wound bed had been achieved or the treatment had been deemed a failure. A sustainable clean wound bed was defined as a wound bed sustainable for skin grafting with greater than 75% granulating tissue, decreased bacterial burden, no evidence of tenacious slough and no odour.

A research nurse trained in the management of chronic wounds completed all wound care at recruitment and at least one daily dressing and one daily follow-up assessment until study completion. This resulted in the daily dressing for the 22 patients in the TenderWet Active 24 group and one (mid morning) of the four dressings per day for the six patients who received normal saline compresses being completed by the research nurse.

Ulcer type – diabetic, venous or mixed ulcer – and ulcer duration were recorded at point of entry, with total wound surface area calculated from wound tracings taken at entry and exit. Wound length and breadth were calculated by planimetry and recorded in mm². Wound depth was not measured. Data were also collected on the presence of the following variables that can influence wound healing – current smoker, diabetic or recent steroid or antibiotic use – as well as the type and duration of each wound.

Recordings of wound appearance, odour and exudate, and any adverse treatment effects (including product-related undesired wound changes, pain scores and peri-wound appearance) were recorded daily by the research nurse. The amount of pain was measured by asking patients to report their pain using a 10 point scale, with 0 being no pain and 10 the worst pain imaginable. Pain scores were completed second daily in the morning immediately prior to the dressing (to determine severity of pain...
during the previous 24 hours) and following the dressing change to determine level of pain experienced during and immediately after the dressing change. Photographs were taken at entry and exit points and second daily to document treatment progress and to provide objective data to compare with documented wound appearance on the day of treatment.

The rate of wound debridement and development of a sustainable wound bed was measured in days. A clean wound bed was verified by recording wound appearance and an independent review of photographic evidence to confirm the percentage of granulation tissue present. The chief investigator independently reviewed many wounds to validate when the wound was clean and sustainable for skin grafting. Two nurse clinicians with wound management qualifications also independently assessed each exit digital photograph and compared this to the final written assessment recorded by the research nurse to validate a final outcome for each wound. Wounds were classified as a success when they were clean and ready for skin grafting. Wounds that could not be classified as clean and sustainable for skin grafting were recorded as a failure.

Bacterial burden was measured by collecting specimens of wound fluid, or wound swabs if insufficient fluid available, at entry and again when the wound was assessed as clean, or at the study end point (7 days). On receipt of the microbiological reports, wounds were defined as ‘contaminated’, ‘colonised’, ‘critical colonised’ or ‘infected’ based on the number and strains of organisms reported and virulence of organisms cultured.

**Data analysis**

Inability to recruit the required sample size of 30 patients into each group (TenderWet Active 24 group and normal saline compress group) prevented the use of inferential statistics. Data for the 32 chronic wounds (TenderWet Active 24 dressings and seven normal saline compresses) were therefore analysed in SPSS V14 using only descriptive statistics.

Where relevant, comparisons were made with patients who had received the normal saline compresses, although caution is required in interpreting any differences because of the small number of patients who received normal saline compresses.

**RESULTS**

A total of 28 patients with 32 wounds were enrolled in the study. Twenty two patients with 25 wounds received TenderWet Active 24 and six patients with seven wounds received normal saline compresses.

**Demographics**

The average age of patients in the study was 72.5 years (female 77; male 69), with more males (16) than females (12). Data on information on confounding factors such as a history of diabetes, current smoking status, use of oral steroids and antibiotics gathered at the time of admission are described in Table 1.

**Aetiology and duration of ulcers**

There were 25 wounds treated for the 22 patients in the TenderWet Active 24 group, with three of these patients having chronic wounds on both lower limbs. There were six patients in the smaller normal saline compresses group and seven wounds as one patient had chronic ulcers on both her lower limbs. The majority of ulcers (50%) were of venous origin, with 41% of all ulcers present for greater than 18 months. Table 2 provides information ulcer type and duration for each group.

<table>
<thead>
<tr>
<th>Table 1. Demographic data and confounding factors.</th>
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<tbody>
<tr>
<td>TW (n=22)</td>
</tr>
<tr>
<td>Mean age (range)</td>
</tr>
<tr>
<td>Gender (% male)</td>
</tr>
<tr>
<td>Diabetic</td>
</tr>
<tr>
<td>Current smoker</td>
</tr>
<tr>
<td>Taking steroids on admission</td>
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<td>Taking antibiotics on admission</td>
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* = 3 missing data, † = 2 missing data

<table>
<thead>
<tr>
<th>Table 2. Ulcer type and duration for each group.</th>
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<tbody>
<tr>
<td>Ulcer duration</td>
</tr>
<tr>
<td>Ulcer type</td>
</tr>
<tr>
<td>Diabetic</td>
</tr>
<tr>
<td>Venous</td>
</tr>
<tr>
<td>Mixed</td>
</tr>
<tr>
<td>Total</td>
</tr>
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</table>
Wound exudate, bacterial burden and odour

There was no difference in the amount of wound exudate or odour observed between wounds in both groups on entry, during, or on completion of the trial. There was little difference found between type of bacterial burden (contaminated, colonised, critically colonised or infected) on entry and exit for wounds in both groups.

Ability to achieve a clean sustainable wound

The number of days to achieve a clean wound bed for all patients varied between 2 to a maximum 8 days (average 5.47 days), with a majority (19, 59%) of wounds being treated for 6-7 days. There was no clinically significant difference in the length of time in the trial between the two treatment groups. However, a larger percentage of patients receiving the TenderWet Active 24 dressing achieved a clean sustainable wound bed (84%) compared with only 29% in the normal saline compress group (Figures 1 & 2 and Table 3).

Table 3. Time to achieve a clean wound bed.

<table>
<thead>
<tr>
<th></th>
<th>TW (n=25)</th>
<th>NS (n=7)</th>
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</thead>
<tbody>
<tr>
<td>Mean days in trial</td>
<td>5.2</td>
<td>6.43</td>
</tr>
<tr>
<td>Median (range)</td>
<td>6 (2-8)</td>
<td>7 (3-8)</td>
</tr>
<tr>
<td>Number success (%)</td>
<td>21 (84%)</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>Number failure (%)</td>
<td>4 (16%)</td>
<td>5 (71%)</td>
</tr>
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</table>

Wound appearance and healing

Wound appearance is a subjective measure of wound cleanliness. Wounds treated with TenderWet Active 24 dressings achieved a higher sustainable clean wound bed than wounds treated with normal saline compresses. The TenderWet Active 24 dressing group achieved a mean decrease of 49% in slough and a mean increase of 49% granulation tissue compared to a mean 30% decrease in slough and a mean 25% increase in granulation tissue for the normal saline compress group. Seventeen (68%) TenderWet Active 24 wounds achieved >75% granulation tissue compared to one (14%) normal saline compress wound (Figures 3 & 4 and Table 4).

Figure 1. Day 1 – TenderWet Active 24 dressing.

Figure 3. Percentage change in slough/necrosis entry to exit by dressing type.
Table 4. Percentage change in wound characteristics.

<table>
<thead>
<tr>
<th>Stage</th>
<th>TW</th>
<th>NS</th>
<th>TW</th>
<th>NS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entry</td>
<td>76</td>
<td>89</td>
<td>24</td>
<td>36</td>
</tr>
<tr>
<td>Exit</td>
<td>27</td>
<td>59</td>
<td>73</td>
<td>11</td>
</tr>
<tr>
<td>Difference</td>
<td>-49</td>
<td>-30</td>
<td>+49</td>
<td>+25</td>
</tr>
<tr>
<td>Wounds with &gt;75% granulation</td>
<td>17 (68%)</td>
<td>1 (14%)</td>
<td></td>
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</table>

Wounds treated with TenderWet Active 24 dressing also achieved a clinically significant overall decrease in total surface area compared with the normal saline compress group, with 92% of wounds treated with TenderWet Active 24 achieving a greater than 1cm reduction in total wound surface area compared to the normal saline compress group. The total surface area for all wounds treated with TenderWet Active 24 reduced from a mean of 58.84cm² on entry to the study to a mean of 49.02cm² at exit, a mean difference of 9.82cm². In comparison, there was slight increase in total wound surface area from 28.06cm² on entry to 28.13cm² for wounds treated with normal saline compresses. Figure 5 illustrates the mean wound total surface area for each of the groups at entry and exit and the mean difference.

Pain scores

The mean pain score for patients in the TenderWet Active 24 group was higher on entry to the study (4.24) compared with the normal saline compress group (2.29). There was a decrease from the entry mean pain score of 4.24 to 2.21 pre dressings and 2.43 post dressings for patients in the TenderWet Active 24 group. However, in the normal saline compress group, there was an increase from entry pain scores for both the pre dressing and post dressing scores (Table 5).

Local tolerance and safety

Incidence of product-related undesirable wound change associated with the use of TenderWet Active 24 was low. There was some slight adherence of the TenderWet Active 24 dressing in two wounds (8%) and minor wound edge maceration in a further two wounds (8%). Adherence of dressing material to the wound was a problem experienced in 43% of the normal saline compress group but neither dressing caused excessive bleeding. No allergic reactions were noted with the TenderWet Active 24 dressing, thus proving it was a safe and simple to use.

DISCUSSION

Very little non-company sponsored literature exists on the use of TenderWet Active 24 dressings, thus the researchers attempted to objectively substantiate Hartmann’s claims of product effectiveness in wound debridement. The main objective – to determine the ability of TenderWet Active 24 pre-soaked daily dressings to manage chronic wounds and to achieve a sustainable, healthy, ‘clean’ wound bed within a 7 day period – was successfully demonstrated.

Table 5. Mean pain scores.

<table>
<thead>
<tr>
<th></th>
<th>TW (n=22)</th>
<th>NS (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(SD)</td>
<td>(SD)</td>
</tr>
<tr>
<td>Mean pain score on entry</td>
<td>4.24 (2.619)</td>
<td>2.29 (2.812)</td>
</tr>
<tr>
<td>Mean pain score pre dressing</td>
<td>2.21 (1.71)</td>
<td>3.49 (3.19)</td>
</tr>
<tr>
<td>Mean pain score post dressing</td>
<td>2.43 (1.95)</td>
<td>4.7 (3.47)</td>
</tr>
</tbody>
</table>
The study provides objective data on the successful performance and effectiveness of TenderWet Active 24 wound dressing in the treatment of 22 patients with chronic non-healing venous leg ulcers (a total of 25 ulcers in total). Some comparisons were made with patients who received normal saline compresses, an established autolytic debridement practice in use for over 3 decades. However, as this was a small study, the results can only be viewed as providing information on the clinical performance and tolerability of the TenderWet Active 24 dressing.

The results showed that more wounds treated with the daily TenderWet Active 24 dressings achieved the wound parameter of a clean sustainable wound bed at the study end point than the normal saline compresses. However, due to recruitment problems and an inadequate sample size in the normal saline group, testing for statistically significant differences was not possible.

One of the more unexpected findings of the study was that of the effectiveness of the TenderWet Active 24 product to decrease the total wound surface area ($cm^2$) when compared with normal saline compresses. Between entry and exit, the TenderWet Active 24 dressing group achieved a mean decrease of 9.82mm$^2$ in total wound surface area compared to a slight increase in total wound surface area for the normal saline compress group. There was also a noticeable difference in the extent of newly developed epithelialisation and granulation tissue, indicating that TenderWet Active 24 was more effective than the normal saline compresses. Similar results for daily TenderWet Active 24 dressings were found in another recent trial.  

**Limitations of the study**

Patients selected for the study were considered to be representative of the ‘usual’ patient presenting for ulcer management requiring admission to a vascular surgical ward. However, during the course of the study, the researchers encountered the following unforeseen challenges that severely hampered recruitment of patients:

- **Decreased length of stay** – as with many major tertiary hospitals, an increasing demand for in-patient beds is an issue. On an acute surgical ward it became increasingly difficult to justify why a patient needing only a daily wound management dressing required admission when community nursing services such as Hospital in the Home (HITH) could meet the level of care required. As a result, a number of the patients suitable for the study were never admitted to hospital and those enrolled to the study were often medically discharged prior to the end point or before all exit data could be collated. Where it was not logistically feasible to follow these patients up in the community, these patients had to be withdrawn from the study.

- **Increased outpatient services** – in February 2006 the Hospital appointed a clinical nurse specialist (CNS) for the vascular service. The CNS brought with her a wealth of knowledge and experience and increased the vascular outpatient services from 5 days per fortnight to a full service Monday-Friday. By increasing the outpatient services, many patients who would have previously required admission for stabilisation of chronic venous ulcers could be dealt with in the out-patient setting – this limited the ability to recruit suitable patients.

**Table 6. Estimated cost for dressings.**

<table>
<thead>
<tr>
<th>TW (daily dressing)</th>
<th>NS (four times a day)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cost of dressing(s) for a medium size wound</strong></td>
<td><strong>Cost of dressing(s) for a medium size wound</strong></td>
</tr>
<tr>
<td>7.5x7.5cm TenderWet Active 24 dressing = $10.75</td>
<td>Ribbon gauze x4 = $1.00</td>
</tr>
<tr>
<td>= $10.75</td>
<td>Saline ampoules x8 = $2.00</td>
</tr>
<tr>
<td>= $10.75</td>
<td>= $3.00</td>
</tr>
<tr>
<td><strong>Estimated nursing time to complete dressing(s)</strong></td>
<td><strong>Estimated nursing time to complete dressing(s)</strong></td>
</tr>
<tr>
<td>15 minutes</td>
<td>30 mins x4 dressings = 2 hours</td>
</tr>
<tr>
<td><strong>Nursing costs (based on CN @ $32 hr)</strong></td>
<td><strong>Nursing costs (based on CN @ $32 hr)</strong></td>
</tr>
<tr>
<td>$8.00</td>
<td>$64.00</td>
</tr>
<tr>
<td><strong>Consumables – dressing pack(s), secondary dressing(s), emollient, crepe bandage(s)</strong></td>
<td><strong>Consumables – dressing pack(s), secondary dressing(s), emollient, crepe bandage(s)</strong></td>
</tr>
<tr>
<td>$2.18</td>
<td>$7.07</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>TOTAL</strong></td>
</tr>
<tr>
<td>$20.93</td>
<td>$74.07</td>
</tr>
</tbody>
</table>
• **Teamwork** – the development of chronic disease management teams during the study period focused on patients and GPs taking a more active role in disease prevention and management. Thus early interventions often prevented the need for acute admissions to hospital.

### Cost considerations

Managing wounds can be expensive – the cost of wound care products and nursing time account for most of the expense. To determine costs associated with the new product, an estimate of the difference in costs between the daily TenderWet Active 24 dressing and the six hourly normal saline gauze compress dressings was also undertaken. Approximate daily costs of the two dressings were calculated by estimating the average nursing time to complete dressings each day, and the cost of each dressing and consumables required for a medium size wound (Table 6). Based on these estimates, a cost saving of $53.14 is achieved by changing from 6 hourly normal saline compresses to daily TenderWet Active 24 dressings.

Anecdotally, the study researchers also found from discussions with the clinical trial nurses that the ease of application of TenderWet Active 24 facilitated a speedy yet thorough dressing change. This is important because time constraints are acknowledged as a major factor impacting on nurses’ ability to deliver patient care.

### CONCLUSION

In conclusion, this study demonstrated that in a ‘real world’ situation, TenderWet Active 24 dressing is a safe, easy to use, effective autolytic wound debridement agent that can achieve a sustainable healthy wound bed when used in the treatment of chronic leg ulcers. The acceptability of the TenderWet Active 24 dressing (ease of removal and application and saving in time) to nurses was superior to normal saline compresses. The need to only undertake the dressing daily has significant advantages for both the patients and the healthcare system – most patients can be treated in the community, which is generally more acceptable to the patient whilst saving the cost to the healthcare system of a hospital admission. With an ageing population, the percentage of patients with venous leg ulcers is likely to continue to increase. The availability of a cost effective, easy to use dressing that appears to have no adverse effects and supports the wound healing process is beneficial to patients, healthcare providers and funding agencies.

### ACKNOWLEDGEMENTS

The researchers gratefully acknowledge the research grant of $16,000 from the Western Australian Nurses Memorial Charitable Trust. Without this funding the study could not have been completed. Thanks are also extended to Murray Rowe and Sarah Jolly, Research Nurses who enrolled patients into the study, undertook the dressings and collected all data. And to Lorraine Linacre, Clinical Nurse Consultant Vascular and Chronic Wounds, for independently assessing exit digital photographs to validate an outcome for each wound.

### REFERENCES

2. Paustian C & Stegman MR. Preparing the wound for healing: the effect of activated polyacrylate dressing on debridement. Ostomy/ Wound Management 2003; 49(9):34-6, 8, 40 passim.
A community based epidemiological study was conducted to document the extent of peristomal skin disorders in people with a stoma.

The 2 most common skin disorders found were:

- Erosion of the skin due to faeces
- Maceration of the skin due to excess moisture

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- Maceration of the skin due to excess moisture

8 out of 10 do not seek help for skin disorders.

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<table>
<thead>
<tr>
<th>To</th>
<th><a href="mailto:au.care@coloplast.com">au.care@coloplast.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>cc</td>
<td></td>
</tr>
<tr>
<td>Subject</td>
<td>Ostomy skin study and Australian data</td>
</tr>
</tbody>
</table>

A comprehensive study was conducted in Australia on ostomy appliances. For your copy of the ostomy skin study and Australian findings, please email as follows:

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Case study

Partial jejunal resection for mesenteric infarction

Lesley Jack RN • CNC Stomal Therapy/Wound Care, Felicia Maguire Dietitian, Blacktown Hospital, NSW

ABSTRACT

This paper is a case study of a 73 year old man who experienced a partial jejunal resection for mesenteric infarction. It outlines the postoperative nutritional and stomal therapy challenges which were experienced over a 3 month period. Factors that are discussed include enteral feeding, total parenteral feeding, preventing dehydration and an attempt at maintaining a healthy weight. Other important aspects of his recovery and rehabilitation were adequate and timely discharge planning, inter-disciplinary communication and the education of visiting nursing staff.

INTRODUCTION

Mr W was a religious man who lived alone, managing independently. He had no children and his wife was resident in a nursing home. His past history included pyelonephritis, gastro oesophageal reflux, fractured neck of femur, right total hip replacement, hypercholesterolaemia and appendicectomy. He did not smoke or drink alcohol. His medications included Lipitor 40mg daily, Pantoprazole 40mg daily and Warfarin. He had been commenced on the Warfarin in hospital 2 weeks previously whencreases he had been diagnosed with mesenteric artery thrombosis, and had been discharged home awaiting vascular surgical review. The superior mesenteric artery (SMA) supplies parts of the duodenum, the jejunum, ileum, appendix, ascending and part of the transverse colon (Figure 1).

29 June he underwent an emergency laparotomy, which revealed copious small bowel fluid throughout an inflammatory mass, and small bowel loops adherent to the sigmoid apex. There was a perforation at this site. The area of ischaemic bowel was 60cm from the distal duodenum and 1.5m proximal to the caecum. Approximately 15cm of jejunum was resected, and the abdomen was packed and left open.

The following day he returned to theatre for a ‘relook laparotomy’ where the small bowel was inspected from stump to terminal ileum and found to be viable with no areas of ischaemia. The jejunal stumps were also inspected and found to be viable. The abdomen remained packed and open.

Two days later (2 July) he returned to theatre for removal of packs, washout, minimal small bowel resection and fashioning of proximal jejunostomy and insertion of a feeding tube into the distal jejunal stump (Figure 2). A jejunostomy is usually

Figure 1. Blood supply to the bowel.
1. Superior mesenteric artery
2. Ileocolic artery
3. Right colic artery
4. Middle colic artery
5. Jejunal arteries
6. Ileal arteries

Figure 2. Copy of surgeon’s diagram from operation record.
1. Proximal jejunostomy
2. 16FG T tube feeding jejunostomy
3. 18FG Blake drain to pelvis

THIS ADMISSION

On this admission he presented with severe abdominal pain due to mesenteric infarction causing perforation of his jejunum. On
performed as a temporary measure, for which the management is challenging.

Postoperatively he remained in the intensive care unit for 5 days on routine post laparotomy nursing care and was mechanically ventilated. Total parenteral nutrition (TPN) commenced on Day 1 postoperatively, with enteral nutrition overlapping via the jejunal feeding tube on Day 3. The fibre containing formula Jevity™ was used, as this is the standard isocaloric formula available at our hospital. His weight on admission was 72kg. TPN was weaned when enteral nutrition reached the goal rate of 80mL/hour. A clear fluid diet followed, which coincided with a heightened jejunalostomy output. During this time the jejunalostomy stomal output was between 2.8-6.0L/day and this was contained without problems in a Coloplast™ postoperative appliance connected to underbed drainage bag.

A high jejunalostomy and the associated diarrhoea results in loss of bile into the stomal effluent along with ingested food, nutrients, pancreatic enzymes, electrolytes and digestive fluids. This can cause dehydration and electrolyte abnormalities if not well controlled. Unlike patients with short bowel requiring all of their nutrition orally, a patient such as this can avoid nutrient and vitamin deficiencies by receiving enteral nutrition through the distal jejunal feeding tube.

Mr W was transferred to the surgical ward on 11 July and was upgraded to a light diet. Mr W found it very difficult to restrict his oral intake as eating had always played an integral role in his social interactions... he liked food! He was recommended to eat minimally for quality of life only, and to receive 100% of his requirements via the jejunalostomy feeding tube. Oral hypotonic fluids (e.g water, coffee, tea) and hypertonic fluids (soft drink, juices, commercial sip feeds) should be restricted to less than 500mL/day in high out-put jejunalostomy patients as they cause increased stomal losses of sodium and water. As the volume and consistency of oral intake increased, Mr W developed problems with stoma management. The outlet on the postoperative bags blocked, causing leakages. He was mobilising well despite having continuous enteral feeding, high output drainage and frequent bowel actions per anus. He described these as being liquid and like Jevity.

On 18 July Mr W developed abdominal cramping and vomiting. He was found to have a bowel obstruction and was impacted at the distal feeding tube site. Enteral feeds ceased and he was commenced on fluids orally. The surgical team requested Mr W receive a low residue formula to prevent a further obstruction. The only low residue formula stocked at our hospital was Ensure Plus™, a high-energy (1.5kcal/mL) formula. Although being hyperosmolar, thus not ideal, continuous feeds using Ensure Plus commenced.

Mr W described his output, per rectum, as foul smelling and of liquid consistency. Pancreatic enzyme replacement was suggested, as Mr W was losing all bile and digestive enzymes in the stomal effluent. Bile is secreted by the liver and is required in the digestion and emulsification of fat. It was felt that Mr W would not manage regular pancreatic enzyme replacement or refeeding of stomal effluent, due to concern that it may block the fine bore feeding tube. To avoid this, feeds were changed to a low-fat elemental formula, Vivonex™. The team ceased IV fluids and requested all fluid requirements (3L/daily) be provided via the jejunalostomy.

Mr W experienced watery bowel motions and feeds were again changed, this time to Osmolite™, with 2 hourly water flushes to meet hydration requirements. Osmolite is an iso-osmolar, low residue formula and was specially ordered for trial. The semi-elemental formula, Peptinex™, was discussed as the next option, but this was not trialled due to the high cost. Mr W could not afford this expense on a weekly basis once discharged.

We were reactive rather than proactive in nutritional management, due to Mr W’s poor tolerance to feeds. This led to a prolonged admission. There were too many variables involved, thus it was difficult to assess weight gain. In the rush for discharge, we were changing several variables at one time, which is not ideal. Table 1 displays the weight fluctuations during Mr W’s hospitalisation. To ensure more accurate weights, it was recommended his appliance be emptied prior to daily weighing.

### General nursing management

Apart from the nutritional and stomal therapy aspects, his recovery was routine and uncomplicated and will not be discussed in this paper. However, he was transferred to a rehabilitation unit on 3 August because, despite his rapid recovery from his surgery, more time was needed in a clinical environment to stabilise his feeding regimes. The feeding regime on discharge was 70mL/hour Osmolite over 24 hours. Continuous feeds were provided due to concern he would not tolerate a higher rate.

### Drug therapy

Mr W was prescribed the somatostatin Octreotide™ to reduce jejunalostomy output. By prolonging intestinal transit time, water, sodium and energy absorption increases. Abdominal discomfort, diarrhoea, steatorrhoea, nausea, flatulence, and the cost and administration via a subcutaneous route are the negative aspects of Octreotide. It should only be used in the adaptation phase, as repeated exposure may reduce effectiveness. Octreotide may inhibit intestinal regeneration, along with ingested food, nutrients, pancreatic enzymes, electrolytes and digestive fluids, which can cause dehydration and electrolyte abnormalities if not well controlled. Unlike patients with short bowel requiring all of their nutrition orally, a patient such as this can avoid nutrient and vitamin deficiencies by receiving enteral nutrition through the distal jejunal feeding tube.

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<table>
<thead>
<tr>
<th>Date</th>
<th>Weight (kg)</th>
<th>Date</th>
<th>Weight (kg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 June</td>
<td>72.0</td>
<td>14 August</td>
<td>60.4</td>
</tr>
<tr>
<td>13 July</td>
<td>65.5</td>
<td>20 August</td>
<td>61.4</td>
</tr>
<tr>
<td>17 July</td>
<td>62.5</td>
<td>25 August</td>
<td>61.4</td>
</tr>
<tr>
<td>27 July</td>
<td>62.8</td>
<td>28 August</td>
<td>61.2</td>
</tr>
<tr>
<td>1 August</td>
<td>63.1</td>
<td>29 September*</td>
<td>59.8</td>
</tr>
<tr>
<td>9 August</td>
<td>61.5</td>
<td>9 October</td>
<td>64.3</td>
</tr>
<tr>
<td>11 August</td>
<td>60.8</td>
<td>* Readmission for closure</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: Weight during hospitalisation.
thereby delaying bowel adaption. The patient was trained in administering Octreotide three times a day during his prolonged hospital stay.

**Stoma management**

The stoma was protruding moderately (Figure 3) and initially, when Mr W was bed bound, a flat-based one-piece appliance was suitable (Coloplast™ postoperative appliance with free drainage to an under bed collection bag). However, once he was more active and sitting out of bed, leakages occurred due to skin creases, peristalsis and because the stoma outlet pointed downwards (Figure 4).

![Figure 3. Protruding Stoma.](image)

Then it was decided to use an Almarys Twin™ convex 2-piece appliance with capacity to deal with a high output of thickened effluent. Even with a deeply convex base, Eakin seals™ and Stomahesive™ paste were required to deepen the convexity and to seal the gap between the appliance and the skin (Figure 5). Weight loss also contributed to his changing abdominal contours. Because of the weight of the high volume of output, a belt was added to help prevent drag on the base (Figure 6). The belt also helped secure the dressings for the adjacent feeding tube. A high output bag (Almarys Twin high-output pouch) was added and connected to an Almarys Flow Collector under bed collection bag (Figure 7). The tubing was primed with Adapt™ lubricating deodorant to facilitate movement of efflux through the tube.

![Figure 4. Skin creases.](image)

![Figure 5. Convex Base Stoma Paste Eakin Seal.](image)

![Figure 6. Belt added.](image)

![Figure 7. High Output Bag.](image)
Although the base plates adhered for about a week, he changed them regularly every Monday and Thursday and changed the bags daily. The high output bags were also changed twice weekly. He did not experience any further leakages or any problems with his peristomal skin. Table 2 summarises the stoma output during hospitalisation.

**Planning for discharge**

Mr W lived alone but required 24 hour feeding with a pump. He had to flush his feeding tube every 2 hours, but refused overnight water flushes as it disrupted his sleep. This placed him at risk of dehydration. The hospital’s discharge planner organised a home pump and feeds, support from the community nurses and home help. The company that hires out the pumps provided a clinical nurse consultant as a resource/support person both in hospital and at home.

Community nurses needed to be educated so that they could provide support in stoma care and an understanding of Mr W’s tube feeding regime. They attended a bedside education session whilst he was still in hospital, and then the stomal therapy nurse attended two co-joint home visits to supplement the education.

**Post discharge**

Mr W entered into the spirit of things in whatever way he could. He bought himself a set of scales to monitor his weight. He also purchased a motorised scooter so he could get about. When travelling on it he disconnected his stomal appliance from the underbed drainage system and put his portable feeding pump in a backpack. He caused quite a stir in his local community!

**OUTCOME**

At home Mr W managed with an output of less than 2L/day. He was readmitted on 27 September for reversal of jejunostomy. His surgery and postoperative recovery were uncomplicated and he was discharged home on the 10th postoperative day. At follow up appointments he was noted to be doing well. However, he expressed a strong fear of losing weight and was reluctant to cease taking his dietary supplements despite having gained 20kg since discharge. The dietitian continues to monitor him.

Mr W’s nutritional status was affected due the early cessation of TPN prior to establishing the goal rate of enteral feeds. Following discussions with other dietitians, it was recommended that TPN should ideally continue whilst trialling enteral nutrition formulas. To help demonstrate fluids shifts versus weight gain, it is recommended to keep a patient nil by mouth for a longer period whilst trialling tolerance to enteral nutrition.

People deserve the best options and costs should not determine availability. Therefore, a trial of Peptinex™, a high protein, low fat, semi-elemental formula, may have been better option for this patient.

Mr W was transferred from the surgical ward to the rehabilitation team whilst his nutrition issues were still under investigation (e.g. faecal fat malabsorption). Being under a different team delayed the discharge process, due to ongoing unresolved acute issues.

### Table 2. Stoma output.

<table>
<thead>
<tr>
<th>Date</th>
<th>Stoma output</th>
<th>Date</th>
<th>Stoma output</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 July</td>
<td>2800mL</td>
<td>25 July</td>
<td>2600mL</td>
</tr>
<tr>
<td>8 July</td>
<td>&gt;6000mL</td>
<td>31 July</td>
<td>2200mL</td>
</tr>
<tr>
<td>14 July</td>
<td>&lt;1000mL*</td>
<td>3 August</td>
<td>2350mL</td>
</tr>
<tr>
<td>21 July</td>
<td>2800mL</td>
<td>7 August</td>
<td>1900mL</td>
</tr>
<tr>
<td>24 July</td>
<td>4000mL</td>
<td>10 August</td>
<td>4500mL</td>
</tr>
</tbody>
</table>

* Query – incomplete stomal chart

**CONCLUSION**

Challenging cases such as this require a multi-disciplinary team approach – we would recommend that one variable be changed at a time, for example medication or enteral formula. This did not occur due to time constraints and differences in opinions between teams. In hindsight, case conference meetings involving all teams may have allowed for better communication of the patient’s progress.

**REFERENCES**

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A stomal therapy nurse abroad:
a Canadian experience

Patricia Sinasac RN BN STN • Currently residing in Oakville, Ontario, Canada; returning to Brisbane, QLD in 2009

It was an ordinary June evening in our home, dinner cooking, homework being done and my husband walking in the front door excited and smiling. He is always smiling on arriving home; however, the excitement revealed an interesting proposition “the company has asked us to move to head office in Canada for 18-24 months, what do you think?” Strange but true; my first thoughts were I could take the International Interdisciplinary Wound Care Course (IIWCC)! It would require an upheaval to our lives but the adventure and opportunity were appealing, I reluctantly resigned my position as CNC Stomal Therapy and Wound Management at the Mater Adult Hospital in Brisbane but considered the benefits of the experience ahead.

During my STN experience, I had on two occasions heard Dr Gary Sibbald speak with his engaging manner on wound care and about the IIWCC, thanks to our ever-supportive corporate sponsors making his visits possible. The IIWCC, proposed by Dr Sibbald, commenced in 1998. The course is offered through the University of Toronto’s Faculty of Medicine and Department of Public Health Sciences (Canada). Applicants are invited and encouraged from all healthcare disciplines. The course committee is a reflection of interdisciplinary participation, including physicians, surgeons, enterostomal therapists, pharmacists, educators, information specialists, consultants and administrative support. In addition, the course faculty is comprised of experts from medicine, occupational therapy, podiatry and clinical nurse consultants to provide a comprehensive, international and interdisciplinary perspective to wound healing. The dedication of this group to promote wound care and best practice is inspiring.

Attendance is required at two residential weekends in October and April, each for 4 days. Arriving on the first day, the auditorium was buzzing with lively discussions amongst the students. Revealed by day’s end was a diverse group of nurses from various practice areas, physiotherapists, surgeons, general practitioners, podiatrists, a nutritionist and a lone corporate representative. Practice areas, including acute, community, urban, rural and clinics, were represented from across Canada and internationally.

During the residential weekend, the course outline, expectations and requirements were reviewed. The expert international faculty presented in their specialty areas to the group. Dr Elizabeth Ayello (USA) on pressure ulcers, Dr Patricia Price (UK) on quality of life and best practice, Dr G Sibbald (Canada) on wound bed preparation and best practice, Professor Keith Harding (UK) on wound care, Heather Orsted RN ET (Canada) on various topics, and several other presenters. The course consists of 12 modules and covers a range of topics – clinical, educational, research, evaluation, best practice, professional development, learning and knowledge transfer. Subjects related to wound healing, infection, chronic wounds, pressure ulcers, leg ulcers, surgical wounds, burns and diabetic foot ulcers. Review and development of depth and breadth of knowledge were achieved through assignments discussing issues or details pertaining to each area. Clearly wound management is a global concern – whether in North America, Africa, Europe, Australia or Asia, similar challenges exist.

An emphasis was placed on education and teaching and the responsibilities of wound care clinicians to passionately and responsibly commit to knowledge transfer of best practice. Engaging in research through reading and applying to practice and conducting and disseminating research knowledge is pertinent to the practice of wound care. Sharing ideas, experiences, research, position statements, guidelines and best practice provide a basis for contributions to improve the global practice of wound care.

Further, the Canadian Association of Wound Care [www.cawc.net] offers a seminar entitled the S-series with three components, S1, S2 and S3. Healthcare professionals are encouraged to attend, with opportunities provided at various locations within Canada over 2 days. S1 addresses Best practice recommendations for wound management: putting knowledge into practice. Highlights include principles of wound healing, wound bed preparation and prevention and treatment of pressure, venous leg and diabetic foot ulcers.

S2 complements S1 in practical application, with lower leg assessment and compression therapy and debridement workshops. The workshops provided an opportunity to apply various compression systems to one another, measure ABIs (ankle brachial index) and perform assessments. The experience of debriding from a cadaver porcine hoof was intriguing and allowed for learning the necessary skill required to safely and competently debride non-viable tissue. The responsibility is then upon the student to return to the clinical area and obtain competency under the direction of a qualified and expert practitioner in debridement.

S3 requires a reflective learning and practice portfolio to be undertaken promoting life long learning. The overall objective is to integrate evidence-based practice with learning. The experience has further re-enforced and developed my knowledge. An introduction of different methods of teaching and learning will enhance any future educational sessions that I provide.

Completing the Canadian experience, I attended the World Union of Wound Healing Societies in June. The conference was huge; over 3,000 delegates, representation from all continents except Antarctica and 10 concurrent session streams ranging from various ulcers, wounds and ostomy to global perspectives...
and research. Plenary keynote speakers second to none provided inspiration and motivation. A Canadian and humanitarian, Stephen Lewis, former UN Special Envoy for HIV/AIDS in Africa, presented a passionate and honest insight of the crisis facing the people and healthcare workers of Africa.

Consensus papers were introduced, including the work of committees devoted to principles of best practice for wound care, a World Union Wound Healing Societies (WUWHS) initiative [www.wuwhs.org]. Another World Union initiative with infrastructure support from Women’s College Hospital and the University of Toronto was launched, woundpedia! [www.woundpedia.com]. The aim is to provide access to up to the minute evidence for best practice. In addition, the inaugural WUWHS lifetime achievement awards and honours were presented to 23 deserving individuals dedicated to the science, education and practice of wound care, including Australian Geoff Sussman, OAM, JP, FPS, FACP, FAWMA.

Several satellite symposiums informed us on areas of wound care practice. As always, industry support was present to provide education and information on products and research and to distribute information; the largest trade display ever at such an event. The volume of poster presentations exceeded 200 and covered a wide range of topics. The social function was as multicultural as the delegates and as Toronto, where 57% of the population are ‘new Canadians’. Cuisine was provided from the Italian, Indian, Greek and Chinese districts. The band was rockin’ and many of the 100 or so strong Aussie contingent were burning up the dance floor! I was excited to see some familiar faces and catch up on all the news as well as make new acquaintances. The conference lasted 5 days and was an amazing experience on several levels – the next one is in Japan 2012 start planning now!

Enriched by the experience of education in an international interdisciplinary environment, I anticipate wound care to continue to be an exciting area in which to practise and develop. Benefits to my practice will evolve in the years to come as I develop networks, share and promote a vision of what can and should occur within wound care practice, and develop a deeper understanding and further appreciation for those involved in the practice of wound care. I look forward to my return to Australia and clinical practice with enthusiasm.

### AASTN: VALUES, PURPOSE AND VISION

**Our values**

Quality, respect, accountability, commitment and innovation.

**Our purpose**

To provide support and leadership to stomal therapy nurses in their endeavour to provide quality nursing practice.

**Our vision**

Enduring recognition for excellence and innovation in stomal therapy practice at a national and international level.
One of the joys of conducting the 2008 WA Stomal Therapy Nursing Education Programme was the opportunity to invite a number of senior, experienced stomal therapy nurses (STNs) to meet the new cohort of 20 student STNs accepted into this year’s programme. Morning tea was arranged to enable the six visitors (Sr Mary Kelly, Mary Jo Kroeber, Helen Simcock, Jane Mikus, Margaret Farmer and Sheila Chater) to meet and mingle with the students, Pam Thompson (subject coordinator) and myself. Val Kraus was unable to join us. As a number of the students had affiliations with some of the hospitals from which these early pioneers of STN in WA, and indeed in Australia, had retired, there was a great deal of excited chatter.

The visitors were invited to stay to hear Keryln Carville’s presentation of the *History of stomal therapy* and, at the conclusion, she requested each visitor to say a few words about their most memorable aspect of the new specialisation. This was of great interest to the new inductees – it provided a great opportunity to see how far stomal therapy nursing has come in the 30+ years encompassed by these ‘living legends’. Sheila also provided some of her photos, and it was fun to see how a number of us looked when photographed at various conferences, study days or meetings clearly remembered.

The students had been provided with a back copy of the *Journal of Stomal Therapy Australia* (ISTA) and agreed to have their photograph included in this September issue as a symbol of the start of their STN journey.
Historical perspectives

Early stoma appliances available in Australia

Terry Carver • Ileostomy Association (Vic) Inc.

There have been many types of stoma appliances over the years. I have only listed here ones that I have examples of.

THE 1940 AND 1950s

Davol colostomy pouch

These were hand made of pure gum, rubber cut and glued together. An inflatable ring was attached to the pouch and the pouch was suspended in a wire frame, the pouch was then held over the stoma with an elastic belt (missing from the photograph is the wire frame and the rubber bulb used to inflate the ring). There was no protection for the skin area around the stoma and it was best to sleep in a reclined position as leakage occurred when lying on one’s side.

Due to Australia’s import restrictions at this time you were issued with one pouch in hospital and, if you required a second one, application had to be made to import another one; this could take up to 3 months to arrive!

THE 1950 AND 1960s

Rubber flange, rubber day or night pouch and Skin Bond

With the availability of Skin Bond, a latex based rubber cement, ostomates had a means of fixing the appliance to the skin. The Skin Bond also helped to protect the skin around the stoma. It was painted around the stoma and onto the face of the rubber flange; this was left to become tacky, then the flange was put in place around the stoma, a belt plate and an elastic belt were fitted, and the rubber pouch was then put in place on the flange. To remove the Skin Bond when changing the flange, the common remover was Shellite until some proprietary brands became available.

There were day and night pouches for colostomy and ileostomy patients; urostomates had pouches designed for them with a small tap at the bottom – these looked like a hot water bottle upside down. Colostomates had a choice between closed end or drainable, with the drainable having a screw cap to remove. These pouches had to be well cleaned as the rubber tended to retain odours. Skin Bond was also used by some ostomates with the Davol colostomy pouch from the 1940s. Skin Bond is still available (2008) on the appliance scheme for those that still prefer the rubber pouches.

The pouches had to be purchased by the ostomate. However, with the formation of the ostomy associations, who acted as a cooperative, things were bought in bulk, thereby passing on the savings to the members.

During the 1960s, ostomates started to experiment to find a cheaper method of collecting the output; one of the best ideas was to buy polythene layflat tubing in rolls and, using a plastic
bag sealer, seal the tubing every 10-15cm and then cut them off with scissors. They would then replace the rubber pouch with the plastic bag using two rubber bands. The associations would do the sealing and sell the plastic bags to the members.

THE 1970s

Stomahesive sets, plastic flanges and Cryovac bags

By the start of the 1970s a few items were being distributed to ostomates free of charge; the start of the Stoma Appliance Scheme. These were the Skin Bond, rubber flanges and rubber bags.

In 1974 the Stoma Appliance Scheme was expanded as a lot of appliance companies were bringing new appliances onto the market. With a concerted push by the Stoma Associations National Body (ACSA), the stomal therapists and the appliance companies, the government introduced the expanded scheme as we know it today (2008).

Up to this time every appliance required a belt plate and belt – it was not until the 1980s that appliances were secure enough to wear without a belt. However, some ostomates today still prefer the security of a belt and most modern appliances are made to accommodate a belt.

Other appliances

Some colostomates are suitable for irrigation, and an irrigation set is used.

The big change was the introduction of Stomahesive sets and Cryovac plastic bags. Cryovac bags were made from a plastic formulated to ensure that, when sealed, oxygen could not permeate through and spoil the contents. This stopped the odour from escaping, although some gas tended to escape past the rubber bands holding the pouch onto the flange due to the amount of gather of the plastic. Also introduced were Stomahesive paste, Stomahesive powder and Orabase paste; the latter was originally developed for the treatment of mouth ulcers and led to the development of Stomahesive wafers.

The Stomahesive sets comprised of the wafer as we know it today plus a double sided sticker that allowed the plastic or rubber flange to be mounted on the wafer. This was then fitted over the stoma and the Cryovac bag could be fitted to the flange using two rubber bands (two in case one broke). The ostomate usually used Micropore or other tape around the wafer and sprayed a waterproofing agent onto the tape, this made the fitting suitable for brief swimming. Some of the ostomates from the early years used the Stomahesive wafer with their rubber flange and rubber bag. Other things that became available were tins of Friars balsam spray and a waterproofing spray called Nobecutane.

All of the new bits and pieces were added to the free scheme except the Cryovac bags, the rubber bands and the Adhesive tape; 100 Cryovac bags cost $2.50 – by 2007 when the last run was completed, the cost had risen to $17.60.

Many different types of appliances have been invented over the years. However, all the early ones gave little or no thought to the protection of the skin around the stoma. A good example of this is an appliance on the market in England called a Schacht appliance. This was dispensed by Boots pharmacy in 1977 and consisted of a belt plate, belt, two foam rings over a plastic tube and a plastic bag to collect the waste. When assembled and fitted over the stoma, it appeared to rely on the foam rings to protect the skin.
Another appliance came in a packet with 10 plastic bags, a plastic ring that fitted over a ring with belt slots and an adjustable belt. The plastic bag was trapped between the two rings and held over the stoma with the belt, with no protection for the skin around the stoma.

A pouch manufactured in New Zealand became available but was not very popular. There was no skin barrier and the flange was integral with the pouch with a soft rubber tube in the centre; this tube fitted snugly around the stoma, sealing the output from the surrounding skin. The flange had two raised circles in the shape of a half ‘O’ ring. The suggested method of fitting the pouch was to lightly coat the ring face with zinc cream; with the tight belt, the rings would sink into the skin making a good seal.
Revolution Ahead . . . Moulding the Future

Coming soon from ConvaTec

A new skin barrier which will help your patients discover a Worry-Free Fit

Call the ConvaTec Support Centre or your ConvaTec Territory Manager to reserve your free sample of this new and exciting product
As the newly appointed Stoma, Wound, Urology Clinical Nurse Consultant at the Women’s and Children’s Hospital in Adelaide, this convention couldn’t have come at a better time. After 13 years in the adult world, the idea of paediatric stomal therapy was not only daunting but also very exciting.

The convention was held over 3 days in beautiful Montreal at the Centre Mont-Royal. As Montreal is situated in one of the French/Canadian provinces, the presentations were in both English and French. It was a different experience listening to the translation, especially if the speaker was female and the translator was male. Over 14 different countries were represented at the convention, with Donna Griffiths from Western Australia and myself the only Australians.

The convention was expertly organised by the visionary Louise Forest-Lalande and her team. The keynote address was by Heather Orstead who has been heavily involved in Camp Horizon, a camp for children/adolescents with stomas; the camp is held every year in Calgary, Canada.

Each day was divided into topics, with the first day dedicated to stomas. The developmental levels of children were discussed in relation to teaching styles. There was a presentation discussing the distal re-feeding process; this is where the proximal stoma effluent is fed through the distal mucus fistula, which provides better overall outcomes for the patient. There was an excellent presentation on ano-rectal surgery for imperforate anus and a debate in relation to stoma formation or primary repair. I learnt many little tricks of the trade in dealing with tiny ‘bellies’.

The second day was the wound day and I found this extremely beneficial. Neonates and paediatric patients are definitely not little adults. Particular risks related to the neonatal patient, for example no products with alcohol are to be used and there must be careful use of thin hydrocolloids on patients undergoing phototherapy. Other topics included epidermolysis bullosa, ulcerated haemangiomas, diaper dermatitis, pressure ulcers and the Braden Q scale, and negative pressure dressings on paediatric patients.

The third and final day looked at gastrostomies and continence. A lot of information covered in 1 day; I felt that I would have liked more time in this area, something I included in my feedback. Skin care and complications relating to gastrostomies were discussed as well as the antegrade continence enema (ACE) procedure. Techniques to manage bowel and urinary continence were briefly commented on. Donna Griffiths (one of our own) presented an excellent case study of a patient with a stoma and adjacent wound which she treated using a bioceramic dressing.

Overall, I found the convention to be a very worthwhile experience for me; it was at the right level for my understanding and relevant to my practice. I also found it reassuring in relation to my current practice, and it was a great opportunity to network. As there is limited literature in relation to paediatric management, we rely on conventions such as this for brainstorming and information sharing. The overall feedback from the delegates is that this will not be the last of its kind; I look forward to the next one.
Behind the scenes

Phil Morton: Website Coordinator – our own quiet achiever!

It is a great pleasure to be involved with the AASTN website. I use it as an example of how to do it right. Some people and organisations don’t see the benefit in having a website, so I show them the AASTN site, how it’s relevant, topical and useful.

After many years working in advertising and in the media, I am now self-employed. Most of my days are spent maintaining and developing websites for small to medium businesses. It is challenging and rewarding work, at least that’s what the sticky note I wrote for myself says. I like to explain that I make my living off something that doesn’t exist. I hope those thick underground and undersea cables that keep the internet connected stay that way, or I’ll quickly be in need of another career change.

I personally avoid anything to do with medical procedures. I fainted giving blood once (I was trying to do the right thing) and at school I lied to avoid a TB vaccination. In recent years I’ve had the pleasure of a cholecystectomy and a cardiac radiofrequency ablation. So I sincerely hope the AASTN policy of not including photos of stoma treatments on the website continues.

Robyn Simcock: AASTN Membership Coordinator

The role of Membership Coordinator for the AASTN began in a formal sense in 2001; it was previously part of the role for the Executive Secretary. The Executive Committee approached me to consider the position of Membership Coordinator after my involvement with convening the 2001 conference for the WA Branch of AASTN.

The role initially involved only the collating the records of memberships from all States and then maintaining those records for the Secretary. A new database developed on Access allowed greater flexibility and usage of the membership data held and has underlined the expansion of my role over the years to include membership renewal distribution, liaison and supply of data to printers, regular membership listing updates as requested and the resolution of member and payment queries. I am also charged with collating and maintaining the data for the State Representative, Executive Committee and Preceptor listings each year, coordinating AGM information mailouts and facilitating email circulars. I regularly attend Executive Meetings. I have now become the general point of contact for AASTN from my office based in Perth.

I am married to the wonderful Bruce, have three fantastic children and one very weird Beagle!
Partnerships in progress: AASTN/ACSA

Peter McQueen • Vice President, ACSA

The close working relationship that has been developed between stomal therapy nurses (STN) and ostomy associations is very much an integral part in the rehabilitation of the new ostomate in the community. The STN has a vital role in selecting the most appropriate appliance and in the training of the new ostomate in the correct use of that product. The ostomy association then has the responsibility to provide the appliances in a timely manner. Associations are not only a provider of appliances; many of them offer support in other areas, not least of all the opportunity for individuals to meet other ostomates. This then lets the new ostomate know that they are not alone and that there are support networks available if they wish to access them.

Many ostomy associations not only have STNs on their staff but also on their management committees, ensuring a professional viewpoint is heard in developing programmes to assist their ostomate members. The Australian Council of Stoma Associations (ACSA) recognises the need to continually foster and nurture this relationship for the benefit of all concerned.

The Stoma Appliance Scheme in Australia is widely recognised as the best scheme of its type in the world. It has some unique characteristics, including appliance distribution through ostomy associations and assessment of all new products by all stakeholders of the ostomy industry. One of the main advantages of the product distribution through associations is the need for the new ostomate to make contact with other ostomates in the process of obtaining supplies for the reasons stated above. Appliance companies who wish to introduce new products do so through application to the Department of Health; the application is then assessed by the Stoma Product Assessment Panel. This panel is made up of representatives from the Department of Health, STNs, ostomy associations and appliance companies. Products are assessed on their merits and, if successful, pricing arrangements are negotiated between the appliance company concerned and the Department.

Some statistics that may be of interest are:

The cost of the Stoma Appliance Scheme in 2007 was approximately $57-60M; 35,412 ostomates were supplied with products that year. The breakdown of ostomates in Australia are: ACT 641, NSW 10,570, VIC 9840 TAS 1225, NT 158, SA 3745, QLD 6331 and WA 2902. There are approximately 7,800 stoma surgeries performed each year in Australia, with 42% classified as temporary. These numbers indicate the amount of work involved in meeting the needs of new and established ostomates alike by both of our organisations. Without the cooperation that exists today, that task would be infinitely more difficult – long may it continue.

A PERSONAL ACCOUNT

It was a bit over 28 years ago that I was diagnosed with bowel cancer, resulting in an AP resection and stoma. It was also about that time that the nursing fraternity advanced to stomal therapy nurses (STNs).

The STN was, and still is, the only medically qualified person to administer care to ostomates. Prior to that time, ostomy associations were the ones who gave what medical assistance they could, if only as ‘fellows of experience’. They were also responsible for the purchase and distribution of stoma appliances; but it worked.

With the arrival of STNs there appeared to be resentment on both sides as to who was in charge. In no way do I suggest this was the case of STNs in every instance. Ostomy associations were also at fault as they felt they were better at advising patients after all those years of being the only source for rehabilitation; in my opinion this still exists in some areas. Generally it appears to be in the older/long standing members of both groups, who are living in the past.

To explain, the first STN I encountered was trying to attach an appliance that in no way resembled the shape of my stomach. I suffered quite severe depression and spent the days moving from lounge to bed to toilet. A visiting friend suggested I consult another STN who, in one visit, turned my life around, (a) by altering my appliance and (b) be being very enthusiastic about her role in my recovery. Some time later I discovered STN 1 was virtually instructed by Matron to attend the STN course and was not very interested in the work, while STN 2 wanted to become part of a new specialist field and was very interested in every patient.

It is with every good intent that I ask that members of both groups who are inclined to be domineering in their endeavours to be ‘in charge’ reconsider their position and work together to improve the conditions for ostomates. Without them, neither of us would exist.

Ed Webster • ACSA Secretary
Good day from Australia! My name is Brenda Sando and I am the new International Delegate for WCET. At the international meeting during the WCET Congress in Ljubljana, Slovenia in June, my name was put forward as your ID and I was duly elected. There was a good representation of Australians at the Congress and I am including a photo of some of the Queenslanders with this report.

I am currently the CNC STN at The Wesley Hospital which is a 448 private hospital in Brisbane, to be increased to a 550-bed facility in 2009. I have been working in this position for the past 15 years and have been a member of WCET during that period. I have been fortunate to be able to attend five WCET conferences, all of which have been a great experience, especially meeting other STNs (or ET nurses) from approximately 53 different countries and to hear papers on many varied topics related to our field of nursing.

The next WCET congress is being held in Phoenix, Arizona in conjunction with the Wound, Ostomy and Continence Nurses (WOCN) of America. This congress will be held in June 2010. Mark it in your diary now and strive to attend the 2010 congress as it is great to be part of this wonderful educational event where people from all over the world give papers on their experiences or research from their countries.

During the Congress, the meeting gives an insight into the workings of our Executive, a group of people from many different countries who strive to work to improve the education and status of ET nurses all over the world. They have achieved the education of ET nurses in a number of Asian countries who are now recognised by colleagues in many countries as professionals in their field.

I would like to encourage you, if you are not already a member, to apply for membership of WCET – not only are you eligible for discounted rates for the Congress but you will receive an excellent quarterly journal which gives you up to date research information as well as interesting case studies which can assist us in our practice.

I would like to take this opportunity to thank Carmen George for carrying out her role as our ID for the past 4 years. Amongst many other tasks, she assisted in making it easier for us to pay our membership online as well as represented all Australian members at the biannual Congress. She also assisted with the education of ET nurses in Indonesia, setting up a WCET recognised training programme. Thank you Carmen for your dedication in your role.

I will email all current members as soon as I have received membership details from Carmen with any information from the WCET Executive which needs to be disseminated to you. I would also like to hear from members if you have any matter that you would like me to attend to or to direct to the Executive. I look forward to serving you as your WCET representative for the next 4 years!

Credentialling report

Congratulations to all!

Sue Delanty • CPD & Credentialling Officer AASTN

Another year has passed, and 65 stomal therapy nurses (STNs) have completed Continual Professional Development (CPD). STNs who meet the criteria are eligible to be an AASTN Preceptor once they have completed a year of CPD.

Could I please remind participants that once you have applied for CPD you do not have to reapply every year. Simply send your completed CPD (remember to put your name on it) with supporting documents to the credentialling officer by 31 December each year. Some people went overboard with evidence while others had to be contacted as they did not send any. However, overall it was a smooth process for 2007.

Congratulations to the participants of the AASTN credentialling process for 2007:
- Liz Howse (WA)
- Wendy Sansom (VIC)
- Diana Hayes (VIC)
- Genevieve Cahir (VIC)
- Shauna Smith (NSW)

The successful re-credential participants for 2007 were:
- Brenda Sando (QLD)
- Rosalind Probert (QLD)
- Sharmaine Peterson (SA)
First of all, I would like to thank the AASTN for awarding me the 2008 travel grant. Without this contribution to my travel funds I would have struggled to get to this Congress. The South Australian branch also contributed $500 to my trip which I am also grateful for; travelling to Europe in the middle of summer is an expensive business.

For me the congress is a very special event. This is the fifth congress I have attended. As the Australian International delegate to the WCET, I have the privilege of being in the parade of countries at the opening ceremony. I struggle to think of ways to demonstrate how to physically show that I am ‘Australian’; this congress I found a creative friend who helped me make a stunning hat with a model of the Sydney Opera House on it.

As a member of the WCET Education Committee, I attended the education meetings that are held during the congress. These meetings are the only time the committee gets together. They are important meetings as the needs of various nations and issues relating to the course curriculum and contents and the process of course recognition are discussed. A second Education Committee meeting is held for directors of courses to share their experiences, problems, goals etc. A third meeting is also held after the general meeting when the new committee is formed. I had the honour to be elected the Chairperson of the Education Committee for the next 2 years. Another part of the job of being a Education Committee member is to assist in the poster judging. Always a large and difficult job, as there are so many brilliant posters all with a relevant message for our nursing speciality.

In spite of spending a large amount of time judging posters, I was able to get in to some of the sessions; it was wonderful to hear quite a few Australian presenters as well as those from around the world. There was a good balance of stoma, wound and continence papers. The social events were good fun despite inclement weather forcing the national evening to be diverted from the beautiful castle on the hill to a large indoor venue. The food and music and camaraderie were wonderful. The other major social event was a trip to the Postojna caves where we went on trains inside these enormous and magnificent caves. This was followed by another delicious spread of local cuisine and some wonderful dancing from all the delegates.

Once again the WCET Congress achieved its goals of being a place to meet and network with other nurses from around the world and a forum to share current clinical experiences, research and direction. Australia also now has a different International Delegate – Brenda Sando took over this position as of the congress 2008; her report follows.
New South Wales

Four of the NSW members have recently returned from Europe after attending the 17th Biennial Congress of the World Council of Enterostomal Therapists (WCET) in Slovenia. There were people from all over the world in Slovenia presenting meaningful insights into their practice. The language of the Congress is English so many people present papers in a language that is not their first language. They need to be congratulated for this alone, as presenting in my native language can be daunting enough at such a conference. There were many papers presented on stoma care, continence and wound care as well as such things as professional issues.

Susan Dunne retired as the Treasurer of the WCET at this Congress. Sue needs to be congratulated on all of her hard work for the last 6 years. Lesley Everingham, Carol Stott and Heather Hill also attended the Congress from NSW. Carol presented a research paper entitled Nurse managed laxative trial among post surgical colostomy patients. Heather is a life member of the WCET and was invited to attend the Congress as it is the 30th anniversary of the WCET.

Carol Stott travelled to Merimbula in August in order to help Wendy Kelland and her team from the Bega Valley Wound Interest Group with their Wound Study Day. The Bega Valley Wound Interest Group has 14 members and meet monthly. The study day had over 60 attendees and the feedback was excellent – they want more education! Lee Gavegan is busily organising a Stomal Therapy & Wound Study Day on 25 October at Westmead Hospital. The programme looks very interesting for those thinking of attending.

The meetings for the rest of the year are all held at Royal Prince Alfred Hospital at 17:45 – Tuesday 7 October and Friday 5 December. There will be an educational session in October and the December meeting is followed by Christmas Dinner in a restaurant in Newtown. The AGM will be held in October.

Carol Stott

Queensland

At our May AASTN meeting Gerry Barry, from the Queensland Ostomy Association, and Ray Garske, from the Brisbane Ostomate Support Visitor Service (BOSVS) attended as special guests. Gerry spent time talking about the services offered by the stoma associations and how STNs can assist to make their job run smoothly. Ray discussed the history of BOSVS and asked if STNs could ensure that the newly trained STNs are also made aware of this invaluable support network and encourage appropriate referrals.

The Gold Coast held an Ostomy Support Day on 21 June with 80 attendees from as far away as Northern Rivers. Dr Galib Ali gave a very interesting and amusing presentation on Gas. The STNs that work in this region did a ‘get to know you’ segment which was well received. The ostomates and staff now can put a face to a name. The Brisbane Ostomy Day has been rescheduled in September due to a lot of members away on conferences and leave. A committee has also been formed to organise a Seminar Day on 18 October.

Six STNs from Queensland attended the WCET conference in Ljubljana. The conference had a wide variety of presentations and excellent speakers. It was interesting listening to the different stoma management practices in other countries. Brenda Sando and Pat Walls gave an excellent presentation on their completed trial for the faecal management system for colostomy care. They had a packed room and a lot of interest in their project.

Sarah Axman-Friend (our National Treasurer) delivered a beautiful baby girl named Chloe Emma on 17 June 2008. A little sister for Jasmine. Roslyn Probert is sporting a beautiful engagement and wedding ring. After the conference in Canada, Roslyn and Rod eloped to Las Vegas and got married. Congratulations from all. Roslyn also has two new trainees at Princess Alexandra Hospital commencing the Graduate Certificate in Stomal Therapy in August and both are very keen.
Anna Plummer has been permanently appointed to Clinical Nurse Consultant for Wound Management and Stomal Therapy for the Cairns & Hinterland Health Service District. Barbara Logan has resigned from the position of STN at Bundaberg Base Hospital. She has been in this position for over 20 years and will be greatly missed. We thank Barbara for all her contributions and wish her well in the future. Cathy Fritz is relieving in this position at present. Cathy was originally an STN at the Royal Brisbane Hospital.

The Gold Coast Ostomy Association sadly lost their Secretary, Judy Lopez, to cancer on 15 July 2008. Gerald Barry, President of the Australian Council of Stoma Association, informed me that Judy had been very involved as a support volunteer, Secretary of the National Council and role of Editor of the journal Ostomy Australia. Judy developed the journal into the exciting format in which it is still presented today. Judy had been Secretary of the GCOA over the last few years and played a pivoting role in leading the association in implementing new ideas, developing closer links to the STNs and ensuring the service the association provides is the best on offer. Judy also was the Chairperson of the 2007 National Stoma Conference, which hosted an outstanding conference. Her enthusiasm, dedication, generosity of spirit and the joy in which she worked will be very much missed.

Helleen Purdy

South Australia

Well, isn’t the year flying past? We are into September already. It has been a busy time for the SA branch of the AASTN. We held our annual Stomal Therapy Professional Development Day on Saturday 26 July at Engineers’ House in North Adelaide. This was a well-organised event with many varied and interesting topics. Some of the presentations included High output ileostomies by Mr Andrew Luck, Colorectal Surgeon, Continence in the aged by Nora Bostock, Continence Nurse Advisor, Anterior resection syndrome by Lynda Staruchowicz, STN Royal Adelaide Hospital, Paediatric stoma therapy nursing by Lisa Kimpton, CNC Women & Children’s Hospital, and a personal account from Lisa, an ulcerative colitis sufferer, on living with the disease, a stoma and pouchitis and the effects on lifestyle, relationships and work. Workshops were also held on Clean intermittent catheterisation (CIC), Wound drain management and Solving stomal problems.

The day was well supported, as usual, by the trade and we sincerely thank them for their ongoing support of stoma therapy nursing education. The Study Day also included the presentation of the Shelley Simper Award. This is an annual award named in honour of the late Shelley Simper, stoma therapy nurse, and is awarded for outstanding contribution to stoma therapy nursing. This year’s recipient is a very deserving one who goes well beyond the call of duty in her passion for stoma therapy nursing – Fiona Bolton. Congratulations Fiona!

The 17th Biennial WCET Congress was held in Slovenia in June. Elizabeth English, as president of the WCET, Carmen Smith as International Delegate (now Chairperson of the Education Committee) and yours truly attended this wonderful conference from South Australia. There were approximately 1300 delegates, including around 25 from Australia; a great attendance. Liz was extremely busy with her presidential role with many functions to attend. She did a magnificent job. There were some excellent presentations during the 4 day Congress in beautiful Ljubljana. The social calendar was a lot of fun too! We wish both Liz and Carmen well with their roles within the WCET.

The Royal Adelaide Stomal Therapy Course has commenced for 2008/09. The Ostomy Resource Module has been held and there are around 8 RNs continuing on to become STNs. The clinical placements have begun, with the students rotating around most of the major hospitals in Adelaide. Once again, Merle Boeree is the course coordinator of this excellent course.
Our branch meetings continue to be well attended. This year we have been having education sessions after the meeting presented by our own STNs on their research, stories and experiences. The May meeting had Lisa Kimpton, CNC Women & Children’s Hospital, present on her attendance at the first Paediatric Stomal Therapy Conference in Montreal, Canada. Kath Gribble also presented a session on her Experiences as a rural STN. We are looking forward to hearing about Sue McKay’s time in Ethiopia as well as Liz English’s presentation on Interesting case studies later in the year.

Margie Reid

Tasmania

Hi to everyone from Tassie, where we are presently putting our winter woollies to very good use! We continue, as I’m sure you all are, to work hard in stomal therapy and our other specialty fields to push the boundaries for improvements and quality of service.

In Launceston a nurse-lead colorectal cancer surveillance clinic has begun this year under the supervision of colorectal surgeons. Enrolled clients will be closely monitored for 5 years with follow up bloods, liver tests and check colonoscopy, thus enabling comprehensive care and early detection of any recurrence.

Sue Delanty has been busy receiving and organising applications for the upcoming credentialling exam and we certainly wish all those who are undertaking the exam all the very best in their efforts.

Both Sue and Sonia Hicks have participated recently in the ANF study day presenting case studies and complication presentations; well done to them both for the hard work they have put in. Margot Hickman has hosted a PEG seminar in Hobart, which was a comprehensive day including herself as the gastrostomy CNM, pharmacist and dietician, and was well received. Margot continues to share her knowledge and experience with others and is currently assisting me to develop PEG services at the NWRH in Burnie.

At our last video-link AASTN meeting in August, our education component was delivered by Karen Campbell. Karen’s presentations were on gynaecological cancers, from diagnosis to treatment and follow up care, and were very informative and interesting.

The Cancer Council of TAS have recently developed new bowel cancer support groups with monthly dates for patients to meet. I was recently invited to speak at the North West group and discussed life after cancer and lifestyle issues. It was great to see that the talk evoked much interest and interaction amongst the group, with many feelings, lifestyle and dietary changes bought up for discussion.

Sonia from the RHH has developed a valuable tool in power point format on Peristomal skin conditions. This is currently undergoing some technical advancements with help from our computer whiz (Sue) and will be an asset in education for both hospital and community settings.

It is with sadness that we say goodbye to our wonderful surgeon Mr Peter Hewitt who passed away recently after a long battle with cancer. We will remember his brilliance as a surgeon and his friendship. Love and best wishes to his family. All the best and bye for now.

Tracey Beattie

Victoria

The Branch extends its sympathy to the family of Elinor Kyte; although not unexpected, her death was sudden earlier this year. Wendy Sansom and Laurie English (retired STN) attended the funeral on behalf of all AASTN members. The family has indicated to us that there remains some memorabilia of Elly’s that will be handed back to the Executive later this year.

We extend our congratulations to Jennifer Byrne (NT) on being named NT Nurse of the Year – quite an honour but nonetheless we are sure well deserved. Best wishes are also extended to Helen Spicer from Beleura Private Hospital in Mornington on her retirement. Rachael Connell will step up into that position. Anne-Marie Strain has taken a sea change to the position of Discharge Liaison Nurse Consultant at Caulfield General Hospital in South Caulfield. We welcome back to stomal therapy Patricia McKenzie who will take up the position left vacant by

Stomal Therapy Professional Development Day.
Anne-Marie at RDNS. Our best wishes are extended to Anne-Marie and we do hope she will stay in touch.

Carolyn Adkins is now STN at Peter MacCallum Hospital city campus. Faye Hector has the role of Breast Care/Radiotherapy Nurse at Peter MacCallum city campus. Carolyn Williamson is consultant Stomal Therapy Nurse for Epworth Richmond and Freemason’s campus.

Lynne Bryant and Stefan Demur conducted a very successful stomal therapy education day for the Barwon Health District. Their programme focused on aged and sub acute care, with attendance from Div 1, Div 2 and PCA nurses. Our country study day for this year was titled Wisdom, wine and whales in Warrnambool. The programme was held over two half days 15 & 16 August. Enormous thanks go to Jenny Fox at Warrnambool Base Hospital for being the liaison person on the ground that did most of the organisation for this event. Because of the unqualified support we enjoy from city members (who give up time and expense to make the trips and speak on the programmes) and our country friends (who support these events through their attendance) and especially our trade friends (who are always in support and attendance), we enjoyed a very successful 2 day event. To explain, the wisdom part of the title came from the programme, the wine part was Friday evening’s dinner and in August the whales come into Warrnambool bay for shelter to have their babies, so it is a tourist time to visit the area – we were not disappointed. Thanks must also go to Steve Williamson at Coloplast IT services for a very professional print of programme and to Jo Campbell for her support and help at this event.

Fifteen students have just completed this year’s Mayfield Stomaltherapy Certificate Course. During one of their clinical placement weeks, the Branch held a meeting that took the format of a clinical evening whereby common and not so common clinical conditions were presented and a round table discussion from all present ensued. Supper on the evening was kindly provided through Jennifer Knoetze from ConvaTec. The students who attended gained good clinical education and even the ‘old hands’ came away richer for the experience with new tricks up their sleeves. The following hospitals provided clinical placement for the students from the course – Children’s Hospital, Royal Melbourne, St Vincent’s Public, Northern Hospital, The Alfred, Austin Hospital, Box Hill Hospital, Cabrini Private Hospital, Melton Health, Geelong Base and Ballarat.

The next initiative for this Branch will start through Jenny Davenport who has been invited to speak to the Lilydale region of general practitioners on stoma care in October. We have been planning to liaise with GP groups and provide education since the beginning of this year and, once Jenny has broken the ice, we are confident other regions will take up the offer for education through our members to the GP fraternity. We also have plans for one more study day in early October.

Our year will conclude with the Christmas party, which will be once again at Wendy Sansom’s home on Saturday 29 November, commencing from 7pm onwards.

Helen Nodrum

**Western Australia**

Hi to all from Perth. My sincere apologies for not having submitted a report in the last journal; I completely lost track of time.

The committee is continuing work towards the biannual conference next March. I would invite you to access the website to download call for abstracts and welcome your correspondence.

Our clinical update in May gave an insight into nursing in the poverty areas of South Africa. Narelle Lurkin, a registered nurse who works in emergency department at Fremantle Hospital, gave a presentation on her experiences as a volunteer in clinics throughout the area. It certainly was a wake up call that we are very lucky to have such a good health service, despite the overwhelming opinions to the contrary; we take so much for granted.

On 13 June the stomal therapy department at Royal Perth Hospital held their annual ostomate seminar day. This was a huge success with many interesting speakers. Topics covered included diet, parastomal hernia, surgical and management, medications and effect on stoma, skin care, bowel pattern post reversal, stoma irrigation and exercise after stoma/bowel surgery. A positive response was received from the ostomates who were in attendance. Additionally, the stomal therapy nursing education programme started on 28 July with 20 participants, many of whom are from acute hospital settings or the Silver Chain Nursing Association. It is hoped that all participants will consolidate their studies soon after completion of the course.

A study day was held in Collie, a small country town south of Perth on Saturday 26 July. Members from the committee spoke on many aspects of stoma care and provided workshops for nurses to attend. There was an attendance of 21 nurses and 20 ostomates. The response to the education was positive, with a real hunger for information. We are receiving more queries from our colleagues in the country areas for education and will endeavour to meet these needs as best we can in the future.

Out next clinical update is on 18 August so I will report on that next issue. Meanwhile take care and keep up the good work.

Regards.

Carmel Boylan
Guidelines for authors

The *Journal of Stomal Therapy Australia* is a quarterly publication which aims to provide educational material to the membership and any other interested bodies.

Accordingly, the Editor welcomes contributions which relate, clinically or professionally, to stomal therapy nursing. These can include scientific papers, case studies, reports or letters to the Editor. Contributions can be four lines or four pages long. If necessary, you can phone the Editor or write for advice on preparing your submission.

Papers will be edited to journal style and it would be appreciated if contributions were formatted as follows.

**Text**

Where possible, please supply your copy on disk (save as Microsoft Word [text only] or ASCII text file format) and also as hard copy, printed on one side of the page only, double-spaced and with a 2.5cm margin on both sides of each page.

**Graphics**

Graphics can include photographs, slides and drawings and may be in black and white or colour. They must be of a good quality either electronic (jpeg) or originals and should be labelled with an appropriate caption.

Since all graphics will be returned to the author after publication, they should be clearly labelled with that person’s name. When including slides and photographs, please indicate which is top and bottom on each, to avoid confusion.

**Permission to publish**

Authors must have permission in writing to publish any material obtained from another source. Written permission must accompany submissions.

**References**

Referencing in the JSTA follows the Vancouver referencing system. References in-text are indicated by means of consecutive superscript numerals; this identifies the source. If the same reference is used again, the same number is used. End-of-text references are shown in numerical order using the following style.

- **Journal article – one author**

- **More than one author – list all authors up to 6. Above 6, use first author only, followed by et al.**

- **Book**

- **Edited book**

- **Chapter in an edited book**

- **Website**

- **Unpublished paper presented at a meeting**

**Deadlines**

To be considered for publication, materials must be in the hands of the Editor by the following dates.

- **October 15 for the December 2008 issue.**
- **January 15 for the March 2009 issue.**
- **April 15 for the July 2009 issue.**
- **August 15 for the September 2009 issue.**
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