

Living with bowel cancer

The ileostomy
and colostomy



Bowel Cancer
NEW ZEALAND

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It's normal to feel uncertain about how life will be after your ileostomy or colostomy

“Will I be able to do all the things I did before? Can I go back to work, swim, play sports, travel, and be as active as I used to be?”

It's natural to have hesitations and concerns, and we hope that this booklet will provide some answers, ideas, and helpful information.

You'll probably have lots of questions too and don't be afraid to ask them because knowledge, experience, and support can help you gain confidence in this 'new normal' and live fully with resilience and strength.

Living with an ileostomy or colostomy will require some changes, but with education and guidance, these changes are manageable, and you can return to a healthy, functioning lifestyle.

Your surgery

Hundreds of people of all ages undergo ostomy surgery each year as a result of complications from a variety of diseases and conditions. Some diseases such as bowel cancer may require the surgical removal of affected portions of the bowel.

An ostomy is a surgically created opening on the surface of the abdomen (a stoma) allowing for the discharge of body waste (faeces) that can no longer pass through the bowel in the usual way. The waste output is collected in an external pouch (also known as a 'bag' or a 'stoma appliance'. In this resource, we use the word 'pouch').

In this resource, we will look at the ileostomy and the colostomy. These surgical procedures may be needed to:

- allow post-surgical healing of the small intestine or colon (for example, if a section of the bowel has been removed as treatment for bowel cancer),
- relieve symptoms of ulcerative colitis, Crohn's disease, familial polyposis,
- enable complex surgery of the anus or rectum.

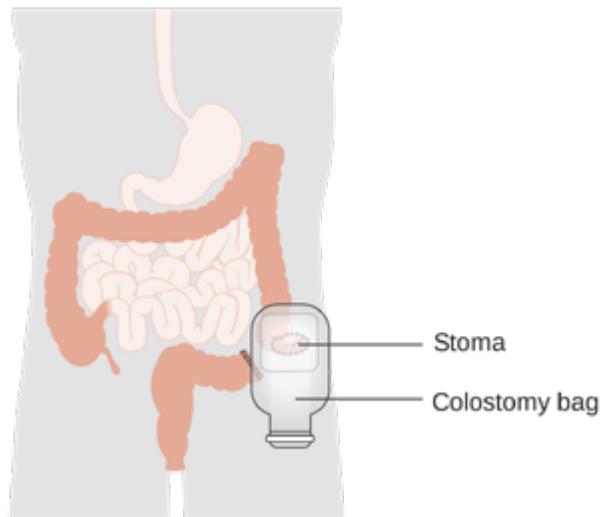


The stoma

The stoma is a surgically created hole in your abdomen. A piece of the bowel is brought through a small incision in the abdominal wall onto the skin surface. It is then turned back on itself like the cuff of a sleeve and stitched. Stomas can vary in size and location, depending on the individual.

'Stoma' comes from the Greek word for 'mouth' or 'oral cavity'. Waste (faeces) that would normally pass through the rectum and anus (back passage) now exits through the stoma into a collection pouch worn on the outside of the body over the stoma. The ileostomy brings the last part of the small bowel (ileum) through the abdominal wall, and the colostomy brings through part of the large bowel. Both procedures allow bodily waste (faeces/stool) to pass through the stoma.

It is not uncommon for the surgeon to request the advice of the stoma nurse when determining a suitable site for the stoma before surgery. Location can affect the care of your ostomy, and the type of clothes you like to wear, and consideration is given to skin folds, scars and other irregularities to ensure the optimal stoma position.



The ileostomy

A surgically created opening in the ileum (lowest part of the small intestine) is brought through an opening in the abdominal wall (made during surgery) to form a stoma, usually on the lower right side of the abdomen. An ileostomy may be temporary to allow for healing or rest of the small intestine or colon, or to enable more complex surgery of the anus or rectum. An ileostomy may also be permanent, depending on the individual circumstances.



After an ileostomy, digestive waste no longer leaves the body through the rectum and anus. It now exits through the stoma. This constant drainage is collected in a pouch that adheres to the skin around the stoma. The pouch is worn at all times and is emptied as needed. There are two main types of ileostomy, the loop ileostomy, and the end ileostomy. In some cases, it may be possible to have ileo-anal pouch surgery.

Loop ileostomy

During surgery, a loop of small intestine is brought out through a cut (incision) in your abdomen, opened up and stitched to the skin to form a stoma. The colon and rectum are left in place. The stoma will have two openings. They will be close together, and you may not be able to see both. One of the openings is connected to the functioning part of your bowel (where waste products leave your body), and the other is connected to the inactive part of your bowel that leads to your rectum. The loop ileostomy is usually temporary and may be surgically reversed at a later date.



End ileostomy

During surgery, the ileum is separated from the colon and brought out through the abdomen to form a stoma. The stitches dissolve over time, and the stoma heals onto the skin. Waste material comes out of the opening in the abdomen and is collected in a pouch fitted over the stoma. The end ileostomy is usually permanent.

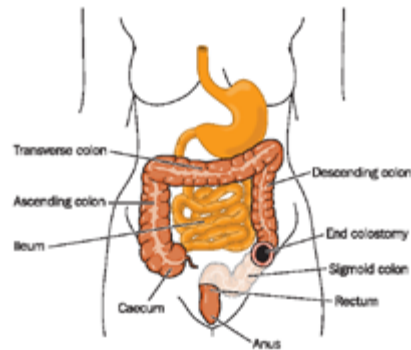
Ileo-anal pouch

In some cases, it may be possible to have ileoanal pouch surgery (also called a J-pouch). This procedure involves the removal of the entire large bowel down to the anus and the creation of a new internal reservoir where the rectum used to be. The anal sphincter muscles are kept. A pouch in the shape of a J is made from the small bowel and attached to the anus. The pouch stores waste until you need to have a motion and the waste passes in the normal way. The area around the pouch requires healing so a temporary loop ileostomy is made above the pouch and a second operation a few months later will reverse the loop ileostomy.

The colostomy

A surgically created opening in the colon is brought through the abdominal wall to form a stoma. A colostomy may only be needed for a short time (3 – 6 months) but may also be permanent, depending on individual circumstances.

The location of the colostomy stoma depends on which part of the colon is affected. Some are on the right, or the left or the middle. The way the stoma looks depends on the type of colostomy the surgeon makes and on individual body differences.



A colostomy changes the way your body passes stool (faeces). After a colostomy, the intestines will work as they did before, but the colon and rectum beyond the colostomy are disconnected or removed, and the anus is no longer the exit for stool. However, the anus will still pass mucus from time to time, and this is normal.

The normal function of the colon is to absorb water, move stool towards the anus, and store stool in the rectum until it passes out of the body. A colostomy affects this function. The higher up in the colon the colostomy is made, the shorter the colon and so it has less time to absorb water, making the stool softer or more liquid. A colostomy further down in the colon, near the rectum, will put out stool that has been in the intestine longer and may be more solid or formed. After surgery, some people may still feel an urge to have a motion and may have some discharge from the anus such as mucus, blood, or stool left from the operation. If the rectum remains after surgery, it will continue to put out mucus that can be passed without harm when you have the urge. The type of colostomy used will depend on your circumstances.

Loop colostomy

This procedure is often used if the colostomy is temporary as it's easier to reverse. During surgery, a loop of the colon is brought out through a cut (incision) in your abdomen, opened up and stitched to your skin to form a stoma. As with the loop ileostomy, the stoma has two openings close together, one connected to the functioning part of your bowel (where waste will leave your body) and the other to the inactive part of your bowel leading to your rectum. In some cases, a support device (known as a rod or bridge) may be used to hold the loop of colon in place while healing. This is usually removed after a few days.

End colostomy

During surgery, one end of the colon is brought out through a cut in your abdomen and stitched to the skin to create a stoma. This type of colostomy is often permanent but can be temporary when used in emergencies to treat bowel obstructions, colon injuries or bowel cancer.

Stoma reversal

A stoma may be permanent or reversible, depending on your individual circumstances.

A temporary (reversible) stoma (either an ileostomy or colostomy although a loop ileostomy is the most common) can be created for a minimum of six weeks but could be present for more than six months as it takes time for scar tissue (adhesions) to settle and any swelling within the abdomen or stoma site to fully reduce. Much also depends on your general health and recovery from your bowel cancer surgery. Further treatment such as chemotherapy may delay the reversal too.

Closing or reversing the temporary stoma is a significant operation. While the procedure may be more straightforward and shorter than your initial surgery, there are still important decisions to be made as there is the potential for post-operative side effects and you'll need to know what to do if these occur.

There is also the possibility that your surgeon may be reluctant to perform a stoma reversal, and this will be discussed with you. The surgeon's decision is based on a few checks that will be made prior to any surgery, such as:

- You are fit and well enough to handle further surgery.
- The bowel has healed or improved since the first operation.
- The bowel and the anal sphincters (which control the flow from your bowels) are working so that loss of control of your bowels (or faecal incontinence) will not develop as a result.
- It is likely the surgeon will perform a rectal examination, and possibly arrange some further tests, before making this decision.

The closure of your stoma involves making a cut around the stoma to free it from the abdominal wall. The bowel is stitched back together to restore continuity, placed back inside the abdominal cavity, and the abdominal wall muscles and skin are stitched.

There is a recovery period after a stoma reversal. You will be given information about potential side effects and complications, caring for the wound as it heals, nutrition and diet, exercise, and getting back into daily life.



After surgery

Even though you knew you would have a stoma, waking up after surgery and realising it's there can be a difficult transition for anyone. Add to this the normal stresses of surgery, and you may feel many unexpected emotions, perhaps fear, sadness, and anger, just to name a few.

This is normal, so allow yourself time to feel whatever you need to.

Chances are you were not too healthy prior to surgery, or a colonoscopy had revealed a problem. Waking up with a stoma and wearing a stoma pouch can be hard to take in, but it is a positive step towards health and recovery.

Looking at your stoma for the first time may cause some emotion. Having your stoma nurse or someone you trust with you may help.

Your stoma nurse

While in hospital, your stoma nurse will show you how to care for your ileostomy or colostomy. The nurse is a qualified professional with additional training in all aspects of this type of post-operative care and will be able to assist you before, during and after your ostomy.

Most large hospitals will have a stoma nurse, and smaller facilities may employ a nurse in a part-time dual position.

Your stoma nurse remains your primary contact for information, support, for ordering your stoma supplies and assisting with the ongoing management of your stoma.

Caring for the stoma

The stoma may look large at first but will shrink to its final size about 6 to 8 weeks post-surgery. The shape will be round to oval. It may stick out a little or be flat against the skin. The stoma will look pink to red in colour and appear moist. A stoma bleeds easily if it is rubbed too hard and can be particularly sensitive in the early months post-surgery. Any bleeding should stop quickly but if it persists or if blood is coming from within the stoma, contact your stoma nurse right away.

There are no nerve endings in the stoma, so it will not be painful or feel uncomfortable. There may also be a 'bridge' (supporting rod) going underneath the stoma to support it for the first few days.

When you wake up after surgery, you will be wearing your first pouch. It will most likely be a clear pouch so the stoma nurse attending you can check your new stoma easily.

Your stoma will begin to work within a few days post-surgery. The initial output may be watery and strong-smelling as your bowel hasn't been working for a while. There may be a small amount of blood, and some wind (flatus) may come from the stoma too. These are all normal effects and will settle. Make sure to drink plenty of water during this time to avoid dehydration. Your doctor will let you know when you can eat and drink as usual.

Patients who still have some lower bowel (rectum) may feel the need to go to the toilet as before and pass some blood and mucus. This is normal, and it may help to sit on the toilet to help the mucus pass.

Keeping a stoma diary can help you track your recovery, stoma appearance, and output from the stoma. You can note any changes in size and colour, any issues with the surrounding skin (redness or irritation), and you can write down any questions you may have for your stoma nurse or doctor.

The ileostomy/ colostomy pouch

After your operation, faeces will pass through the stoma. Unlike the anus, the stoma has no shut-off sphincter muscle or valve so you will not be able to control the faeces passing from the stoma.

An ileostomy/ colostomy pouch collects the faeces as it passes through the stoma. There are several different types of pouches, and your stoma nurse will show you the ones that are best for you.

Faeces is often quite watery in the first few days after surgery. Your stoma nurse will help with emptying the bag and other tasks until you are ready and have learned how to do it for yourself.

The pouch sticks onto your abdomen, over the stoma, and has a filter that releases wind (flatus) so the pouch will not inflate (called 'ballooning') and a deodorising action to minimise odour. The pouch is waterproof and can be worn while showering or bathing.

There are two main types of pouch systems

Each system has different advantages, and your stoma nurse will advise on the right one for you. Both include a skin barrier and pouch. The barrier is the part of the system that fits around your stoma. It protects your skin and holds your pouching system in place.



The one-piece system

The one-piece system has a collection pouch with an integrated baseplate attached which fits firmly around your stoma.



The two-piece system

The two-piece system is the most versatile. The collection pouch is separate from the baseplate, and the two parts are securely clipped or sealed together making it easy to detach the pouch without removing the baseplate around the stoma every time you change the pouch.

Both systems are gentle on the skin, lightweight, leak and odour proof and available in a variety of sizes to suit your specific needs.

Choosing the right pouch

Having the right ostomy supplies for your individual lifestyle and stoma is important for a good quality of life.

Your stoma nurse will advise you on the ostomy supplies best suited to your needs and is the first point of contact for enquiries and ordering supplies. Suppliers can be contacted directly if you would like to try something new (they will send a sample for you to try) however, any changes should be made in consultation with your stoma nurse. New Zealand suppliers are listed at the end of this resource.

Pouches are available in different lengths, and in ultra-clear, transparent and opaque. You can also choose one with a soft cover for comfort. There are two types of pouches, drainable and closed, and each has its own advantages.



Drainable pouch

These are emptied through an opening at the bottom. If you have an ileostomy, a drainable pouch is best as the output from your stoma will never be thicker than the consistency of toothpaste.



Closed pouch

A good choice for a colostomy where stools are firmer and similar to pre-surgery consistency. As you recover and begin to eat normally, faeces will usually become more formed, but if the output from the stoma is more liquid, a drainable pouch may be better. Closed pouches must be replaced after being emptied.



Emptying and changing the pouch

The frequency of emptying and changing can vary from person to person, and depend on the amount of faeces and how often you open your bowel. Generally, an ileostomy pouch needs to be changed every other day and emptied about 5-6 times a day. A colostomy pouch can be changed 1-2 times a day. It may be a good idea to familiarise your partner or a close friend in the changing and emptying process so they will know what to do in case of emergency or sickness.

The skin around the stoma may become red and inflamed due to damage when removing the base plate. Wiping with an adhesive remover may prevent this, and with a two-piece system, the base plate stays in place for several days, and this will reduce the likelihood of damage. Sore skin can also result after contact with pouch contents. Stomas can change in size and shape so check every few months to ensure the base plate sits snugly around the stoma, so the skin is not exposed.

If you are using a drainable type, it is recommended that you empty the pouch before you remove it, then seal the pouch inside a disposable bag and place it in the bin. If you are out and about, public disabled toilets should have suitable facilities, and you can also use nappy changing bins or sanitary bins if available. Do not flush it down the toilet as it will cause a blockage.

Over time, you will notice that your stoma is more active at certain times of day, for example, after a meal. Getting to know these patterns can help you establish a routine for emptying and changing your pouch.

Choose a time to change your pouch when the stoma is relatively inactive, perhaps first thing in the morning. Make sure you have everything you need at hand before you begin changing the pouch.

You may find that changing first thing in the morning before eating or drinking, or while showering, works well. The stoma can be cleansed with soap and water at each pouch change but rinse well as residual soap may interfere with the adhesion of your pouch system. Water will not enter a stoma, so you do not need to cover it while bathing or showering.

Have your new pouch ready, remove your old one, and hop in the shower. It's okay to use all your usual soaps and shampoos and rinse with care. Your stoma nurse will provide information about caring for your stoma and surrounding skin.

Colostomy irrigation

If you have had an end colostomy, then you may be able to manage your stoma with a colostomy plug or by irrigation. Ask your stoma nurse or doctor if these options are available for you.

A colostomy plug is a two-piece system consisting of an adhesive base plate and a disposable colostomy plug attachable to the plate. The plug is made of a soft, pliable plastic material with open cells containing a carbon filter allowing flatus (wind) to pass odour-free. The plug allows you to control your colostomy. Research has shown the plug works effectively for an average of 8 hours, somewhat longer if the individual is using colostomy irrigation.¹

Colostomy irrigation involves putting water into the colon through the stoma. This causes the colon to empty and can help avoid constipation. Regular repetition of the process (once a day or once every second day) can train your colon to empty without spilling faeces between irrigations.

You may be able to irrigate if you have a permanent end colostomy opening in the descending or sigmoid portion of the colon because your stool will be more formed. If your stoma is in the ascending or transverse parts of the colon, or if you have stomal problems or irritable bowel syndrome, irrigation may not be an option.

¹Lancet. 1986 Nov 8;2(8515):1062-3.

The colostomy plug: a new disposable device for a continent colostomy.
Burcharth F, Ballan A, Kylberg F, Rasmussen SN.



Recovering

It can take a while to recover from your surgery and become comfortable with the stoma and ostomy pouches. You may be wondering:

“Can I go back to work or still play the sports I enjoy, will I be able to fly and travel, what can I eat, and will people know I’ve had this surgery just by looking at me?”

Over time, you may find you can return to many of the same activities you enjoyed before your surgery.

Diet

After an ileostomy

In the early part of your recovery from an ileostomy, the discharge from the stoma may be quite fluid. To reduce the output, try to avoid fibrous foods as these can stimulate the small intestine and chew your food thoroughly before swallowing to aid the digestive process.

Before surgery, your large bowel would have absorbed water and salt from waste material. The small intestine will gradually adapt by increasing its absorption of water, but this may take some time so be sure to drink plenty of fluids (a minimum of 8 cups per day equivalent to 2.0 – 2.5 litres) to avoid dehydration.

‘Isotonic’ sports drinks may be recommended over plain water. These drinks contain electrolytes and higher levels of salt and glucose (sugar), encouraging the absorption of water into the gut rather than it passing through into your stoma bag. Monitor your urinary output. Ideally, this should be about one litre/ day, and straw-coloured urine is a good indicator that you are hydrating well. If in doubt, talk to your specialist about the optimum ways to stay hydrated and well after your ileostomy.

If there is a major increase or decrease in the output from your stoma, check with your stoma nurse or doctor. Such variations may indicate a blockage (decreased output or none at all, an increase in watery discharge, a change in colour and quantity) caused by a plug of food or a post-surgical issue. Most blockages will clear, but some may not. If you feel unwell, have stomach pains or experience nausea and vomiting, contact your stoma nurse or doctor. Stop taking solid food but do keep drinking water.

Some foods can help to thicken the stool. You may wish to try apple sauce, mashed potato, ripe banana, noodles, yoghurt and cheese.

After a colostomy

Eating a well-balanced diet is important for anyone. When your doctor has given you the 'all clear' and that no special diet is needed, you may return to having your favourite foods and resume a healthy diet. However, some foods, and the quantity of food you eat, may affect your digestive tract differently.

For the first 2-4 weeks after surgery, you may find it easier to eat little and often and build up to three meals a day to avoid feeling bloated. Getting back to regular meals will help you have a more predictable bowel movement too.

Some foods may have given you gas before and will likely do so now. This doesn't mean you can't have them, but you may prefer to eat these foods sparingly, or at home so as not to feel self-conscious. Other foods may cause diarrhoea, constipation or incomplete digestion. If they bother you, then cut down on these foods or eliminate them altogether. Experiment and find the diet that's right for you. Chewing your food well and drinking plenty of water will aid digestion. Alcohol can be taken in moderation, and you may want to avoid carbonated drinks as they can cause gas. If you pick up a stomach bug, output through the stoma may increase and be watery so drink plenty of fluids to avoid dehydration. If you cannot tolerate oral fluids, seek medical assistance.

Medications

After an ileostomy

Some medications (large tablets, coated pills, time-release capsules and birth control pills) may be only partially digested as they pass through your system. It's a good idea to tell your doctor, dentist, and pharmacist that you've had an ileostomy as they may be able to suggest alternative medications. Do not take laxatives after an ileostomy as they can cause severe dehydration and electrolyte imbalance. Some medications may change the colour, odour, or consistency of your stool and non-prescription medicines like antacids can cause constipation or diarrhoea. If you have questions about any medications you are taking, talk to your stoma nurse or doctor.

After a colostomy

If you were taking medications before your surgery, you can continue to do so now, and they will still be effectively absorbed into your body. Some may change the colour, odour and consistency of your stool. Non-prescription medicines like antacids may cause constipation or diarrhoea, and some antibiotics may make your stool thinner and could also cause diarrhoea. If you have questions about medications you are taking, talk to your stoma nurse or doctor.

Going back to work

You'll need time after your surgery to heal and recover, but you can return to work. Returning to employment is a good way to transition back into a normal routine and can make you feel more confident. You might choose to ease back into it and decide upon a part-time schedule with your employer for a period of time. If your work involves manual labour or lots of lifting, your doctor may recommend ways to protect your stoma on the job and if you have concerns about caring for your stoma at work, talk to your doctor or stoma nurse. Workmates may be curious about your stay in hospital. They may ask questions so think ahead of what you'll tell them. If talking about your procedure makes you feel uncomfortable, you could say you've had 'abdominal surgery' without going into the details. You may find it helpful to tell someone at work about your surgery if you need assistance, understanding, or some special arrangements.

Exercise and sports

Returning to usual exercise routines, and even starting new ones can really help your recovery from surgery. If you have any doubts over whether you can return to the activities you enjoy, seek advice from your stoma nurse. Some activities may not be possible until you have completely healed from surgery.

If you are worried that running, swimming or other athletic activity may loosen your pouch and cause leakage, talk to your stoma nurse about special belts or binders that can help to hold the pouch in place.

If you played contact sports such as rugby before surgery or lifted weights at the gym, you may not be able to return to these activities due to the risk of injury to the stoma and surrounding area. Contact sports carry a higher potential for injury, and the muscles around your stoma will not be as strong as they were before. Talk to your stoma nurse and doctor about continuing these activities. There may be special products and precautions you can take to protect your stoma. Generally speaking, lifting anything of significant weight is not recommended after ostomy surgery.





To tell, or not to tell

Some people prefer to keep their surgery private, and others will tell anyone who asks. Who you tell is up to you, and you may find talking about it gets easier as you become more comfortable caring for yourself. You may want to tell those closest to you because explaining your surgery could help ease their fears and worry. Talking with loved ones can help you cope with your own emotions and feelings too.

Your ileostomy/ colostomy pouch may feel very obvious to you and every gurgle from your stoma so loud you think everyone can hear it. Most people won't notice anything unless you tell them and as you get used to your ostomy, you'll find more ways to feel comfortable and confident. Here are some ideas to get you started:

- Empty your ostomy pouch when it is two-thirds full so it won't bulge under your clothes.
- Find the pouch system that works best for you.
- If you're worried about the odour when emptying your ostomy pouch, ask your stoma nurse about pouch deodorants or air sprays to reduce odour.
- Ask someone whose opinion you trust whether the pouch is visible under your clothes or if the sounds from your stoma are as loud as you think they are. Don't let a fear of what could go wrong keep you from going about your day.

Don't worry if you have an awkward moment or two while you're getting used to your ostomy pouch. That's normal, and you may handle it better if you can keep your sense of humour.

What to wear

Your stoma's location may make some clothes less comfortable, for example, tight waistbands or belts may feel restrictive over your stoma. Have some fun experimenting with different styles and types of clothing to see what works best. Some companies make special high-rise pants and underwear with a pocket to hold your pouch. You also can find swimwear with a mesh lining or gathered fabric to hide any bulges.

Travel

Having a pouch should not stop you from travelling, and some additional planning will help you make the most of your time away. Take extra supplies for a flight (packed in your carry-on luggage and checked-in bags) and if your destination does not offer ready access to purchasing more supplies, take double the amount you will need for each day you are away. It may be helpful to have a statement from your doctor explaining your surgery and asking that your privacy be respected during any security searches.

Intimate relationships

Sexual activity can continue after your surgery. You'll need time to recover and may not feel like having sex right away, so take it slowly and talk to your partner about other ways of enjoying intimacy with each other. You may need some reassurance too, so take your time.

Certain aspects of sex may change. Depending on the type of surgery you've had, you may experience some temporary side effects such as erectile dysfunction or vaginal dryness. Some sexual positions may now be uncomfortable because they put pressure on your stoma. Experiment with new positions but do not use your stoma for any type of sexual activity.

Take steps to feel more confident. Empty and clean your pouch beforehand or, if possible, remove the pouch and use a small stoma cap instead. Don't be embarrassed to ask your stoma nurse or doctor about intimacy issues as they would have given such advice many times before.

If you're not in a relationship and would like to be, you may wonder when to tell a new partner about your ostomy. That is up to you. Some people like to get it out in the open right away while others prefer to wait until they feel a bond of trust with a potential partner. Give a new partner time, answer questions openly and honestly and be prepared for their reaction. They may seem upset by what they see, but this doesn't mean they don't want to have a relationship with you. Some people may reject you because of your ostomy, and this could knock your confidence. Try not to let that stop you from going on to meet someone else. New relationships don't always work out, so you haven't failed.



Glossary of common terms

Source: Dansac <https://www.dansac.com.au/en-au/glossary>

Absorption

Digested nutrients and fluids are absorbed via the gastrointestinal system into the blood. Disease or surgery may reduce the body's capacity to absorb nutrients and fluids.

Anus

The natural exit at the end of the gastrointestinal system, where faecal waste leaves the body.

Ballooning (of stoma appliance)

Occurs when a stoma pouch/ bag that is being worn by the patient fills up with flatus (gas). This is most likely to be seen when a filter is blocked or ineffective or where there is no filter on the pouch/ bag.

Baseplate

The part of a two-piece appliance that adheres to the peristomal skin and to which the pouch/ bag is attached.

Bowel

The bowel is made up of two parts: the small intestine (duodenum, jejunum, ileum) and the large intestine (large bowel/ colon and rectum).

Colostomy

Surgically created opening in the large bowel/ colon. The bowel is brought through the abdominal wall and sutured to the skin. A colostomy can be formed

in the ascending, transverse, descending, or sigmoid colon, although the most common colostomy sites are sigmoid (left iliac fossa) and transverse (right upper quadrant) colon. The colostomy diverts the faecal flow through the stoma, and a pouch/ bag is worn to collect the faeces.

Colostomy irrigation

A method of bowel management suitable for sigmoid/ descending colostomies to regulate bowel movements and provide continence between procedures. The irrigation is self-administered through the colostomy (every 24–48 hours) and makes it unnecessary to use a normal size stoma appliance. A stoma cap is often sufficient. Medical advice should be obtained prior to education and training of procedure.

Constipation

Irregular and infrequent defecation, accompanied by hard, dry stools, which are difficult to pass.

Diarrhoea

Classified as increased amounts of loose, watery effluent or the number of loose or unformed bowel movements in a 24-hour period.

Digestion

The conversion of food into absorbable substances in the gastrointestinal system. Digestion is accomplished through the mechanical and chemical breakdown of food into small molecules, which can then be absorbed into the bloodstream.

Duodenum

First 25 cm of the small intestine extending from the pylorus to the jejunum. It plays a vital part in digestion due to the digestive enzymes being delivered from the liver/ gallbladder and pancreas. The main function of the duodenum is to neutralise acidic gastric contents, emulsify fats, and absorb carbohydrates.

Electrolytes

In nutrition, this term refers to essential minerals found in blood, sweat and urine. When dissolved, these minerals form electrolytes, positive or negative ions used in metabolic processes, including proper nerve and muscle function. Electrolytes include sodium, potassium, calcium, and magnesium and are essential for proper hydration too.

Faeces

Solid/ semi-solid waste products excreted by the body through the anus. Faecal material consists primarily of bile pigments, mucus, unabsorbed minerals, undigested fats, cellulose, desquamated epithelial cells, potassium, sodium, bicarbonate, and water. Faecal composition is three parts water and one part solid material. Amount of faeces evacuated is approximately 150 to 250g daily.

Fibre

The roughage constituent from indigestible foods. Daily recommended intake of fibre is 18 to 30g. Dietary fibres contribute to a healthy diet for people with or without a stoma but should be used with caution for a person with an ileostomy.

There are two forms of fibre:

- Soluble fibre attracts water and turns to gel during digestion. This slows digestion and the rate of nutrient absorption from the stomach and intestine is increased. It is found in oat bran, barley, nuts, seeds, beans, lentils, peas, and some fruits and vegetables.
- Insoluble fibre is found in foods such as wheat bran, vegetables, and whole grains. It appears to speed the passage of foods through the stomach and intestines and adds bulk to the stool.

Flatus

Gas/ wind formed in the large intestine as a result of the action of bacteria on undigested food. We produce between 400ml and 2L of wind/ gas in 24 hours.

Ileo-anal pouch

This is an optional surgical procedure primarily for patients with ulcerative colitis and familial adenomatous polyposis. During this procedure, the colon and rectum are removed, and a reservoir/ pouch is constructed, using the distal ileum. The configurations of the pouch can vary depending on surgeon preferences. The most common ones are the J-pouch and W-pouch. The pouch is then joined/ anastomosed to the anus to restore continuity of bowel function. To facilitate healing in the post-operative period, the patient may require a temporary loop ileostomy.

Ileostomy

An ileostomy is a surgically created opening in the small bowel, the ileum. In most cases, the surgeon uses part of the terminal ileum (last section of the small intestine) to form the stoma. The ileum is brought through the abdominal wall, everted to form a spout, and sutured to the skin. The output/consistency will vary depending on the location of the stoma within the small bowel. A stoma pouch/ bag is applied to allow for the collection of faeces. The stoma does not possess any nerve endings; therefore, any trauma to the stoma will be painless but harmful, e.g., injury from an ill-fitting stoma appliance.

Ileum

The final and longest segment of the small intestine. It extends about 4m (13ft) from the jejunum (middle section of the small intestine) to the ileocaecal valve, where it joins the large intestine.

It is the site of absorption of fluids, nutrients, vitamin B12 and re-absorption of about 90% of conjugated bile salts. Disorders of the ileum produce problems of absorption and vitamin B12 deficiency. Fluid imbalance caused by diarrhoea will occur as a result of malabsorption and the presence of bile salts in the large intestine interfering with water absorption.

Intestine

A part of the alimentary canal extending from the stomach to the anus.

Jejunum

The middle part of the small intestine that extends from the duodenum to the ileum. It measures about 3 meters (9 feet) in length. The jejunum is the major organ for nutrient absorption.

Most of the fats, proteins, and vitamins are absorbed in the jejunum, as well as any remaining carbohydrates not already absorbed in the stomach or duodenum. Approximately 3 to 3.5L of intestinal fluid are secreted into the jejunum per 24 hours.

Large bowel (Intestine)

The large bowel (intestine) begins at the ileocaecal valve, terminates at the anus, and is about 1.5 m (4–5 feet) long. Its main functions are the absorption of fluid and electrolytes, mixing and propelling contents from the terminal ileum towards the anus, storage, and defecation. It also produces mucus to facilitate the passage of faeces and harbouring of colonic bacteria for the breakdown of complex carbohydrates and synthesis of vitamins B and K.

Ostomy

A surgically created opening for the excretion of faecal waste (ileostomy, colostomy) or urine (urostomy) that can be temporary or permanent.

Pancaking (of stoma appliance)

Refers to the presence of faeces staying on top of the stoma and not dropping/ moving down into the bottom of the pouch/ bag. Most commonly seen in colostomy management. Occurs when the filter on the stoma pouch/ bag eliminates all air in the appliance, creating a 'vacuum/' sucking in' of the appliance onto the mucosa of the stoma.

It is not an easy problem to solve, but primarily the use of an adhesive cover over the filter can help to minimise the problem.

Pouch/ bag (external)

A term used to describe a stoma appliance or stoma pouch/ bag. It is worn over a stoma to collect faeces or urine.

Rectum

The rectum is positioned between the sigmoid colon and the anal canal. The rectum measures 12 to 15 cm in length, and its main function is for the storage of faecal waste. The rectum is usually empty and collapsed until just before defecation; when fully distended, it can hold up to 400 ml.

Small intestine

The small intestine is 4 to 5 meters (12–15 feet) in length and consists of the duodenum, jejunum, and ileum. It is the major organ for digestion and absorption of nutrients and is crucial for life and health.

Stoma

From the Latin word for mouth. Denotes a new opening into or out of the body.

Stoma appliances

A collective term referring to pouches/ bags worn over a stoma. All categories of appliances are available in both 1-piece and 2-piece versions. The 1-piece is where the pouch/ bag and baseplate/ wafer are integral. The 2-piece product has a detachable pouch/ bag from the baseplate/ wafer. This enables the person with a stoma to change the pouch/ bag without removing the baseplate/ wafer.

Stoma cap

The smallest closed pouch. Can be worn following colostomy irrigation, during intimacy and sex, or when bathing. Very useful in the appliance management of a mucous fistula.

Wafer

The baseplate of a 2-piece stoma appliance. The wafer, which consists of an adhesive skin barrier with a pre-cut hole, is placed over the stoma and adheres to the skin. The wafer will also have an attachment system where the pouch/ bag can be secured onto the wafer. This allows for frequent pouch changing without having to remove the wafer. The wafer can remain in place for an average of 3 to 7 days.

The term "wafer" also refers to a protective sheet (usually hydrocolloid) used as a skin barrier in stoma management.

Support services

Talking to others who 'know how it is.'

Talking to someone else who has shared a similar experience can be reassuring, helpful, and can really boost your confidence when you need it most. You can ask questions, share stories, and get helpful tips for everyday life.

Joining a local ostomy support group or a private online support group can offer opportunities to share with others in a safe environment, to pick up information and practical tips, and to be with people who understand 'how it is'.

Support group meetings are not just for talking but also places to make connections, form friendships and have fun. The experiences shared are common to most people.

Bowel Cancer New Zealand

We are a national charity for people and their whānau affected by bowel cancer. We are working to raise awareness of symptoms, promote early diagnosis, and encourage fair and affordable access to treatment for you. We are committed to reducing the impact of bowel cancer on our community through awareness, education, support and research.

Bowel Cancer New Zealand Inc.
PO Box 301517
Albany
Auckland 0752

www.bowelcancernz.org.nz
info@bowelcancernz.org.nz

Bowel Cancer New Zealand Patient and Family Support Group

Our Facebook group provides a forum for people to discuss bowel cancer and their journeys with others going through similar experiences, all within a supportive environment. All are welcome, and the closed group allows maximum privacy. Only members of the group can see the posts. Join by searching for 'Bowel Cancer New Zealand Patient & Family Support Group' on Facebook.

Bowel Cancer New Zealand Nurse Support

You are not alone. Our registered nurse is available to answer any questions you might have about your diagnosis and to help you navigate your treatment path. We are here for you.

Here4you@bowelcancernz.org.nz

Ostomy New Zealand

Ostomy NZ represents, at a national level, the interests of 19 regional Ostomy Societies located throughout New Zealand. Our focus is to help Ostomates and their families or caregivers. It's our goal to help them feel educated and empowered so they can lead a normal life. Ostomy NZ also lists contact information for local support groups throughout New Zealand. Visit <https://ostomy.org.nz/find-support>

p. 0508 OSTOMY
e. secretary@ostomy.org.nz
w. www.ostomy.org.nz

OstoMATES

OstoMATES is a closed Facebook page, a place where people with an ostomy can ask questions, chat, and just be there as a support for each other within New Zealand. Join the group by searching for OstoMATES NZ on Facebook.

Supply Companies

All companies can provide information about the products they supply, and your stoma nurse can assist with supply and recommendations.

Hollister

58 Richard Pearse Drive
Airport Oaks, Auckland 2022

0800 678 669
nzcustomerservice@libmed.co.nz
www.hollister.co.nz

ConvaTec

PO Box 62663
Greenlane, Auckland 1546

0800 441 763
connection.nz@convatec.com
www.convatec.co.nz

Dansac

58 Richard Pearse Drive
Airport Oaks, Auckland 2022

0800 678 669
www.dansac.co.nz

Omnigon

PO Box 24139
Royal Oak, Auckland 1345

0800 440 027
www.omnigon.com.au

Ainscorp Pty Ltd

(local rep Salts Healthcare Ltd)

PO Box 16150
Sandringham, Auckland 1351

0800 100 146
service@ainscorp.com.au
www.ainscorp.com.au

3M Healthcare New Zealand

94 Apollo Drive
Rosedale, Auckland 0632

(09) 477 4040
www.3mnz.co.nz/3M/en_NZ/
cavilon-nz/patients/ostomy/

Coloplast Products

Available from EBOS Healthcare

Lovell Court
Rosedale, Auckland 0632

0800 105 501
www.eboshealthcare.co.nz





Bowel Cancer
NEW ZEALAND

*Reducing the impact of
Bowel Cancer on our community*

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