

MORRIS COUNTY OSTOMY ASSOCIATION OF NEW JERSEY

AN AFFILIATE OF UNITED OSTOMY ASSOCIATIONS OF AMERICA, INC.

GAS IN THE DIGESTIVE TRACT

Everyone has gas and eliminates it by burping or passing it through the intestines. However, many people think they have too much gas when they really have normal amounts. Most people produce about one to three pints a day and pass gas 15 to 30 times a day.

Gas is made primarily of odorless vapors—carbon dioxide, oxygen, nitrogen, hydrogen, and sometimes methane. The unpleasant odor of flatulence comes from bacteria in the large intestine that release small amounts of gases that contain sulfur.

Although having gas is common, it can be uncomfortable and embarrassing. Understanding causes, ways to reduce symptoms and treatment will help most people find relief.

Points to remember

- Everyone has gas in the digestive tract.
- People often believe normal passage of gas to be excessive.
- Gas comes from two main sources: swallowed air and normal breakdown of certain foods by harmless bacteria naturally present in the large intestine.
- Foods such as carbohydrates tend to produce more gas, whereas fats and proteins cause little gas.
- The most common symptoms of gas are belching, flatulence, bloating, and abdominal pain. However, in conditions such as inflammatory bowel disease (IBD) excess gas may be a common symptom of the disease process.
- The most common ways to reduce the discomfort of gas are changing diet, taking non-prescription or prescription medicines, and reducing the amount of air swallowed.
- Digestive enzymes, such as lactase supplements, actually help digest carbohydrates and may allow people to eat foods that normally cause gas.

Source; National Digestive Diseases Information Clearinghouse

**MAY 2013
NEWSLETTER**

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SHORT BOWEL SYNDROME

Short bowel syndrome is a condition in which nutrients are not properly absorbed (malabsorption) because a large part of the small intestine is missing or has been surgically removed.

CAUSES

When areas of the small intestine are removed by surgery, or they are missing due to a birth defect (congenital defect), there may not be enough surface area left in the remaining bowel to absorb enough nutrients from food.

This condition is likely to develop when one-half or more of the bowel is removed during surgery. Risk factors include diseases of the small intestine that may require surgery, such as Crohn's disease. Necrotizing enterocolitis is a common cause of short bowel syndrome in infants.

SYMPTOMS

Diarrhea • Fatigue • Pale, greasy stools • Swelling (edema), especially of the legs • Very foul-smelling stools • Weight loss.

EXAMS AND TESTS

Blood chemistry tests (such as albumin level) • Complete blood count (CBC) • Fecal fat test • Small intestine x-ray • Vitamin levels in the blood.

TREATMENT

Treatment is aimed at relieving symptoms, and may include:

A high-calorie diet that supplies essential vitamins and minerals, as well as certain types of carbohydrates, proteins, and fats • Some vitamins and minerals may need to be given by injection • Treatment for anemia is vitamin B-12, folic acid, and increased dietary iron • Medications to slow down the normal movement of the intestine (lengthens the time nutrients spend in the small intestine) • If a patient is not able to take in enough nutrients, feeding may need to be given through an IV called parenteral nutrition.

OUTLOOK (PROGNOSIS)

The condition may improve over time if it occurs as a result of surgery. There may be a gradual improvement in nutrient absorption. In some patients the condition may be permanent and may require care monitoring by a dietician or physician.

POSSIBLE COMPLICATIONS

Bacterial overgrowth in the small intestine • Nervous system problems caused by a lack of vitamin B12 • Too much acid in the blood (metabolic acidosis due to diarrhea) • Gallstones • Kidney stones • Malnutrition • Weakened bones (osteomalacia) • Weight loss.

WHEN TO CONTACT A MEDICAL PROFESSIONAL

Call for an appointment with your health care provider if you develop symptoms of short bowel syndrome, especially if you recently had bowel surgery.

THE J-POUCH

At the April 17th MCOA meeting, Dr. J. Shehebar, MD, MMC, colorectal surgeon, gave a very interesting presentation on surgical interventions for patients with intestinal diseases. In particular, he spoke about the J-Pouch.

What is a J-pouch?



When the colon (large intestine) and rectum are removed (due to chronic colitis, cancer or other colorectal diseases), another method must be devised for solid waste to exit the body. Surgically creating a “J” shaped reservoir, or J-pouch, out of an individual’s own small bowel (small intestine) is an alternate way for you to store and pass stool.

What are other names for a J-pouch?

Other commonly used names include ileal pouch and pelvic pouch. Similarly constructed ileal pouch types include the S-pouch and K-pouch (Kock pouch or continent ileostomy). Most patients at Cleveland Clinic Florida request and receive a J-pouch, which is the current “gold standard” of surgical procedures.

How is a J-pouch created?

In a surgical procedure called a total proctocolectomy and ileal pouch anal anastomosis (IPAA), the entire colon and rectum are removed. A reservoir is created from the distal small bowel (called the ileum), which is then joined to the anal canal. This pouch serves as a storage place for the stool that the patient is able to pass through the usual route, eliminating the need for a permanent external bag (ostomy).

Who is a J-pouch for?

J-pouch procedures have become the preferred option for treating chronic ulcerative colitis (CUC) in which medical therapy fails to control symptoms. J-pouches also are used for familial adenomatous polyposis (FAP) and occasionally, colon and rectal cancer.

What are the benefits of a J-pouch?

In a survey of patients who had J-pouch procedures at Cleveland Clinic, one of the greatest benefits cited was having control over bowel movements and being free from the need to instantly find a restroom.

Source: Cleveland Clinic Florida

POOR FITTING FLANGE/ ODD SHAPED STOMA LEAKAGE PROBLEMS

Possible Solution: Ostomy Stoma Seals

Example: Eakins Seals [<http://www.eakin.eu>]

Eakins Seals are moldable and flexible rings of a putty-like that is very similar to the hydrocolloid that is used to manufacture the adhesive flange on most current ostomy pouches. To use them you stretch the ring out so that the hole in the center matches the size of your stoma, and then you fit it into place on to your skin first, smoothing the outer edges outwards a bit to make the join between your skin and the end of the seal flatter. Then you fit the adhesive flange of your pouch system on top.



The seals work best if you make sure that the hole for your stoma in your flange is a snug fit. In an ideal world there should be no more than a 1mm gap between your stoma edge and the edge of the flange’s stoma-hole. If your stoma is not perfectly round or oval, and you have trouble cutting a snug fit into your flange, then you have a couple of options.

Get your partner, or a close friend/relative to help you cut a cardboard template to the shape of your stoma. This is easier with someone helping you, as they can see if the fit is snug all around the stoma from a face-to-stoma angle. Then you can draw around this template hole on to your flange, and then cut the hole out safe in the knowledge that the hole will be near perfect every time.

Alternatively, after making your template, send it to one of the many ostomy appliance home delivery companies who will likely offer a service to electronically cut all the flanges in your order to your submitted template, and usually this is a free service. However, it is worth noting that this service is usually only available for two piece flanges. Other examples of this type of product is the Coloplast Assura Seal.

Source: www.ostomyland.com

MORRIS COUNTY OSTOMY ASSOCIATION

The Morris County Ostomy Association is a community based, local organization made up of volunteers whose purpose it is to reach out to ostomates and their families, providing them with a network from which they can share experiences, obtain information, and gain emotional support.

The association's voluntary visitation program offers support on a one-to-one basis to patients and their families. The ostomy volunteer visitor is carefully chosen and trained. The visitor is well adjusted to his/her ostomy and is able to offer additional support and information on ostomy care and management at home.

The Morris County Ostomy Association holds regular monthly meetings. The meetings normally consist of an informal gathering of ostomates and individuals who may be contemplating ostomy related procedures. Families and friends as well as significant others are always welcome.

The evening usually involves an informal talk by a physician, a nurse specialist, a distributor of ostomy supplies, or social worker. Presentations are always on a topic of interest to the entire group. A display of current ostomy products is on hand for inspection. Most importantly, the meeting offers the opportunity for individuals to share information and discuss mutual interest and concerns.

MCOA

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MEETING SCHEDULE

May 15, 2013:

Guest Speaker, Theresa
Rooney, Hollister
representative

June 19, 2013:

Guest Speaker on nutritional
supplements for people
living with ostomies

July 17, 2013:

To come

If you do not wish to receive future MCOA newsletters, call George Salamy at 908-879-1229.