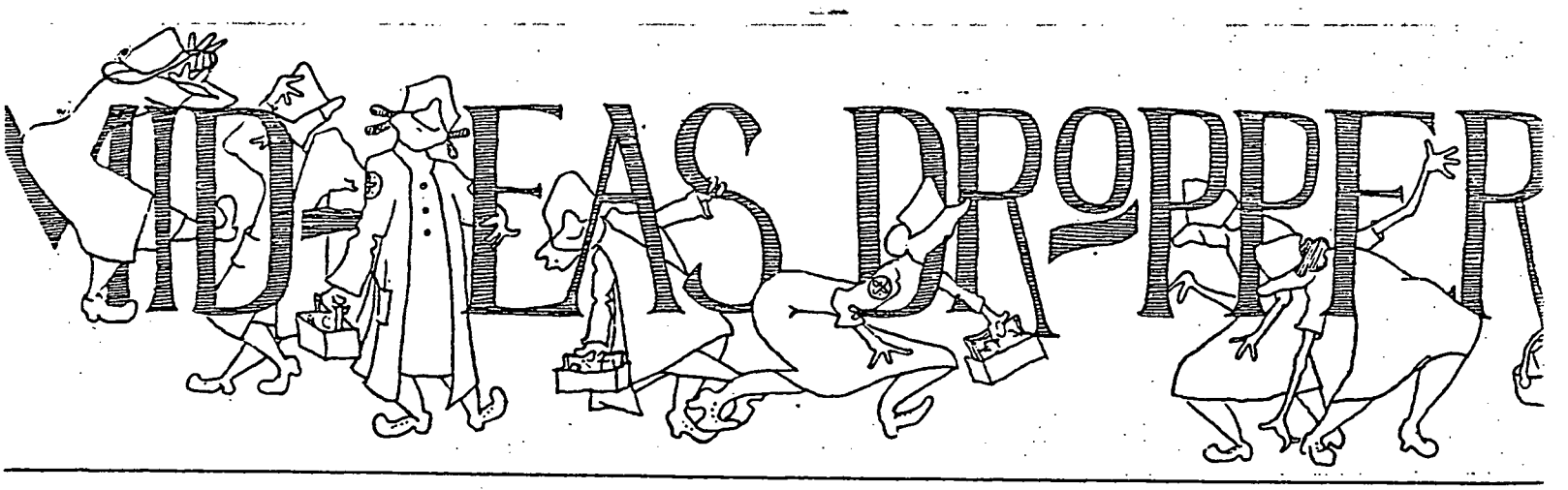

VOL. VI MARCH 1980 NO. 2

EDITORS

Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210
(614) 422-~~6900~~ 6446 ASK FOR HOSPITAL OPERATOR ~~(Have us paged)~~
422-2194 (Leave a message)

MIDEAST REGION I.A.E.T. OFFICERS

PRESIDENT:	*Helen Arend*
PRESIDENT ELECT:	*Joyce Hawley*
SECRETARY:	*LuAnn Hartley*
TREASURER:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Jan Joseph* *Barbara Montgomery* *Betsy Hewitt*
COMMITTEES:	
Membership --	*Jane Beerck*
Budget & Finance --	*Jane Beerck*
Education --	*Jean VanNeil*
By-Laws --	*Jan Joseph*
Publication --	*Barbara Montgomery* *Betsy Hewitt*
HISTORIAN:	*Maude B. Timmons*
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FROM THE PRESIDENT

You will note that this issue of the newsletter is coming from Columbus. I think I speak for all Mideast members when I say thanks to Jane and Joyce for the great job as editors for the last two years. Barbara and Betsy, our new editors, are on deck for the next period. Please give them as much help and support as you can. We need our newsletter for communication. Those of us who have done the editing in the past know that it does take much time and that the job is much easier if lots of people contribute.

Conference time is gain approaching--rapidly. The program looks great and, of course, we are anxious to see our friends again. For some of us, it is the only time of the year we can get together.

This year the Mideast Region will not have an exhibit at the conference. This was discussed pro and con at great length at the November meeting and the members present voted against participating in the activity this year. This is something that can be changed in the future if enough of you are interested.

Don't forget the Spring Regional U.O.A. Conference in Grand Rapids, April 19-20. Many of our Mideast E.T.'s will be helping the Grand Rapids Committee.

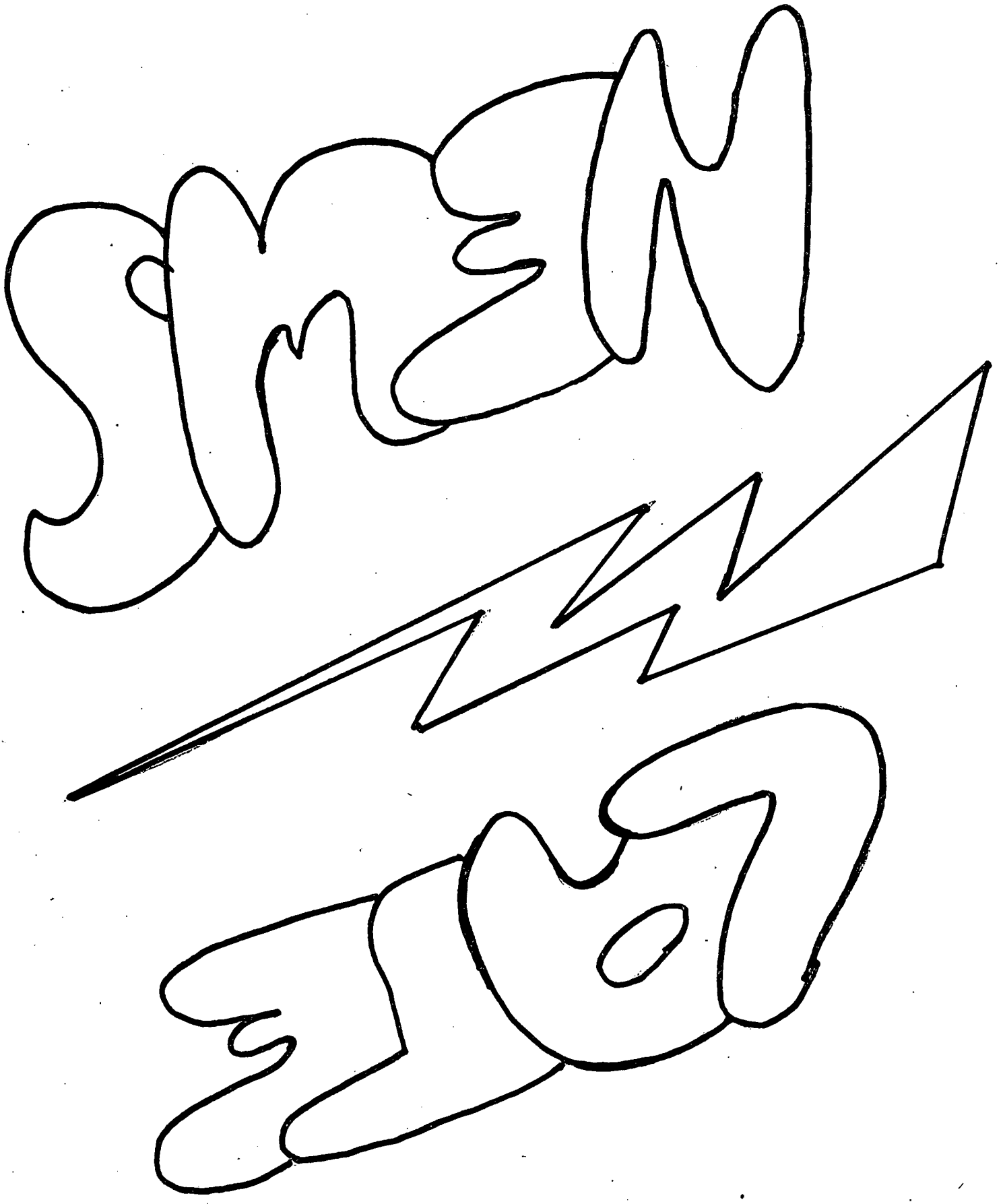
Please pay special attention to the correction (concerning the certification exam) in another place in this issue. We made a big mistake and we do apologize. Hopefully, no one has been inconvenienced greatly.

Norma is busy planning the W.C.E.T. in August. Anyone who can help with hosting duties, notify Joyce Hawley. It is not necessary to be there the whole time to volunteer your services.

Let's have a good turnout for the conference in Washington, D.C. The regional meeting will be on Thursday, May 22. "Look in your packets for the time and location."

See you there!

Helen


SHEN
GUO

MIDEAST REGION

INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY, INC.

Indiana Kentucky Ohio Michigan West Virginia

Kalamazoo, Michigan
March 18, 1980

Dear Mideast Members,

As most of you already know, the World Council of Enterostomal Therapy will have its annual conference in Cleveland, Ohio, August 10 - August 14, 1980. You should be receiving a brochure with details about the program and activities.

The Mideast Region will be assisting Norma and her crew with hostess duties for this conference. We can use at least twenty members who will be willing to commit some of their time for this effort.

This is our opportunity to meet and talk with E.T.s from all around the world. We can learn what's going on in the Ostomy field without leaving our region!

There will be a planning meeting in Washington in Joan Van Neil's room on Saturday, May 24 from 10:00 to 12:00 noon. If you aren't going to Washington, you still can help at the W.C.E.T. Conference. Just let either Joyce Hawley or myself know.

I am enclosing an application blank for W.C.E.T. membership in the event that you wish to join prior to the Conference. There is to be a luncheon meeting on May 23 from 12:00 - 2:00 at the hotel in Washington for all USA - W.C.E.T. members. Watch postings for the location.

Let's all get behind Norma in this monstrous venture. We need your help.

Sincerely,

Helen M. Arend

Helen M. Arend, President
Mideast Region I.A.E.T.

mp

WORLD COUNCIL OF ENTEROSTOMAL THERAPISTS

Application for Membership

_____
Date of Application

/__/ Associate (non-voting membership)

Professional field: _____

Area of specialty: _____

Has your country organized an E.T. association on a national level? (check appropriate box) Yes /__/ No /__/

Title of Association: _____

Comments: _____

_____

_____

_____

DUES

Dues payable with this application to current treasurer in the form of a certified bank check, the equivalence of $10 (Ten Dollars) USA currency.

_____
Signature

Sent to: Barbara Foulkes, Treasurer (send airmail)
Central Nursing Office
St. Mary's Hospital
Colchester, Essex,
ENGLAND

Tel: 0206-77341 Ext. 204

Revised 3/79

** PRINT CLEARLY **

WORLD COUNCIL OF ENTEROSTOMAL THERAPISTS

Application for Membership

Date of Application

Name _____
Last First Title

Complete Home Address _____

_____

(State/Country) _____

Phone Number _____
Area Code

Complete Business Address _____

_____

(State/Country) _____

Phone Number _____
Area Code

Type of membership applied for: (check appropriate box)

/__/ Regular (voting) membership

Name and address of school of enterostomal therapy:

_____

_____

Year if graduation with diploma: _____

or Grandfather clause provision
Year started practice: _____

Verified by
title: _____

Address: _____

_____

_____

EDITORIAL

Starting with this issue, Betsy and I are your new editors for the next 8 issues and we hope with your help the Newsletter will be interesting and informative.

This is your Newsletter and your way to let us know your successes and your problems or things that make you unhappy. Let's make "Dear Ettie" a growing success--we all have so much to share. Let us hear from you! To help us get the Newsletter out on time we will "aim" for the following dates.

DEADLINE FOR MATERIAL

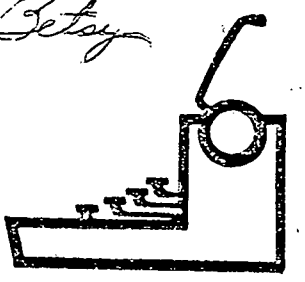
May 15
August 15
November 15
February 15

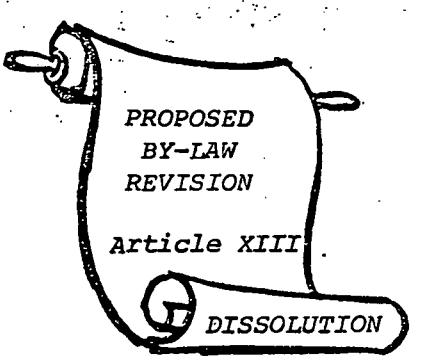
DATE PUBLISHED

June 15
September 15
December 15
March 15

Material received after the deadline will be placed in the following issue.

Barb & Betsy





Section I -- Dissolution

Upon the dissolution or termination of the Region, all remaining assets after the payment of the legal debts and obligations of the Region shall be distributed to a non-profit organization or organizations in such manner as the Trustees or persons in charge of the liquidation or dissolutions shall determine.

The following is a revision of the above:

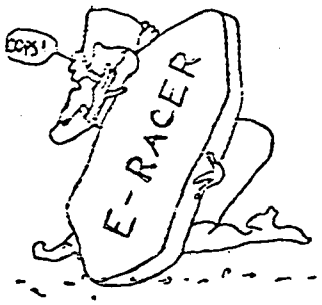
Upon the dissolution of activity of the Region, all remaining assets after the payment of the legal debts and obligations of the Region shall be turned over in full to the treasury of the International Association for Enterostomal Therapy, Inc. along with all financial records, by the Trustees or persons in charge of the liquidation or dissolution.

Rationale:

To comply with requirements for tax-exempt status.

CANDIDATES NEEDED

Candidates are needed for the offices of secretary and treasurer of the I.A.E.T. As of this time, there is only one person on the slate for each office. We need to have an eligible person from the region who will run for these offices. The work involved with these offices is large but the rewards are great, too. The experience that can be gained from working at the national level for an organization such as ours is invaluable, both personally and professionally. There is still time! If you know of someone who would make a good officer, submit the name to the nominating committee.



Please change the spelling of name and hospital you have listed for the following:

Mary Ann Wethington, RN, ET
O'Bleness Memorial Hospital
Hospital Drive
Athens, Ohio 45701

****

The December 1979 issue of the Mideast Dropper printed a serious error. In the membership meeting minutes, it was stated that certification exam could be given anywhere any time. THIS IS WRONG. The exam must be given on the date and at the place designated by the testing corporation. Arrangements to have an alternate site on that same date are possible only if certain criteria are met and only if the testing corporation can make this accommodation.

We hope there will be many ET's at the Great Lakes Regional Conference, April 18-20, 1980, in Grand Rapids, Michigan. If you need more information, you can contact:

S.E. Buffin, LPN, ET
Program Chairman
Great Lakes Regional Conference
Ferguson-Droste-Ferguson Hospital
72 Sheldon Boulevard
S. E. Grand Rapids, Michigan 49502

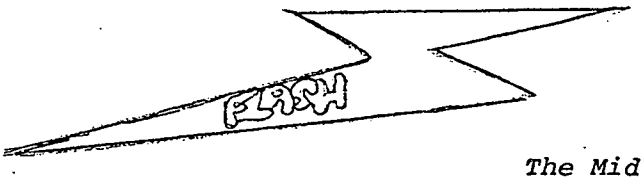
A big thanks to the members of the Mideast Region for the lovely graduation gift. This event was so special for me, my family, and my friends. Your unexpected good wishes and gift made it extra special. The briefcase is not only handsome, but very useful; please notice it at the conference.

Helen

****

A special thanks to everyone for your cards and prayers. I am doing better, but have a way to go.

Maude Timmons



The Mid-East Regional Conference October 31 - November 1, 1980. The program will be on "Skin Care" with an educational day October 31 for those E.T.'s who schedule ahead. .6 CEU's will be granted.

NEWSLETTER INFORMATION

Would you like to attend the I.A.E.T. Convention in Washington, D.C., but have no one to share a room with? If so, contact Nancy Rioux, R.N., E.T., at Grant Hospital, 309 East State Street, Columbus, Ohio 43215 with the following information and I will try to coordinate a convention partner for you.

Your Name:

Address:

Telephone #'s:

Hospital:

Telephone #:

Age:

Smoker Preference:

Non-Smoker Preference:

No Preference:

Date you plan to arrive at Hotel:

Date you plan to depart Hotel:

Please send this information on two 3 x 5 cards with a self-addressed and stamped envelope.

All plans should be completed by April 14.

Nancy Rioux

ARTICLE

"How to Cope When Your Patient Has an Enterocutaneous Fistula", by Evonne Fowler, Katherine Jeter, Arthur Swartz, AJN, March, 1980, pages 426-429.

MONTHLY MEETINGS HELP US GROW!

The E.T.'s in Columbus, Ohio have been meeting for Rap Sessions since 1975. Originally there were five, two of whom have been transferred out of town. We now have ten, nine are employed in hospitals and our latest E.T. is in Public Health Nursing and to whom we refer our patients when they are discharged from the hospital.

The agenda of our meetings may include bringing a patient who is difficult to manage whether to be fitting an appropriate appliance or baggin wound drainage, discussions with U.O.A. members to utilize each others' services, representatives from Ostomy Equipment Manufacturers, sharing IAET National and Regional conferences, inservice program ideas, slides, etc. We all feel we benefit so much from these rap sessions.

We are especially grateful that Barb Montgomery has shared her expertise with Op-Site. We hope you will plan to attend the Fall Regional Meeting in Columbus so you too can learn about this exciting new treatment for numerous skin problems. Watch for details in future newsletters.

Pat Hurd

"A NEW THEORY FOLLOWING CYSTECTOMY OR TOTAL PROSTECTOMY"

Dr. Andy Von Eschenbach, a urologist at M.D. Anderson, has been doing a study on patients who have cystectomies and total prostectomy and has found, contrary to established opinion, that when questioned 15% of the patients stated they were able to attain an erection and 53% said they were orgasmic after their surgery. He said that although we must tell them about the possibility of becoming impotent, that we should encourage them to try sexual activity as soon as they feel up to it. And that perhaps more men could have satisfying sexual relations than we have felt possible in the past, following these surgeries.

"A NURSES ROLE IN SEXUAL CONVERSATION"

Sex is not only fun but an intense biological need. It is an important factor in one's mental and physical well being.

Even without ostomy surgery, developing a satisfactory sex life is not always easy--for couples who did not get along well before ostomy surgery, this may only be an excuse to reduce or cease intercourse--but for couples who had a warm, loving relationship before surgery, are usually able to work out any sexual problems caused by surgery.

Also, in discussing possible sexual dysfunctions with our patients we may find that many patients are reluctant to open up such a discussion, because of their doubts, fears, and a sense of ignorance.

Specific questions may have to be asked to discover what a patient wishes to know and whether a sexual problem exists. If you are satisfied no problem exists, no further questions are necessary. However, only a rare person will not welcome a chance to voice what is on his or her mind without shame.

Many patients do not need indepth sexual counseling--they simply need someone to whom they can express their feelings and who can offer understanding and support.

Some reasons nurses become anxious and avoid discussion in sexual matters with the patients are:

1. *Fear of incrimination*
2. *Embarrassment*
3. *Confusion*
4. *Lack of knowledge*

To become prepared and comfortable, involves acquiring sufficient knowledge on the subject of sexual functioning. You must develop the ability to accept another's sexual beliefs, feelings and behavior. You must understand another's point of view as well as becoming fully aware of your own values and opinions regarding sex.

It's most important that the patient feel he has at least permission to discuss his sexual concerns within the nurse--patient relationship.

When giving information be sure to talk on the patient's level--you may have to use explicit sexual terminology whenever called for. Vague language may be unclear and hinder communication.

In asking questions, use open ended comments and a positive expression. Open ended questions require more than a one or two word response. Leading questions are non-therapeutic in any circumstance--it implies an answer the questioner wants to hear. Open ended questions neither demands a specific answer nor compels the patient to reveal information or discuss an event before he is emotionally ready to.

You must be able to deal with the patients' responses and that's very difficult at times--for you must be open, honest and non-judgemental.

All this is saying is to be aware of your limitations--you do not have to be a sexual counselor for the patient but you do have the responsibility to be aware of their concerns and give them permission to discuss and be able to feel free to ask you about their sexual concerns. All most patients need is someone with whom he can communicate.

Barbara Montgomery

The following is a brief bibliography list of sexual rehabilitation articles. If you are interested in a more complete list, let us know by sending a note addressed to the editors.

I. *General*

Dlin, Barney, M., Abraham Perlman, and Evelyn Ringold, "Psychosexual Response Ileostomy and Colostomy", American Journal of Psychiatry, Vol. 126, 1969, pp. 374-381.

Elder, Mary Scovill, "The Unmet Challenge...Nurse Counseling on Sexuality", Nursing Outlook, November 1970.

II. *Spinal Cord Injury*

Hanlon, Kathryn, "Maintaining Sexuality After Spinal Cord Injury", Nursing '75, May 1975, Vol. 5, #5, pp. 58-62.

Romano, May D., Robert D. Lassiter, "Sexual Counseling with the Spinal Cord Injured", Archives of Physical Medicine and Rehabilitation, December 1972.

III. *Additions*

Cole, T.M., "Sexuality and the Physically Handicapped", Human Sexuality: A Health Practitioner's Text. Richard Green, M.D. (Ed.) Williams and Wilkens Company, Baltimore MD, pp. 146-170.

Cole, T.M. and S.S., "A Guide for Trainers: Sexuality and Physical Disability", Program in Human Sexuality, University of Minnesota Medical School; Center for Continuing Education, Region V., Multi-Resource Center, Inc. 1976.

Cole, T.M. and S.S., "Sexuality: The Practitioner and the Patient: A Problem or an Opportunity", Highlights of the 20th Annual Conference, Veterans Administration Studies in Mental Health and Behavioral Sciences, Chicago, April 1975, pp. 83-91.

Lyons, Albert S. and Brockmeier, Marlene, "See After Ileostomy and Colostomy", Medical Aspects of Human Sexuality, January 1975, pp. 107-108.

Montague, Drogo K., "Sex After Cystectomy", Medical Aspects of Human Sexuality, December 1977, pp. 91-92.

Pattullo, Ann W., "The Socio-Sexual Development of the Handicapped Child--A Preventive Care Approach", Nursing Clinics of North America, Vol. 10, No. 2, June 1975, pp. 361-373.

Picconi, Jean, "Human Sexuality--A Nursing Challenge", Nursing, February 1977, pp. 72D-72M.

Romano, Mary D. and O'Connor, John F., "Sexual Needs of the Physically Handicapped", Medical Aspects of Human Sexuality, September 1978.

FILMS: Spinal Cord Injury

1. *Just What Can You Do? (16 mm, color, sound, 23 minutes).*
   Filmmaker: Laird Sutton; Production Consultant: Tom McIlvenna;
   Producer: Multimedia Resource Center 340 Jones Street, Box 439E San Francisco, CA 94102
   Subject: A discussion by three couples, one member of each couple being cord injured.

2. *Touching: (16 mm, color, sound, 17 minutes)*
   Filmmaker: Laird Sutton, Production Consultant: Tom McIlvenna;
   Producer: Multimedia Resource Center 340 Jones Street, Box 439E San Francisco, CA 94102
   Subject: Graphic film of C_6 (incompleted quadriplegic engaging in sexual activity with able-bodied partner.

3. *Psycho-Social Rehabilitation on A Spinal Cord Injury Service.*
   Filmmaker: M. Eisenberg and L. Rustad;
   Producer: M. Eisenberg, Spinal Cord Injury Service, Veterans Administration Hospital, 10701 East Boulevard, Cleveland Ohio 44106
   Subject: Illustration of a psychosocial rehabilitation program (filmed at VAH--Cleveland).

Op-Site

You've all been hearing about me using op-site and how pleased I am with it. I'd like to share some information and hints that may be helpful to you.

Barb

"Moist" wound healing--a new principle in wound healing has been verified by many, after years of studies on humans and pigs.

I've been using op-site here at O.S.U. over a year with excellent results, it is not the "answer" to all our problems but I've found it to be an excellent "helper".

What is op-site? It's a polyurethane dressing which acts as a "second skin" for covering wound and skin surfaces. It:

1. *Facilitates in re-epithelialization of injured tissue.*

2. *Protects a wound from secondary infection.*

3. *Prevents Skin breakdown over a pressure area.*

What are its advantages?

1. *Moisture vapor and air permeable which allows for moist environment yet prevents skin maceration.*

2. *Elastic so it conforms to body contours.*

3. *Transparent--allowing visibility to assess healing.*

4. *Adhesive to surrounding tissue isolation the wound from external contaminants, but does not adhere to the moist wound surface.*

5. *Water and bacteria proof--excludes water, bacteria, and dirt thus reducing chance of secondary infection and the patient is able to wash and bathe.*

6. *The wound is bathed in physiologic fluid--which facilitates patient's comfort reducing pain.*

Although op-site is an excellent surgical drape and post-op dressing, I've used it most on donor sites, venous stasis ulcers of both patients with P.V.S. disease and diabetics, abrasions and lacerations of renal transplant patients, 1st and 2nd degree burns, pressure sores, and as a skin protector prior to skin breakdown.

NOTE: Op-site is not a substitute for good nursing care such as turning, flotation pads, etc.

(Continued on next page)

The hardest thing to get used to, is the fluid collecting under the dressing. The fluid will discolor depending on the bacterial flora and may appear purulent. This is normal and need not be drained off unless the drainage is excessive as it may leak out the edges. The dressing does not need to be changed because of the drainage but I usually change it every 3-5 or 7 days depending on that particular wound. "But you do not need to change it just because it looks bad." NOTE: Most all wounds have colonized bacteria, and when you change the dressing you clean it with the appropriate solution, e.g. staph--betadine--pseudomonas 1/4% acetic acid solution and yeast-mycostation. But if clinical signs of infection occur (i.e. the wound becomes hot and inflamed, and the patient becomes febrile). You should change the op-site daily until the infection subsides.

I've found to help enhance adherence in irregular surfaces, I will apply a thin layer of tincture of benzoin to the surrounding area, and allow it to get tacky then apply the op-site. I may also border the edges with paper tape and also apply cornstarch lightly to the op-site and on the bed to help in movement of the patient over the bed linens.

More suggestions--there are many different sizes. If possible, use a size that allows 2" to 3" on all 4 sides to allow for the fluid collection. Be sure and shave surrounding skin if Hirsute--you may also need to defat the undamaged skin with alcohol or acetone.

There are a couple of MUSTS!!

1. Allow surrounding skin to dry thoroughly--it will not adhere to moist surfaces.

2. Use the "appropriate" number of people needed to insure an easy application. You may only need them for a couple minutes but you can't do the larger pieces alone--don't even try (the patient may help pull off the paper backing).

3. Be sure and document the date, location, size of wound, appearance of exudate (color and amount) and any infection control measures taken (culturing and cleaning of wound).

I can't help being excited about this dressing--the cost to the outpatient is so much less than a dressing changed 3 or 4 times a day (one of my patients was spending $5.24 a day and with op-site only $5.00 a week)--the time saved by the nurse and the significant decrease in pain for the patient and in "most" cases, the rapid healing that takes place. If I can help you in any way, please feel free to call me at (614) 422-6900 and have me paged.

6446 Hosp. op

Barbara Montgomery

E.T. IN PUBLIC HEALTH

I have recently completed an educational course at the Cleveland Clinic Foundation to become an Enterostomal Therapist. I am the first Public Health Nurse (PHN) in Ohio to become an E.T. and to be affiliated with a community health organization.

I became interested in the nursing care of ostomy patients during my student education. Later, as a PHN, I discovered that continuity of care between the hospital and the community could be improved and upgraded for ostomy patients. Since patients are discharged from the hospital earlier, there is a greater need for continuing nursing care to patients and teaching patients and their families in the home situation. There is also an increase in terminally ill ostomy patients who have chosen to die at home. Consequently, referrals for home health care from hospitals and physicians have significantly increased. The initial nursing assessment, plans, and objectives established in the hospital are often altered due to the home environment. Hence, I saw the need in my agency for an Enterostomal Therapist who could visit patients in their home. I provide nursing care to ostomates and offer consultation, joint visitation, and inservice education to staff nurses. I participate in community groups such as United Ostomy Association and American Cancer Society (Rehabilitation Team).

I maintain a patient caseload by providing nursing care to patients with ostomies, draining wounds and fistulas, and decubitus and related skin problems. By seeing the ostomate in his/her home environment, I counsel, advise, and instruct. This will contribute to the ostomates total and comprehensive rehabilitation which entails the physical, psychosocial, family, home, social and economic environment.

I have visited a total of forty-eight ostomy patients and six patients with a draining fistula or wound since I began serving in my new role as a PHN/ET in August, 1979. I have intermittently limited new referrals due to my high caseload. Henceforth, new referrals are given to staff nurses with E.T. consultation and joint visitation offered as the need arises. Due to the high number of ostomates referred, I have not had the time to offer service to patients who have decubitus and skin related problems.

I have found this new professional experience to be most challenging and rewarding. The nine other E.T.'s in Columbus have been most supportive and helpful in coordinating services for the ostomate.

Sandy Lovejoy, R.N., PHN, ET
Columbus Department of Health
Division of Nursing and
Rehabilitation

We would like to share ideas!! We all have expertise to share. Please help by sending questions and answers to Dear Ettie. Our address: c/o Barbara Montgomery, RN, ET or Betsy Hewitt, RN, ET, Room 221, University Hospital, 410 West 10th Avenue, Columbus, Ohio 43210. Let's keep "Dear Ettie" busy!!!

"Dear Ettie",

I have been working with the new hollihesive for the last several months--I have developed some ideas about the new product but I would like to hear your successes and failures. Can you help!

Signed,
Interested E.T.

"Dear Ettie",

I have had a reoccuring problem and I need your help.

I have taken care of a number of spinal injury patients with ileal conduits. Many of these patients have a strong persistent odor to their urine which permeates their clothing. I have tried vinegar, disposable bags, frequent changing, banish with poor results. Diluting the urine by forcing fluids does help but not enough. Help!

Signed,
Sensitive Nose

"Dear Ettie":

I need some new innovative ideas for the patient with badly irritated buttocks and rectal area from either rectal drainage or any other moisture source.

Besides routine helpers such as bagging, heat lamp, lomotil , Zinc Oxide, aluminum paste, op-site, mucolog, kenalog, etc.

Have you any soothing ideas?

Signed,

"Rear end helper"

"Dear Ettie",

We have been using Surfit appliances and have found with several of our patients who's stool is loose, that it will leak between the plastic ring and the wafer. Have you had this problem too?

Signed,

Leaky Wafer

Many people think that the future is a far-off, never-never land that has nothing to do with practical matters like earning a living or making a success of one's life.

But nothing could be further from the truth. <u>All of us are going-to spend the rest of our lives in the future</u>. So, if we want to be practical, we must focus our attention on the world of the future - not the past or even the present, for that too is largely beyond our power to change. Winston Churchill once stated that "If we open a quarrel between the past and the present, we shall find that we have lost the future."

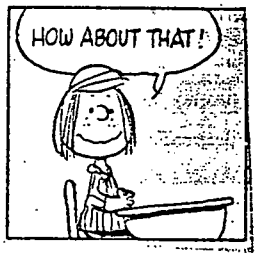
Whether the future turns out to be as bright as we hope depends upon our ability to understand a world of rapid change.

Four (4) categories of change have been identified. They are gradual change, revolution and major disruption, rapid change, and radical change. The I.A.E.T. has found themselves deeply involved in this change process. However, I think we have now entered an era of what might be called convulsive change. We are surviving these changes quite well and I feel we will continue to prosper, develop and improve our services to the membership because of our concern for the future.

Be a part of these changes. Plant a seed for the future and attend the 1980 I.A.E.T. Annual Conference.

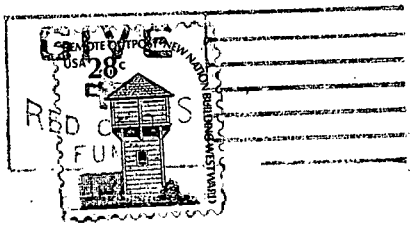
See you in Washington.

Sue Hughes, R.N., E.T.
Regional Trustee



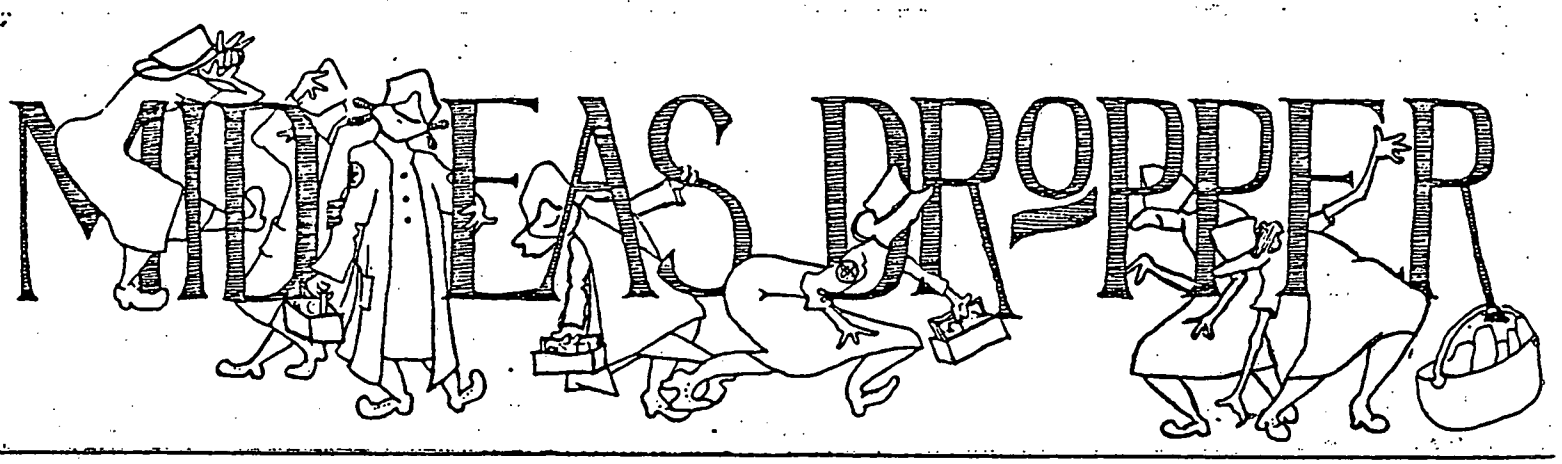
Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

COLUMBUS
OHIO



MAUDE B. TIMMONS, RN ET
5319 Velle Vista Drive
Louisville, KY 40272

FIRST CLASS



VOL. VI JUNE 1980 NO. 2

EDITORS

Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

Notice

MIDEAST REGION I.A.E.T. OFFICERS

PRESIDENT:	*Helen Arend*
PRESIDENT ELECT:	*Joyce Hawley*
SECRETARY:	*LuAnn Hartley*
TREASURER:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Jan Joseph* *Barbara Montgomery* *Betsy Hewitt*
COMMITTEES:	
Membership --	*Jane Beerck*
Budget & Finance --	*Jane Beerck*
Education --	*Jean VanNeil*
By-Laws --	*Jan Joseph*
Publication --	*Barbara Montgomery* *Betsy Hewitt*
HISTORIAN:	*Maude B. Timmons*
PARLIAMENTARIAN:	*Trudy Blied*
MEDICAL ADVISORS:	*Ananias C. Dickno, MD* *University Hospital* *Ann Arbor, MI*
	Victor W. Fazio, MD *Cleveland Clinic* *Cleveland, Ohio*
	W. Patrick Mazier, MD *Ferguson Clinic* *Grand Rapids, MI*
	Joseph Rinaldo Jr., MD *Providence Hospital* *Southfield, MI*

MESSAGE FROM THE PRESIDENT

What a great conference Washington was! Every year seems to be better than the last.

I'd like to pass a few points of information for the benefit of those who could not attend.

There were 450 individuals registered for the Washington conference. As of April, 1980, the total membership of the I.A.E.T. was 1062.

On Wednesday, May 21, 150 members took the certifying exam. Among those were quite a few Mideast Region members. Congratulations, all.

Fred Droz, the executive manager of I.A.E.T. talked of building for organizational growth. Some projects in the works are a new E.T. booklet for public education and a new accounting system which will change billing times to save money.

The annual conference time will be changed to June starting in 1982 in New York. Hotel and other costs will be less at that time than in May.

Any of you who have not filled out the blank in the E.T. Journal should do so to be included in the stoma directory which is being compiled. It is not necessary to have a formal stoma clinic to be included in the directory.

Problems with compiling data from the annual forms sent by I.A.E.T. to each member have caused a discontinuation of that program for the present. Anyone with ideas for data collection should contact the national executive board.

The Washington division of the A.C.S. is distributing two handouts which were developed by E.T.'s "Traveling with Ease", and "Nutritional Hints for Ileostomates". Contact your local A.C.S. chapter for details of obtaining.

The Information and Research Center of the N.I.H. is actively promoting research in digestive diseases. This year ten million dollars has been allocated for that purpose.

We have the services of an attorney available to us for legal questions and consultation. Any inquiries in this area should be channeled through Fred Droz.

Press release forms for local use are available from I.A.E.T. office.

The E.T. Journal editor, Victor Alterescu, reported that they are looking for new publishers and new manuscripts and hope to get included in the Index Medicus.

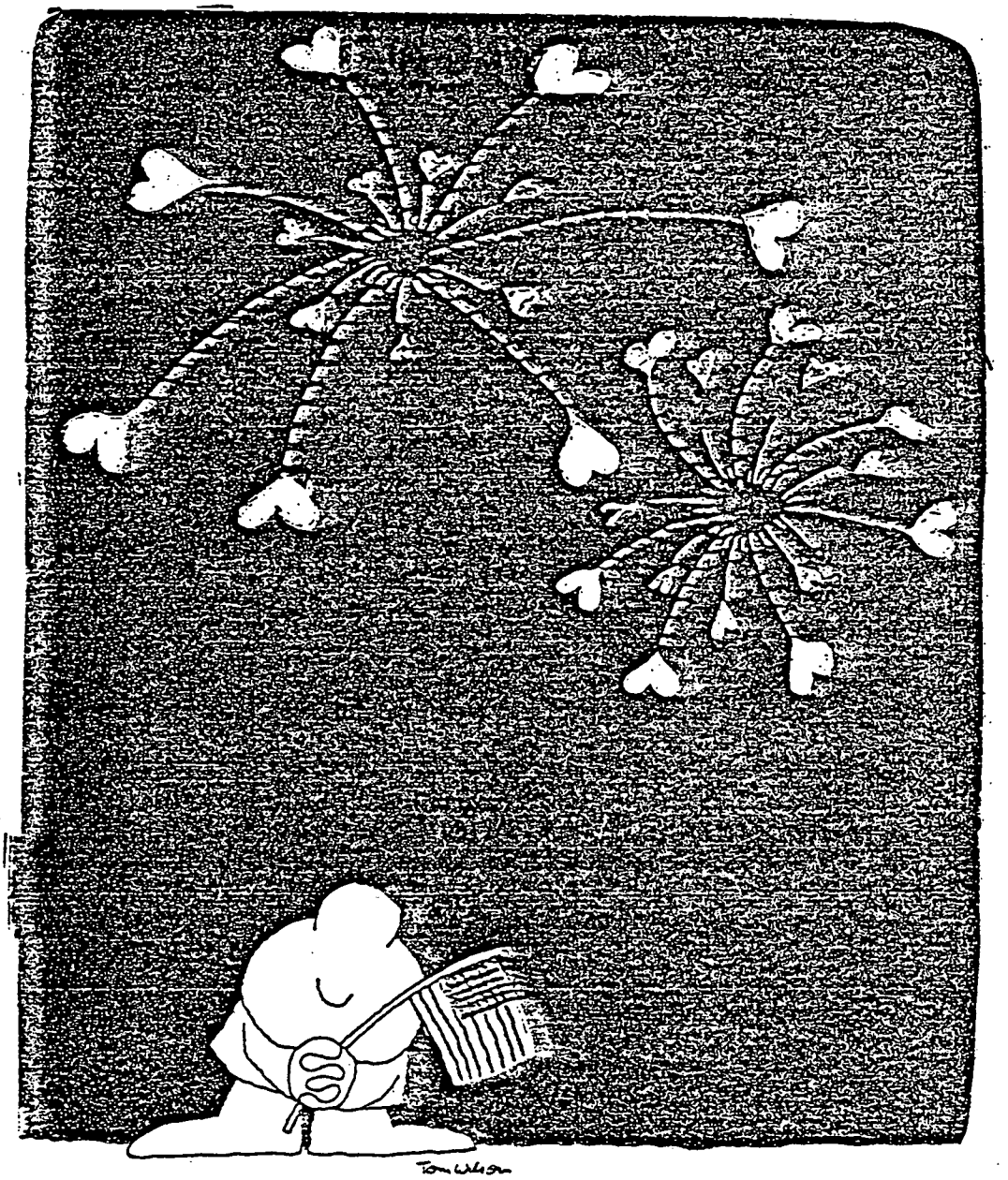
MESSAGE FROM THE PRESIDENT (Con't)

The I.O.A. held their annual conference in Washington immediately after the E.T. conference. Reports from that activity are very interesting. One E.T. found herself on a panel with four individuals who spoke only French, Spanish, and Italian. Some of us have enough trouble holding up with only one language.

Those people who have told me that they will help at the W.C.E.T. conference will be getting a letter soon. If you want to help and do not get contacted by June 31, please contact me.

Happy summer months to you all,

Helen Arend



EDITOR'S NOTE

Barb and I were fortunate enough to attend the IAET Conference in Washington D.C. We would like to thank this year's participants for an outstanding program.

We will be happy to print any information the members feel was especially informative at the Conference.

We are looking for volunteers to write short summaries of the various presentations. I especially felt the address by Delegate Goldwater on "Nurses in Politics" raised many controversial issues. I believe the political arena is an area we should pursue so as not to be left out when decisions are being made as to the future of nursing.

Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET

NEW ARTICLES

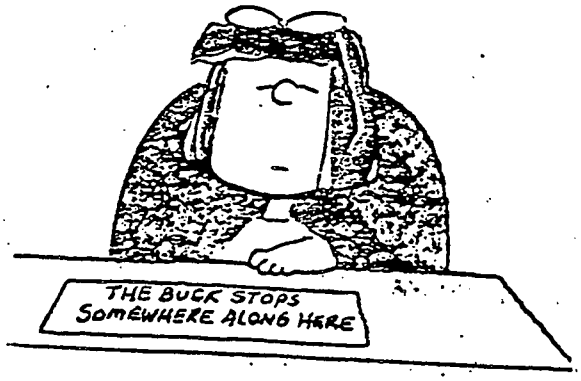
1. "How to Help Wound Healing in Your Abdominal Patient", Delores Schumann, R.N., M.S., April, Nursing 80, page 34-40.

2. "Are You Prepared for your Ulcerative Colitis Patient?" Kristine Konner, R.N., B.S.N., April, Nursing 80, pages 43-46.

3. "The Story of Melissa's Surgery: An End to Ulcerative Colitis", Martha Craft, R.N., M.A., Beverly Folkedahl, R.N., B.S.N., April, Nursing 80, pages 46-50.

4. "The Human Side of Assessment," Jane Farrell, R.N., B.S.N., April, Nursing 80, pages 74-76.

5. "Wound Healing--Intraoperative Factors", Judith Besst, R.N., M.S., Helen Wallace, R.N., M.S., Nursing Clinics of North America, Volume 14, No. 4, December, 1979



Again let me remind you of our Mid-East Reg. Skin Care Workshop. An Educational Day will be here in Columbus, October 31, 1980.

The educational day will be Friday with our business meeting and sharing of ideas on Saturday morning. Suzanne DiMascio Joyner, Shirley Gibbs, Katherine Jeter, Barb Montgomery and the other E.T.'s in Columbus will be presenting.

I hope we can look forward to seeing you all in Columbus.

We mentioned in our last newsletter that the E.T.'s in Columbus have a monthly meeting (their are 10 of us). This is a good time for sharing ideas and problem solving. I'm sure there are other groups who do the same--we would love to hear from you and find out what you're doing.

Barb and Betsy

6. "The New Tube Feeding Sets: A Nursing 80 Product Survey", Mary Hoppe, R.N. B.S.N., March, 1980, pages 79-86.

7. "Interventions that Promote Dec bitus Healing", Marcia Blechery, Current Practice in Nursing Care of the Adult, Kennedy, M.S. Pfiefer, G.M., C.V. Mosby, St. Louis, 1979.

8. "Meeting the Challenge of Fistulas and Drainage Wounds", Sister Virginia Taylor, R.N., M.S.N., June, Nursing 80, pages 45-51.

ABOUT THE ARTIST

LPN/Artist Creates Humorous Sketches

Most of us doodle now and then, but the end product is seldom very meaningful or even attractive.

When Becky L. Feigle, L.P.N. doodles, people not only appreciate her lively sketches but realize she has an innate talent as an artist.

Recently nurses from surgical units used Becky's drawings of characters portraying various hospital roles on a promotional sheet distributed to nursing seniors at the January job fair, sponsored by the Recruitment and Retention Committee in conjunction with Nursing Administration.

Becky has illustrated another promotional brochure for a musical group performing in various clubs throughout the U.S. She is also illustrating a children's book being written by a friend.

At the OSU Hospital Employee Arts and Crafts Show last year, Becky won first place in graphics, second and honorable mention in black and white photography, and first in color photography. Although pencil is her favorite medium, Becky designs with ink and paints with watercolors.

(About the Artist Con't.)

Most of her work is created "at home, sitting on the couch, listening to music." A bass fiddler with a family old-time string band in Chardon, Ohio, she delights in sketching musicians with their instruments.

We wish to thank Miss Becky L. Feigle for the lively sketches she did for our MID-EAS DROPPER. Becky recently resigned as an LPN here at The Ohio State University Hospitals and is doing art work at her home. Anyone wanting to contact her at home the phone number is: 216-286-3664. Her home address is P.O. Box 637, Chardon, Ohio 44024

E.T. Corner

We want to welcome to our membership Betty Sinclair, RN, ET, who graduated from the Enterostomal Therapy Education Program on March 20, 1980. Her address for both home and work are listed below:

Home: *2828 Meadowwood Drive*
Toledo, OH 43606

Work: *Saint Vincent Hospital and Medical Center*
2213 Cherry Street
Toledo, OH 43608

SOCIAL

IMPORTANT ADDRESSES AND PHONE NUMBERS

Bonnie Bolinger, President of IAET
52 Terrace Park Boulevard
Brookeville, Ohio 45309
513-833-3258

IAET National Headquarters
714-541-5227

12th ANNUAL IAET CONFERENCE

The 12th Annual IAET Conference was held from May 22 to May 24, 1980 in Washington, D.C. The Mid-Atlantic Region hosted this year's conference. The theme was 'Our Purpose, Our Commitment--Quality of Patient Living'.

A record crowd of over 450 persons attended this year's conference. The certification exam was given on May 21, 1980, with approximately 100 ET's taking the exam in Washington, D.C.

The lecture sessions were very interesting, with a wide variety of current topics of interest to the E.T. The choice of topics ranged from "Understanding Research and Statistics" to "Update: Koch Pouch" and "Writing for Publication" to "Homosexuality and the Ostomate", to name a few.

In addition to attending an informative and well-planned conference, conference goers had the pleasure of being in our nation's capital. There was never a dull moment between attending the conference and finding enough time to see all of the magnificent sightseeing.

Karen Granby, R.N., E.T.
Miami Valley Hospital

On January 24th - 26th, I attended a meeting of The Federation of Specialty Nursing Organization in Louisville, Kentucky. Representatives from IAET were the hosts. Bonnie Bolinger presided over the entire meeting and did a great job. Deborah Broadwell, ANA Liaison, and Sue Hughes, Mid-East Region Board Trustee, are our representatives. Those in attendance were: Fred Droz, our Executive Director of IAET, Past President, Betty Jackson and Deborah Broadwell. Unfortunately due to a family illness, Sue Hughes was unable to attend.

If my records are correct, we had 20 groups represented (R.R., O.R., Anesthesia, Neuro, Oncology, etc.).

A comment was made by a nurse during the meeting that "they did not want any group patterning themselves after the National group". Apparently this comment resulted from the fact that the Ohio group wrote letters requesting assistance from National on how to develop their organization.

I did not understand a lot of the politics but I hope to help our group by sharing ideas and our knowledge with the other specialties.

Fred Droz will send me minutes of any other things we need to know. I'll share these with you.

Thanks, etc.

Margaret Milem, RN, ET

The following is an article published in the February, 1980 issue of Nursing 80 we thought might be of interest to you. Reprint from Northwest Notes, March issue.

WHY PURPLE URINE BAGS?

I work at an extended care facility, and recently we noticed that several patients' urinary catheter bags had turned purple. We sent the bags to our laboratory, but no significant abnormalities showed up in either the urine or the bags. Can you shed some light on this mystery?

--Regina Shatner, RN, Milwaukee

Over the years, nurses at our hospital have occasionally reported purple urine bags. But recently, when we came across 12 patients in 4 months whose bags had turned purple, we decided to see what patient characteristics or laboratory findings might account for the phenomenon.

The age, sex, and race distribution for the 12 patients was not statistically significant because it correlated well with the total hospital population of patients with urinary catheters--about 120 patients out of 1,000. Though all 12 patients had chronic constipation, we found no common dietary or drug factors.

Neither could we established a correlation with the catheter type or the length of its use.

We were surprised that none of the tested urines grew Pseudomonas. So the pigments fluorescein and pyocyanin, as suggested by earlier researchers, seem unlikely to have caused the discoloration. Also, we found no traces of indican in the urine samples, even though other researchers have hypothesized that indican in the urine causes the color change.

We did, however, find Protens or Providencia in 11 of the 12 samples. In our hospital on any given day, only about 40% of the urines from patients with urinary catheters will grow these organisms. These closely related organisms may interact somehow to produce the purple.

Unfortunately, the exact cause for the purple pigment production continues to elude us. Perhaps other readers can furnish some clues to this mystery.

--Shashi K. Agarwal, MD
Marian R. Ginsberg, RN, BS
Bergen Pines County Hospital, N.J.

"Dear Ettie":

1. *On Hollihesive, we have had a case of sensitivity reported on one of our patients. Has anyone else? I solved another by using skin prep underneath.*

2. *On the spinal injury patients, try by mouth Pedmauth capsules or liquid for deodorizing. The P.D.R. will have the dosage etc. Wyeth Laboratories, I believe.*

3. *On the Sur-fit applicance for the ileostomy patient, the Sur-fit must fit exactly as fitting a stomaplate. If a stoma measures 1", if the plastic ring is larger than 1 1/8", and if the abdominal area is soft, most probably the Sur-fit will leak. The same as with the Hollister. The plastic ring makes a firmness. And if the firmness is not near the stoma, then there is leakage.*

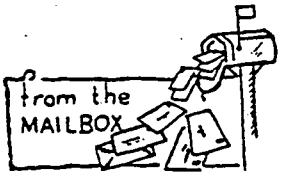
Norma N. Gill, ET

"Dear Ettie":

Helpful Information When Irrigating with the Sur-Fit Applicance

Many colostomy patients like the new Sur-Fit (Squibb Co.) pouches. Some of the patients irrigate on various schedules and still need a pouch between times. We tried different sleeves on the wafer but ended up with leakage during the irrigation or dislodging the wafer as the sleeve was removed.

We have made our own irrigation sleeve that fits on the bushing of the Stomahesive Sur-Fit Wafer. Divide the front from the back of the Sur-Fit pouch the patient normally wears. Discard the front half and retain the back half that contains the flange. A Coloplast irrigating sleeve may then be adhered to the flange half of the pouch. This "sleeve" may then be "snapped on to the Wafer and the colostomy irrigate in the usual manner.



"Dear Ettie" (Con't.)

When the procedure is finished, the sleeve is easily removed and the patient's regular Sur-Fit pouch is snapped onto the Wafer. The "sleeve" may be washed and reused many times before a new set-up is needed.

We were using a 1 3/4" pouch and wafer, but feel this could be adapted to other sizes.

Jane Beerck, R.N., BS, ET
and
Ellen Gebhart, BSN

NOTE: Surfit is testing an irrigation sleeve that fastens right onto their wafer. We'll be looking forward to trying it out.

Dear "Ettie":

This is in response to the inquiry from "Rear End Helper".

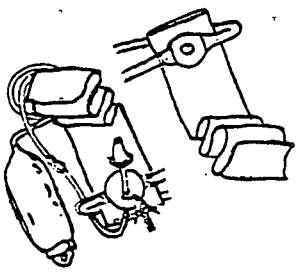
She wanted to know if anyone else had a routine that helped sore bottoms. We have found the following to be very effective:

Clean area with Uni Wash, rinse and apply Uni Salve. It is very soothing. (These are United Products).

If your hospital stocks Sween products you can use Peri Wash and then Peri Care to accomplish the same thing.

This is not an endorsement of either product. It has been found that patients get relief with this routine.

Liz O'Connor
Silver Spring, Md.



Dear "Ettie":

The Bard Company has assured me that its new skin barrier does breathe under the op-site and we have now used it under the op-site on patients who might have had a problem with the tincture of benzoin or on the patients who are diaphoretic and it seems to stay 24 hours or more.

Our hyperal nurse has also used this on several of her patients who were also diaphoretic and was pleased with the results as the dressing stayed on 3 days.

Barbara Montgomery, R.N., E.T.

PUBLICATIONS OF INTEREST (contributed by Susan M. Currence, RN, ET, St. Joseph Hospital, Towson, MD.)

Correlating Stress and Cancer: Seyle, 'American Journal of Proctology', Gastroenterology & Colon/Rectal Surgery, Vol. 30 #4, 1979 pp. 18.

Cancer Statistics--1980; 'CA-A Cancer Journal for Clinicians', Silverberg, Vol. 30 #1, 1980, pp. 23.

Urologic Manifestations of Regional Enteritis; Greene, McLeod, Mittemeyer, 'The American Surgeon', Vol. 45 #12, 1979, pp 802.

Acute Effect of Diphenoxylate Atropine (Lomotil) in Patients with Chronic Diarrhea and Fecal Incontinence; Harford, Krejs, Santa Ana, Fordtran, 'Gastroenterology', Vol 78 #3 1980, pp. 440.

Applying Orem's Self Care Theory in Enterostomal Therapy; Bromley, 'American Journal of Nursing', Feb. 1980, pp. 245.

Human Sexuality: 'Topics in Clinical Nursing', Vol. 1 #4 1980.

Entry Into Practice: Progress Report; 'The Maryland Nurse', Feb. 1980, pp. 17.

Drug Therapy in Cancer Pain; Lipman, 'Cancer Nursing', Vol 3 #1 1980, pp. 39.

Cancer and Suicide: 'Cancer Nursing', Maxwell, Vol 3 #1 1980, pp. 33.

CANCER SCREENING

Last Saturday we completed the Second annual Cancer Screening for employees and family members at The Ohio State University Hospitals.

One year ago, I developed the first comprehensive Cancer Screening at our hospital. The program was structured in two parts--the physical exam and the self-teaching program. The physical exam was performed by staff physicians (surgeons, urologists, gynecologists, oncologists and Cancer Fellows). The exam included oral, head, neck, skin, breast, lymph nodes, abdomen, rectum, vaginal, and prostate. A blood specimen for CEA was also drawn.

Following the physical, the employee was offered teaching modules on self-breast, testicular exam and hemocult testing. After the instruction, printed material was provided for home reference.

At first, I though developing a program of this magnitude would be a monumental task. Instead, I found that all the resources were readily available waiting to be tapped.

I had many volunteers which included staff nurses, clinical specialists, physicians, secretaries, etc. (of course, some needed a gentle nudge).

We had the facility and essential equipment supplied by the hospital.

The Ohio Chapter of the American Cancer Society was of tremendous help by providing unlimited pamphlets, films on self-exams, volunteers and the hemocult slides.

The eight physicians examined six hundred and eighty-seven employees and family members. We referred approximately one hundred and twenty people for further follow up. These people were not all referred for suspect cancer. Among the demonstrated findings were: recurrent cervical cancer, prostate tumor, skin lesions, vaginal infections, and abdominal aneurysms.

I felt this was a tremendous, rewarding pilot program. The response from the employees was very positive. It also gave the volunteers who have a special interest in cancer a shared experience bringing us closer together as a health care team.

As all good promoters should, I turned over this year's chairmanship to our 2 oncology nurses. They have continued to improve on the original program.

I urge you to attempt such a program in your community. I will be glad to supply details to anyone interested.

All it takes is the enthusiasm to make it happen!

Betsy Hewitt, R.N., E.T.

OUTREACH 1980

The IAET Outreach 1980 was held June 11, 1980 at the Terrace Hilton in Cincinnati, Ohio. The program, "Nursing Care for Patients with Ostomies and Draining Wounds" was attended by 86 nurses and E.T.'s from several states.

Bonnie Bolinger opened the program and intrc ducted all the E.T.'s in attendance. Sue Hughes (Jewish Hospital, Louisville, Kentucky), Betty Girth (Bethesda North, Cincinnati), Mary Lou Walker (Christ Hospital Cincinnati) and I attended as official representatives of the Mideast Region. There were several other regional E.T.'s there.

The purpose of the program was certainly met by the excellent speakers. I'm sure all in attendance left better acquainted with the newest management techniques and nursing intervention for patients with ostomies and draining wounds.

Phyllis Metcalfe from Hollister runs a well organized program. The E.T. faculty were excellent.

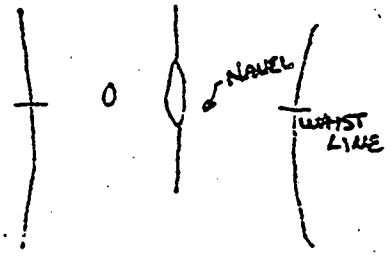
It was a day well spent.

Joyce Hawley, R.N., E.T.
President Elect--Mideast Region

CASE PRESENTATION
Reprint from Midwest Update
OP-SITE Successful for Fistula Care

Mary Brown, RN, ET
Providence-St. Mary's Hospital
Kansas City, Kansas

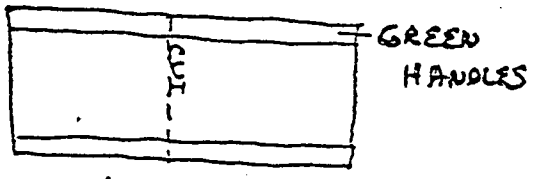
A 72 year old lady developed a subcutaneous fistula after incision and drainage of an abdominal abscess one year following cholecystectomy. The fistula developed in the midline incision and in the drain site.



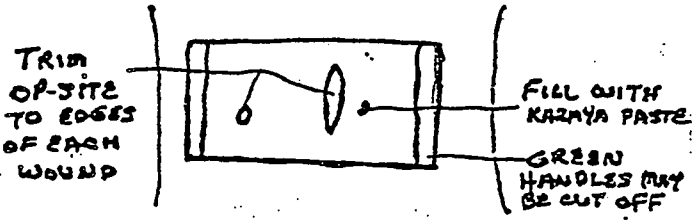
Initially, to contain drainage, we used Karaya Paste, 1/2 of an 8 x 8 Stomahesive and an extra large Bongort drain. The average length of time the seal would last was 24-48 hours. Sometimes it did not hold as long since the patient was receiving Physical Therapy BID, was sitting in a chair TID and the fistula was in the waistline. We decided to try Op-Site as an alternative (it had the added benefit of being less expensive).

Instructions to nursing staff were as follows:

-*Cleanse skin thoroughly, rinse well*
-*Dry skin completely*
-*Fill navel with Karaya Paste to make a flat surface*
-*Cut a 30cm x 28cm OP-SITE in half being sure to cut so that green handles are on both ends.*

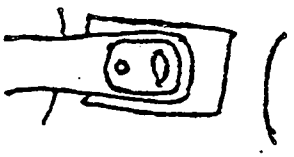


-*Peel protective paper away by grasping green handles on one end and peeling carefully (be careful not to let OP-SITE stick to itself - it will not come apart).*
-*Anchor OP-SITE about three inches to the right of the navel before removing all of the protective paper. Smooth over wound and surrounding skin and be sure drain site is also covered.*



-*Prepare Bongort drain to cover wound and drain site. May use regular size Bongort #1117 or Large Bongort #1085. If regular Bongort is used, need to bag both areas separately.*

-*If large Bongort is used, may bag both areas together.*



The OP-SITe helped to extend wearing time to four days average. The cost comparisons are:

Stomahesive - $18.60 per box of 3 6 applications per box $3.10 per application.
OP-SITE - $31.30 per box of 10 sheets 20 applications per box; $1.56 per application

An ostomy is not the end of living; it is simply living with a new end in view.

Golden Gate Chapter
San Francisco, CA.

The article below is from a section of the March UOA Newsletter written by Susan E. Buffin, LPN, ET at the Ferguson-Droste-Ferguson Hospital in Grand Rapids, Michigan.

While grabbing a quick supper with a few of the 1980 Conference committee members the other day, I heard something that made me think (just a little thought). "For the first time in weeks we are in the minority." It seems that out of 5 people only 2 were ostomates. In that statement I felt there had to be food for future thought. I'd like to share it with you. The first point to consider is the word MINORITY. I don't consider this a negative thought. In order to be a member of a minority, there has to be other members. I'll bet I have heard over 100 new and future ostomates relate feelings of being "alone," "the only person who has had this happen," "being different", etc. etc. with approximately 2000 ostomates being in Grand Rapids alone, I think we better ask, "Why do these people feel alone."

The first and most obvious reason is that they are unaware of the large number of people who have had ostomy surgery. A large number of new ostomates discover they have been working with, acquainted with, or living next to a veteran ostomate for years without being aware of it. Well there is no reason to wear a sign telling the world your medical history and surgical experiences. Can you tell me how many people you know by name and/or occupation who have had their gall bladder removed? You don't run into too many door to door surveys asking "Is your bladder missing" or "Has your colon, or any portion of it, been removed?" There is no reason to question these things and that may be the only logical reason for an ostomate to feel like he is alone.

Among all the other reasons, of course, is the part of the world we live in. About the time they were burning witches in Salem, someone came up with the brilliant idea you had to have one bowel movement a day "to rid yourself of the impurity your sins created." I suppose since everyone wanted to get to heaven the first laxative was invented. Since that time, we have thought of bowel functions as something "I don't want to talk about," as seen on national T.V. Our mothers convince us that unless we are toilet trained, we are bad kids but when we do accomplish our first solo flight in the bathroom, we can't run to the neighbors and brag about it. Now, this must mean it is a good thing no one else is supposed to know about. Is it any wonder we don't want anyone to know we have the new and revised edition of the old disposal system? For some people this has got to have deep meaning and create a few problems with acceptance of an ostomy. This could be the toughest hurdle to get over because we don't know why we feel that way, but we do.

Only a few years ago, the national television networks refused to allow a show on ostomates to be shown. They said the public wasn't ready for it yet. It seems ironic to me that we were ready for "violence" and "high sexual content" but not ready to learn of the life saving surgical procedures that were available. Not to mention letting people know not only what an ostomy is but also that it is something that is done to improve and save life. Were they afraid that someone might find out an ostomate can lead a normal and productive life if given proper management techniques and equipment?

Yes. I suppose ostomates are in a minority. But it is a minority I'd be proud to join. If becoming a member of the group means I have been given a second chance at life, or a better quality to the life I have left, or getting rid of a dangerous and malfunctioning part of my body I didn't need in the first place, then I'll joint that minority group anyday. I may not always be overjoyed about the dues I pay but the fact I'm here to do so and the fact "I'm not alone" can more than make up for the minor inconvenience.

W.C.E.T. CONFERENCE

The third annual World Conference of Enterostomal Therapists is being held in Cleveland, Ohio on August 10-14, 1980. This promises to be the greatest meeting ever. An outstanding group of international speakers will be doing the presentations. The following is a condensed portion of the final program.

This is an opportunity for us to share ideas with E.T.'s from England, Australia, Italy, Sweden, France, etc.

If unable to attend the entire workshop, special arrangements can be made through creative travel for either Tuesday or Thursday. The Tuesday program is open to only Enterostomal Therapists but Thursday program is open to nurses and E.T.'s. If at all possible, it should be a must as an educational opportunity.

FINAL PROGRAM OF WORLD COUNCIL OF ENTEROSTOMAL THERAPISTS
August 11-14, 1980, Cleveland, Ohio
"FOCUS ON THE ENTEROSTOMAL THERAPIST"

Sunday, August 10, 1980 -- Marriott Inn

12:00 - 9:00 P.M.	-	Registration

Monday, August 11, 1980

8:00 - 9:00 A.M.	-	Manufacturer representatives to show products (10 minutes each)

PROGRAM P.M. -- BUSINESS MEETING--W.C.E.T. MEMBERS ONLY

2:00 - 4:00 P.M.	-	NOMINATION OF OFFICERS

EVENING

8:00 - 9:00 P.M.	-	"OLD WEST" BARBECUE--Dancing

Tuesday, August 12, 1980 -- CLEVELAND CLINIC FOUNDATION

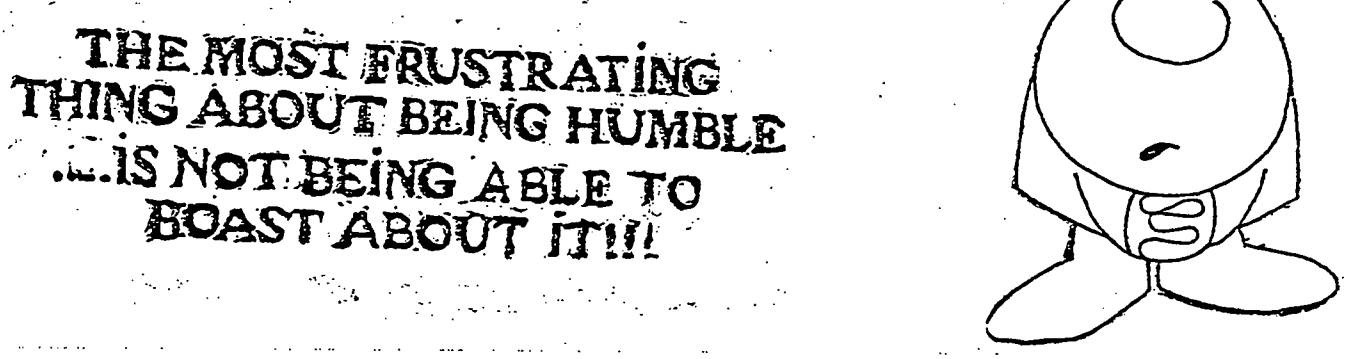
THEME: "The Expanded Role of the Enterostomal Therapist"

PROGRAM A.M. MODERATOR: Victor W. Fazio, M.D.

9:00 - 9:10 A.M.	-	"Familial Polyposis Coli: The Controversy in Treatment"--D.G. Jagelman, MS (Long.) FRCS (Eng.), FACS
9:10 - 9:40 A.M.	-	"Reconstruction of Over One-Hundred Defective Conventional Ileostomies"--Professor JC Goligher
9:40 - 9:55 A.M.	-	"Side Affects of Radical Colon Surgery"--Professor Dr. Med. H. Kivelitz
9:55 -10:05 A.M.	-	"Stoma Complications for Enterostomal Therapists and Surgeons"--Ian C. Lavery, M.D.
10:05 -10:35 A.M.	-	PANEL OF ABOVE SPEAKERS
10:35 -10:50 A.M.	-	Coffee Break
MODERATOR: Frank L. Weakley, M.D.		
10:50 -11:00 A.M.	-	"Post-operative Care and Skin of the Loop Colostomy"--Pavle Kosorok, M.D., M.S.
11:00 -11:05 A.M.	-	Questions
11:05 -11:20 A.M.	-	"Ostomy Care from Viewpoing of the Gastroenterologist"--Professor F. Halter
11:25 -11:40 A.M.	-	"Delayed Maturation of the Colostomy"--Professor G. Guillemin
11:45 -12:00 Noon	-	"Continent Ostomy by Free Smooth Muscle Transplantation"--E. Schmidt, M.D.
12:05 - 2:00 P.M.	-	LUNCH AT HOFBRAU HOUSE

PROGRAM P.M. MODERATOR: Ian C. Lavery, M.D.

2:00 - 2:20 P.M.	-	"The Unhealed Perineal Wound Following Proctectomy"--Frank L. Weakley, M.D.
2:20 - 2:45 P.M.	-	FILM: "Loop-End Myotomy Ileostomy in the Obese Patient"--Rupert B. Turnbull, Jr., M.D.
2:45- 3:05 P.M.	-	"Results of Surgery for Cancer of the Large Bowel"--Professor E.S.R. Hughes
3:20- 3:40 P.M.	-	"How to Teach Stoma Therapy to a Surgeon"--Ira J. Kodner, M.D.
3:40- 7:40 P.M.	-	"Sexual Adaptation of the Ostomy Patient"--Mary Van Versteeg, R.N., M.S.
4:40- 8:00 P.M.	-	"The Role of the Enterostomal Therapist in Sexual Adaptation--Dorothy Rodriguez, R.N., M.S., E.T.
8:00 - ?	-	Manufacturers Hospitality Suites Open.



Wednesday, August 13, 1980 -- MARRIOTT INN

THEME: "PROGRESS OF CARE FROM MY HOMELAND"

8:00 - 9:00 A.M.	-	Exhibits Open. A Representative from each country should give a report of the progress of their country.
9:00 - 9:20 A.M.	-	YUGOSLAVIA--Pavle Kosorok, M.D., M.S.
9:20 - 9:30 A.M.	-	ENGLAND--Ann Leedham, S.R.N., E.T.
9:30 - 9:40 A.M.	-	AUSTRALIA--Nonie Collins, S.R.N., E.T.
9:40 - 9:50 A.M.	-	UNITED STATES--Bonnie L. Bolinger, R.N., E.T.
9:50 -10:00 A.M.	-	CANADA--Marie Burroughs, R.N., E.T.
10:20 -10:30 A.M.	-	JAPAN--Taiso Tamura, M.D., E.T.
10:30 -10:40 A.M.	-	INDIA--Report given by Norma N. Gill, E.T. for Anjali Patwardhan, R.N., E.T.
10:40 -10:50 A.M.	-	FRANCE--Suzanne Montandon, R.N., E.T.
10:50 -11:00 A.M.	-	SINGAPORE--Margaret Liew, R.N., E.T.
11:00 -11:10 A.M.	-	SWEDEN--Inger Palselius, R.N., E.T.
11:10 -11:20 A.M.	-	GERMANY--Dagmar Link, R.N., E.T.

EARLY EVENING

5:00 - 5:15 P.M.	-	"Sexuality/The Physically Handicapped and Stomas" --Mary Josephine Kroeber, F.C.N.A., B.A.
5:15 - 5:30 P.M.	-	Marilyn Spencer, L.P.N., E.T.
5:30 - 5:45 P.M.	-	"The Sexual Problems of the Male Patient After Ostomy Surgery"--Bart Tappe, R.N., E.T.
5:45 - 6:00 P.M.	-	"Irrigation of Colon Via the Perineal Route for Faecal Incontinence"--F. McInerney, SRN, SCM, ET
6:00 - 6:15 P.M.	-	"The Use of Silastic Foam"--Robyn Shell, SRN, ET
6:15 - 6:30 P.M.	-	"The Role of Stoma Therapy in Gynecological Cancer"--Priscilla J.d'E. Stevens, SRN, ET

Thursday, August 14, 1980 -- MARRIOTT INN

PROGRAM A--LOCAL NURSES AND USA ENTEROSTOMAL THERAPISTS -- THEME: "WE SHARE"

8:00 - 9:00 A.M.	-	Exhibits Open. MODERATOR: Trudy Blied, RN, ET
9:00 - 9:30 A.M.	-	"Basic Colostomy Care"--Jean W. Fitzgerald, RN, ET
9:30 - 9:50 A.M.	-	"Basic Ileostomy Care"--Susan Buffin, LPN, ET
9:50 -10:10 A.M.	-	"Basic Urology Care"--Bonnie Bolinger, RN, ET
10:10 -10:30 A.M.	-	"TESTIMONIALS--E.T. Effectiveness"--Chairman: Brenda Stenger, ER, ET; Panel: John Velardo, Ostomate and Anita Wulf, Ostomate
10:45 -11:05 A.M.	-	"Basic Fistula Care"--Bonnie Blackburn, RN, ET
11:05 -11:20 A.M.	-	"Nutritional Needs of the Ostomate"--Frances J. Tyus, R.D.
11:20 -11:40 A.M.	-	"The Beginning of Ileal Conduit Surgeries in Arkansas"--Ralph A. Downs, M.D.
11:45 -12:00 Noon	-	"The Enterostomal Therapist--A Clinical Nurse Specialist"--Genevieve Thompson, RN, ET

PROGRAM P.M. MODERATOR: Joyce Hawley, R.N., E.T.

2:00 - 2:20 P.M.	-	"Interpersonal Skills--The Essence of Sharing and Caring"--Katherine F. Jeter, E.T.
2:20 - 2:40 P.M.	-	Victor W. Fazio, M.D.
2:40 - 3:00 P.M.	-	"Grafting of the Perineal Wound"--Janet M. Blanchard, M.D.
3:00 - 3:20 P.M.	-	Phillip Nasrallah, M.D.
3:40 - 4:00 P.M.	-	"The Surgeons Role in Professional Education"-- Ira J. Kodner, M.D.
4:00 - 4:15 P.M.	-	"Information vs. Education"--Joan Van Niel, R.N., B.S.N., M.A., E.T.
4:30 - 4:45 P.M.	-	"Vaginal Displacement After Proctocolectomy"-- Leif Hulten, M.D.
4:45 - 5:00 P.M.	-	"Self-Defense of the Ostomate"--Helen Arend, R.N., E.T. and Trudy Blied, R.N., E.T.

PROGRAM B - W.C.E.T. MEMBERS

ELECTION OF OFFICERS -- W.C.E.T. MEMBERS

AFTERNOON SESSION LIMITED TO 90 PERSONS, ONLY. W.C.E.T. MEMBERS--TICKET REQUIRED--CHOICE OF THREE (3)

THEME: "THE NEVER ENDING LEARNING SESSION"

Table Sessions - 40 minutes apiece - break in between; 10 minutes, only.
Nine (9) Tables - Ten (10) persons at each table.
Time: 2 p.m. - 4 p.m.

There will be two (2) moderators at each table, 15 minutes of lecture, and then group discussion.)

MODERATOR(S): Frances Helmick, R.N.
Director of Professional Education
American Cancer Society

NOTE: Following the W.C.E.T. Kathryn Jeter and Evonne Fowler will be presenting a Skin Care Seminar entitled, "Dynamic Dimensions". This is a separate venture from W.C.E.T.

MIDEAST REGION

INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY, INC.

Indiana Kentucky Ohio Michigan West Virginia

SEMI-ANNUAL MEMBERSHIP MEETING
WASHINGTON, D.C.
MAY 22, 1980

TIME: 6:00 p.m.

PLACE: Capitol Hilton
Washington, D.C.

PRESIDING: Helen Arend, President

MEMBERS PRESENT:

Phoebe Alfke
Ethel Pryor
Mary Ann Wethington
Jean Weber
Jane Beerck
Pat Hurd
Harriet May
Nancy Rioux
Juanita Jenkins
Lois Williams
Barbara Montgomery
Teresa Chaffin
Chris Walsh
Sara Crawford
Sue Hughes
Sue Brady
Rosemarie VanIngen
Susan Cecil
Sandy Lovejoy
Mary Lou Walker
Margaret Milen
Pat Zollars
Jan Joseph
Joyce Hawley
Trudy Blied
Lois Jean Holloway
Helen Arend
Mary Ann Sammon
Leona Mandich
Marie Lonz
Lynne Bieberitz
Judy St.John
Sue Buffin
Betsy Duffy
Sherry Birdsall
Betsy Hewitt
Sandy Kanat
Nancy Martin
Cherly Van Horn
Betty Sinclair
Julianne Dzwonkowski
Pat Martin
Marilyn Pekal
Marjorie Rose
Karen Gramby
Susan Muench
Rita Kerschner
Sr.Consalata Wolkinz
Bonnie Bolinger
Olga Cameron
Judy Schaffer
Joan Van Niel
Marky Kriete
Joan Baptie
Kathleen Wood
Norma Gill
Sally Thompson

ORDER OF BUSINESS

Helen Arend, President welcomed all members to the meeting. All new ET's and the ET's who were attending their first

Conference were asked to stand and then identify themselves and their place of employment. Officers and other members then identified themselves.

A quorum was established. Trudy Blied, Parliamentarian announced the rules of order applying to this meeting.

SECRETARY'S REPORT

Jane Beerck, Acting Secretary, noted a correction of information for the minutes. That is Special arrangements must be made to take the certification exam. With this correction, the minutes were accepted as printed in the newsletter.

Bonnie Bolinger, President of I.A.E.T. spoke on the Hollister Outreach Program. Four ET's from the area of Outreach Conference (Cincinnati) were to attend the program at Hollister's expense.

TREASURERS REPORT

The treasurers report was read and a copy of the report made available to members. The report will be held for audit.

MEMBERSHIP

Jane Beerck reported that as of Oct, 1979 there were 118 members of the Mideast Region. The Dues rebate for 80 members and one associate member had been received the previous week for January, February, March and April. The names of these members were not sent by National. Therefore, we cannot determine the actual count of the membership. Helen Arend suggested that someone other than the Treasurer chair the membership committee. Nancy Rioux was appointed to chair the membership committee. Marky Kriete suggested a means be found whereby members who did not pay their dues could be periodically contacted to encourage their participation in the organization. Joan VanNiel stated her school would send the names of the new graduates to the membership chairman as well as National. Sue Hughes questioned the confidentiality of releasing the names of the new grads. Joan VanNiel stated each student is given the option of signing a release form to cover such matters.

The meeting was interrupted for a presentation by members of the "Dynamic Dimensions in Health Care", Evonne Fowler and Katherine Jeter. They presented information on a program of decubitis care to be given in the Region in August. Jan Joseph questioned the content of the program especially the validity of the treatment modality.

Norma Gill, the first ET was introduced to the membership.

REGIONAL TRUSTEE

Sue Hughes our Regional Representative representative reports that Dian Traviniti is the person to contact at the Fred Droz management organization if there are problems. The National Board meeting will be Oct. 24th, 25th, and 26th. (Our Regional Meeting will be Oct. 31st and Nov. 1st.) Sue encourages any ET's who take referrals and see patients from outside their own area to complete the clinic registration form in the ET Journal and send it to Bonnie Hornberger. The address is in the Journal.

Hollister Outreach programs sent $24,000 to National last year. Some members questioned the use of the same faculty. Others felt the I.A .E.T. should have some imput because of their sanction. Pat Zollars suggested we present these concerns to the podium at the I.A.E.T. business meeting. Jan Joseph noted there is cohesiveness with the same faculty - working well together. She also informed us the area ET's are now welcomes and identified as area resource people.

Victor Alterescu, Editor is looking for manuscripts for the Journal. Members are encouraged to share - especially "how to" articles.

CONTINUING EDUCATION

Joan VanNiel informed us she is ineligible to be a Continuing Education chairman because she is a School Director. She will continue to do so until the Fall when we should appoint another chairman. Information of any programs with which we are involved should be sent to the Newsletter. Anyone interested in a "Refresher for Certification" should contact Joan at the Cleveland Clinic. She has in mind Feb. or March 1981. Jan Joseph suggested a bibliography would be helpful.

PUBLICATIONS

Barb Montgomery reports her hospital (Ohio State) is printing the newsletter free of charge. All the School Directors are now r eceiving a copy of the Newsletter. Barb requests articles to be sent to her for printing. There has been good response to some of the "Dear Ettie" questions.

BY-LAWS

Helen Arend reports we now have an updated - current issue of by-laws available. A copy will be sent to any member on request.

The proposed by-law revision as printed in the Newsletter was read by Joyce Hawley:

"Article XIII Dissolution. Upon the dissolution of activity of the Region, all remaining assets after the payment of the legal debts and obligations of the Region shall be turned over in full to the treasury of the International Association for Enterostomal Therapy, Inc. along with all financial records, by the Trustees or persons in charge of the liquidation or dissolution." Ethyl Pryor moved the proposed revision be accepted. Nancy Rioux second it. The motioned passed.

HISTORIAN

Marky Kriete reported Maude Timmons our Historian is still recuperating from last summer's accident. She would enjoy hearing from us.

OLD BUSINESS

Federation of Ohio Nursing Specialty Nurses Organization report was made by our representative Margaret Milem. A full report will be in the Newsletter.

W.C.E.T.

Norma Gill discussed the W.C.E.T. meeting to be held in August at Cleveland. Many impressive speakers were announced. There are close to 2,000 ET's in the world. Twenty two countries have ET's and six to seven countries now have schools. The W.C.E.T program runs from August 10th to the 14th. Thursday will be a simultaneous meeting with nurses of the area. There will be a Rupert Turnbul School of EnterostomalTherapy (Cleveland Clinic) reunion. The Fee for Thursday will be $35. Mideast Region ET's are asked to help with the meeting. (Contact Helen Arend if you can help.)

CONFERENCE BOOTH Sue Brady to be our judge.

U.O.A.

Sue Buffin reported the Regional meeting of the U.O.A. at Grand Rapids registered 294 persons, and was a successful meeting. Thanks to Bonnie Bolinger for her help and to the others who participated in the program.

NEW BUSINESS

Ethel Pryor if the new by-laws chairman. Ethel will also help on the National by-laws committee.

YOUTH RALLY 1981

Olga Rammous, Marky Kriete and Sue Brady are the members of the

Committee. Marky reported the Youth meeting will be limited this time to the ages 11 to 17. By limiting to this age group there should be less problems. Marky says the older, over 17 needs a group of their ovm. She encouraged ET's to help the older handicapped ostomate. The Youth Rally will be held in Boulder, CO 1981 in August.

Helen Arend announced we will be voting on the National offices of Treasurer and Secretary. All members were encouraged to vote. Phoebe Alfke will be our monitor.

NOMINATING COMMITTEE

Phoebe Alfke, Chairman asked for volunteers. Sue Buffin, MI and Juanita Jenkins, W VA "volunteered."

FALL MEETING

Barb Montgomery reports the meeting is scheduled for Columbus, Oct. 31st and Nov. 1st. It will be a "Skin Care" workshop. It will include prevention, treatment and new treatment modalities. The nurses meeting will be Friday and the Regional Business meeting willbe Saturday. The Annual Regional meeting fall, 1981 will be in Detroit.

MISCELLANEOUS

Nancy Rioux will place a note in the newsletter re: A group to take the Certification test inColumbus, OH. (This test would be taken in accordance with the special rquirements.)

Sue Hughes motioned the meeting adjourn. Marky Kriete second it. The meeting was adjourned at 7:30p.m.

Respectfully submitted,

Jane Beerck

Jane Beerck, Acting Secretary

From: Midwest Regional UPDATE Vol. 5, #2 March 80

Ten Simple Rules
By Howard Whitman

"Ten rules for keeping out -- or -- getting out of trouble"

(Professor Wallace B. Donham of Harvard, and associates from other universities did research for a course in Human Relations and the art of getting along with other people. These are distilled from the professor's collected experiences.)

1. Learn all about a problem before trying to solve it. Listen a lot; talk a little.

2. See the total situation. Don't act on just a part of it.

3. Don't be deceived by logic. Most problems are full of emotion. Emotions aren't "logical."

4. Watch the meaning of words. Look behind words to get their full impact.

5. No moral judgements, please. Until you have diagnosed a problem don't leap to conclusions about what is right and what is wrong.

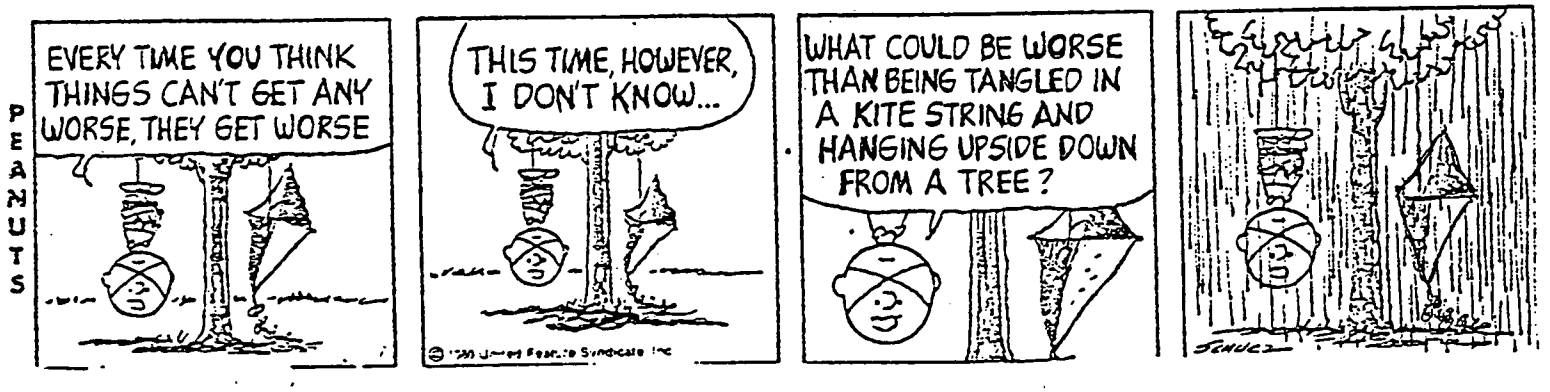
6. Imagine yourself in the other persons' shoes. See how the problem looks from where he sits.

7. When a problem gets you down, get away from it; put it in the back of your mind for a week. When you approach it again, the solution may be obvious.

8. Ask yourself, "what are the forces acting upon the other person? Why does he behave as he does?"

9. Diagnosis must come before action. Use the "doctor's" approach. Don't prescribe until your sure of what is wrong.

10. Easy does it. Quick solutions are often the quick route to trouble. Take your time.



Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

COLUMBUS, O
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1300

USA 28¢

I A E T

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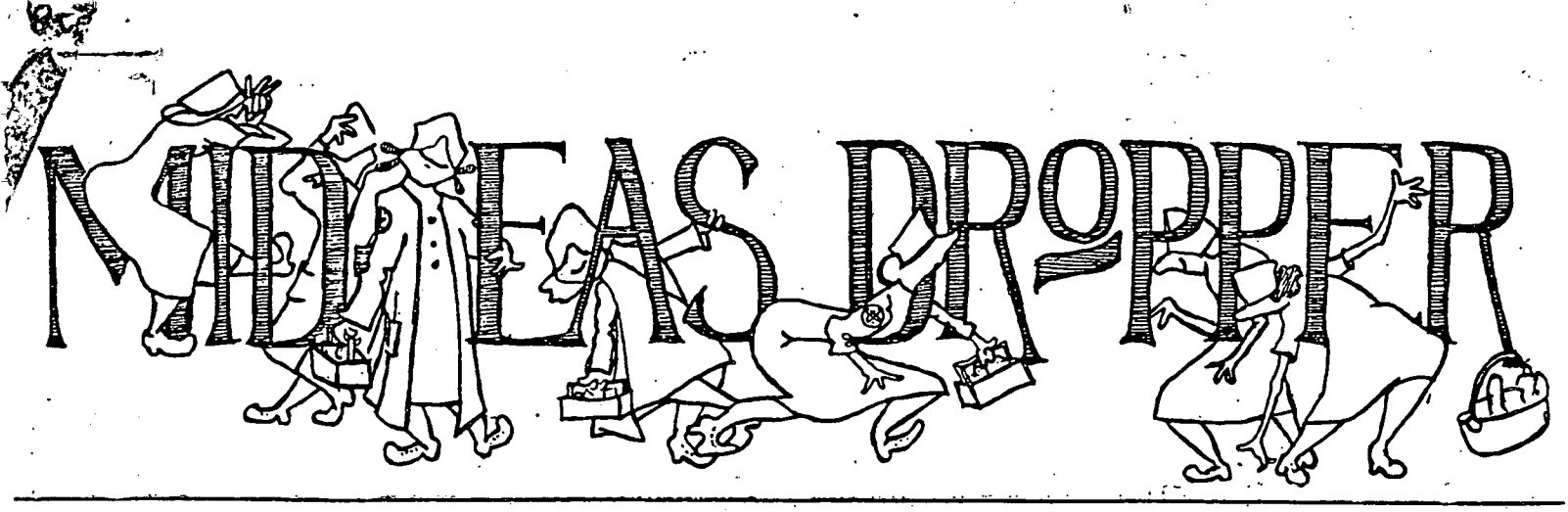
MAUDE B. TIMMONS, RN ET
5319 Velle Vista Drive
Louisville, KY 40272

FIRST CLASS



VOL. VII SEPTEMBER, 1980 NO. 3

EDITORS

Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

Notice

MIDEAST REGION I.A.E.T. OFFICERS

PRESIDENT:	*Helen Arend*
PRESIDENT ELECT:	*Joyce Hawley*
SECRETARY:	*LuAnn Hartley*
TREASURER:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Jan Joseph* *Barbara Montgomery* *Betsy Hewitt*
COMMITTEES:	
Membership --	*Jane Beerck*
Budget & Finance --	*Jane Beerck*
Education --	*Jean VanNeil*
By-Laws --	*Jan Joseph*
Publication --	*Barbara Montgomery* *Betsy Hewitt*
HISTORIAN:	*Maude B. Timmons*
PARLIAMENTARIAN:	*Trudy Blied*
MEDICAL ADVISORS:	*Ananias C. Dickno, MD* *University Hospital* *Ann Arbor, MI*
	Victor W. Fazio, MD *Cleveland Clinic* *Cleveland, Ohio*
	W. Patrick Mazier, MD *Ferguson Clinic* *Grand Rapids, MI*
	Joseph Rinaldo Jr., MD *Providence Hospital* *Southfield, MI*

from the "PRES"

This will be the last time I will, as president, address you in this newsletter space. It seems impossible that time can pass as rapidly as the last two years have.

Our membership has increased greatly in the last few years. Many of us "old timers" no longer recognize all the faces we see at meetings and conferences. It is easy to turn away from someone we don't know and seek a familiar person to talk to and to be with. New members are then left alone--and they often do not come back. After all, part of the reason for attending functions is to learn from others and if that doesn't happen, it is less effort and definitely cheaper to stay home.

All of us need each other for stimulation to learn and to improve. Reaching out to the unknown increases the likelihood that we will grow.

New members, too, need to project themselves and get involved in a group. Oftentimes they send out messages which tend to slow or prevent interaction with others from happening.

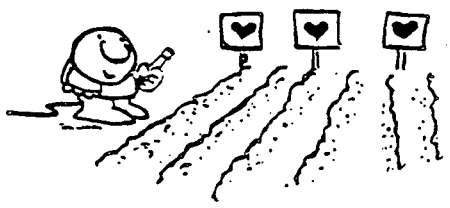
Our Mideast Region has been good--let's keep it that way, and GROW, not only in size, but in all other ways also.

Being your president has been interesting, exciting, humbling, and at times, frustrating--but always fun. I want to thank everyone who has cooperated and made the last two years a rewarding experience for me.

See you ALL in Columbus,

LOVE BLOOMS WHERE SEEDS OF FRIENDSHIP ARE PLANTED!

Helen



The Mideast Region members can be very proud of our President, Helen Arend. She worked like a trouper during the WCET Conference and kept things moving along--as smoothly as possible the entire week. The E.T.'s from the U.S.A. presented her with a corsage and dried flower arrangement at the banquet on Thursday night. We all send her a special thanks for her extra effort above and beyond the call of duty to make the conference a success.

Also, thanks to the volunteers who made a valuable contribution to the conference. (You should have seen us in our blue and white outfits with red sashes and straw hats--everyone looked so cute.) The volunteers were:

Helen Arend	*Joyce Leben*
Trudy Blied	*Betty Lowe*
Susan Buffen	*Barbara Montgomery*
Barbara Davis	*Mary Ann Sammon*
Betty Gerth	*Sally Thompson*
Lois Halloway	*Cheryl VanHorn*
Joyce Hawley	*Kathleen Wood*

ATTENTION! ATTENTION! ATTENTION!

The certification examination for Enterostomal therapists will be held in Columbus, Ohio, October 4, 1980. It will be held at The Ohio State University Hospitals. The exact location will be sent to you by the Psychological Corporation.

LOST AND FOUND DEPARTMENT

Missing:

E.T.s who have not as yet become part of our Mid-East Region. Please help us find each other!

If you know of an ET in your community or neighboring area who has not become a member as yet, please let me know. I would sincerely like to become acquainted and invite them to our Lost and Found Rap Session, October 31st; evening following Skin Care Educational Program.

It's going to be new and different and just for you! Feel free to contact me if you need someone to share a room with and I will try to coordinate this for you.

Looking forward to seeing you soon.

Nancy Rioux
Membership Chairman
Mid-East Region
OFFICE: Grant Hospital
309 East State Street
Columbus, Ohio 43215
614-461-3232
or
HOME: 614-459-1741

The Pressure Sore Workshop presented by Dynamic Dimensions in Cleveland following the WCET conference was very informative and offered many suggestions for the prevention and treatment of pressure sores. This is a very worthwhile program if you ever have the opportunity to attend one of these workshop I don't think you'll be disappointed.

Barbara Montgomery

Now speaking of seminars--HERE'S OURS!!

Special Event

The Ohio State University
Center For Continuing Medical Education
announces a

SEMINAR

SKIN CARE — "WHAT DO WE TRY NEXT?" PART II

October 31, 1980

Sponsored by:
Mid-East Region of Enterostomal Therapists

Hosted by:
Columbus Enterostomal Therapists

Columbus Hilton Inn
3110 Olentangy River Road
Columbus, Ohio

PROGRAM

Friday, October 31

Morning

8.00	**Registration and Exhibits**
8:50	**Welcome** — *Barbara Montgomery, R.N., E.T., Chairwoman* ***"Let's Treat and Prevent Instead of Promoting Decubitus Ulcers"***
9:00	**The Scope and Vocabulary of Decubitus** *Pat Hurd, R.N., E.T.* *Nancy Rioux, R.N., E.T.* *Barbara Montgomery, R.N., E.T.*
10:00	**Systematic Approach to Skin Care** *Suzanne Joyrier, R.N., E.T.*
10:30	***Coffee Break***
10:45	**Wound Colonization vs. Infection** *Leona Ayers, M.D.*
11:15	**Decubitus Care — Prevention is Easier!** *Shirley Gibbs, R.N.*
12:00	***Lunch***

Afternoon

12:45	***Exhibits***
1:30	**Understanding Ourselves As Well As Others — Imperative to the Nursing Process** *Katherine Jeter, E.T.*
2:30	***Coffee Break***
2:45	**New Treatments and Modalities** *Barbara Montgomery, R.N., E.T.*
3:30	**Sharing of Ideas: *"The Old and New"*** (Helpful common sense approaches: also fistulas, flaps, and other wounds.) *Sheri Birdsall, R.N., E.T.* *Sandy Lovejoy, R.N., E.T.* *Judy Clancy, R.N., E.T.* *Margaret Milem, R.N., E.T.*
4:30	***Post Test*** ***Exhibits***

OBJECTIVES

(1) To provide nursing personnel with current information on decubitus management.
(2) To clarify existing skin care principles for their correct application by nursing.
(3) To develop resource persons in other health care facilities for application of these principles.
(4) To provide information on accessibility of companies and products.
(5) To share ideas with other facilities.
(6) To assist with continuity of care between hospitals and community health services in respect to decubitus management.
(7) To meet the new JCAH statement effective January 1, 1979. "The hospital that provides home care services shall coordinate the effective provision of physician-directed medical, nursing, and related health care services of high quality in the home. These shall be specified and documented."

PARTICIPANTS

Target group is registered nurses and licensed practical nurses from hospitals, nursing homes, extended care facilities, and public health agencies throughout the State of Ohio.

NOTE: To all Mid-East Region Enterostomal Therapists Friday's program will be our annual educational day followed on Saturday, November 1, by our business meeting and any sharing of ideas you may have. This meeting will be from 8 a.m. to 12 noon at the Columbus Hilton Inn.

FEES: The $30.00 fee for registered nurses and licensed practical nurses and the $23.00 fee for Mid-East Region Enterostomal Therapists includes the cost of all registration materials, coffee breaks, and lunch. Fees will be refunded **ONLY IF** notice of cancellation is received **NO LATER** than October 15, 1980. All registration fees are subject to a $7.00 nonreturnable administrative charge. Confirmation of registration will not be sent unless specifically requested.

PLEASE NOTE: Deadline for registration is October 15, 1980. Luncheon space and registration materials will not be guaranteed after this date.

CREDIT: The Ohio Nurses Association has approved this continuing education offering for .6 CEU's.

ACCOMODATIONS: A block of rooms has been reserved at the Columbus Hilton Inn for the night of Friday, October 31; check-in time is 1:00 p.m. Reservations are the participant's responsibility. When calling the Hilton (614/267-7461), please identify yourself with the CCME program.

We are very excited about our up coming seminar on skin care. This is presented by the E.T.'s in Columbus and will be the Mideast Region's annual educational day. It is similar to the one we sponspored here at The Ohio State University Hospitals last year but it has been updated. We cover many aspects in skin care, helpful ideas, prevention and treatment, a systematic approach to skin care. We've tried to prepare a program that will help you go back to your hospital and feel comfortable in tackling the skin care problems you find there.

We have lowered the fee to $23.00 for all Mideast Region E.T.'s which includes the cost of registration, materials, coffee breaks, and lunch.

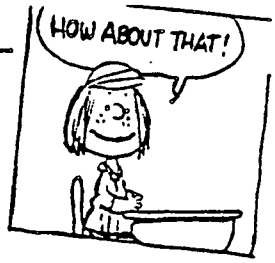
We hope you all can make it that day, it should be a good educational experience for us all.

Barbara Ann

NOTE

Our annual Mideast region business meeting will be Saturday, November 1, 8 a.m. - 12 Noon at the Hilton. Coffee and doughnuts will be served. We would like to "share ideas." Bring yours!

Pharmacia is extending an invitation to a wine and cheese party Friday evening to E.T.'s and all the participants attending the seminar. Be sure to drop by and share the "fruit of the vine".



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The Not Yet Ready For
Prime Time Press —

EDITORS' NOTE

Barb and I are caring for an increased number of cancer patients both chronic and acute. We are sure that probably many of the Mideast Region E.T.'s are doing the same. We thought we would devote part of this issue to current concepts of practice for cancer patients.

This issue will begin with an article by Randy Schad, Pharmacist, on pain control at The Ohio State University. We have asked Randy to submit this article because of the great assistance he has been to our cancer patients, at home as well as in the hospital.

Frequently after surgical intervention is completed, the cancer patient returns to The Ohio State University Hospitals for additional treatments such as chemotherapy, radiation therapy or follow up. These patients are placed on various nursing units and medical services such as Hematology, Medicine, Surgery, etc. In a university setting, many times the patient is subjected to decisions of an intern, resident or new staff nurse as to what pain therapy they should receive.

How many times have you overheard the medical or nursing staff make statements such as "he really isn't having <u>that</u> much pain" or "he is becoming addicted." Many times the staff do not understand the extent of disease or outside influencing factors such as frequent admission, family problems or reoccurrence of illness.

Randy has helped immensely in following patients with chronic pain, making recommendations, scheduling dosages, and following patient reactions.

E.T.'s are in a unique position of following patients through frequent hospitalizations--perhaps you too could be effective in helping your patient to receive adequate pain relief. The important thing is that we don't make rash or morale judgments on patients with chronic retractable pain from cancer.

Barbara Montgomery
Betsy Hewitt

THE USE OF ANALGESICS IN TREATING CHRONIC PAIN OR MALIGNANT DISEASE

by

Randy F. Schad
Assistant Director of Pharmacy
Department of Pharmacy
(Pharmacist Consult to Hospice of Columbus)

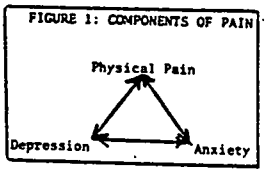
Pain is the major symptom that people are concerned about when they learn that they have cancer. Nurses have a very important role in caring for the cancer patient. They should assess the patient's need for pain medication, and then provide this information to the physician so that the patient can be placed on a rational pain control regimen.

The purpose of this article is to assist the nurse in selecting the right pain medication. This article will be divided into two parts. The first part will discuss the components and types of pain and the most recent methods for the control of cancer pain with medications. The second part of the article, appearing in the December issue, will discuss the individual drugs used in pain control.

Pain: Components and Types

Pain is composed of two components, the physical component and the psychological component. The physical component is caused by the cancer producing distension of organ capsules with traction on nerve endings or by compression or distension of peripheral nerve trunks. The physchological component is made up of the patient's anxiety and depression which cause a deviation from normal sleep, eating, and social interactions with the family.

There are two types of pain, acute and chronic. Acute pain is often associated with trauma, surgery, and childbirth. It is of limited duration, for once the problem resolves, the pain goes away. The other type is chronic pain. It is the type most often experienced by the cancer patient. It is the chronicity of the pain combined with the patient's knowledge that the pain will remain that contributes to the anxiety and depression experienced by the cancer patient. Anxiety and depression increase the patient's perception of pain and many times makes the pain worse. Figure 1 illustrates how the various aspects of pain are interrelated.



When chronic pain occurs, it envelops the patient's entire existence so that the pain becomes the focus of the existence. Often, patients in agony do not retain their dignity. Furthermore, the nursing and medical staffs as well as the patient's family often cope poorly with the dying patient. Many times the patient will be avoided and left alone, isolated from the environment. All of this results in anger, frustration, and often psychological problems for the people remaining after the patient dies.

There is no reason for the cancer patient to suffer. The various medical, pharmacological, surgical, radiological and physical technologies are available today to treat the patient's pain. They must, however, be used properly.

Both the psychological and the physical components of pain can be treated with medication. However, it is not only important to treat the pain with medications, it is also necessary to give the patient emotional support and let the patient communicate his problems. In a pain study done at McGill University in Montreal, Canada, Melzack found that the nursing staff who provided comfort and good cheer to the cancer patient had a strong psychological effect on pain. He found that the amount of pain medications that the patients received decreased over time because the patients were taken care of by a highly concerned nursing staff.

Anxiety

Anxiety is due to the patient's knowledge that pain is inevitable, that it will return after each analgesic dose sears off. Pain is best treated by administering each dose of analgesic loses its effect. This is why the physician should order analgesics on a scheduled basis, not prn. In many patients, once the pain has reappeared, it is more difficult to control. Also because of the concern about drug dependence, many physicians prescribe doses of narcotics that are either too low or too infrequent, thereby causing the patient

unnecessary suffering. All health professionals have a fear of addicting the patient, but no cancer patient should ever wish for death because their pain medication dose is too small, too late, or not given at all.

Anti-Anxiety Medications

The first medication that can be used to treat anxiety is hydrooxyzine (Atarax^{R} Vistaril^{R}) in a dose of 25-50 mg. every 4 to 6 hours. However, there is one problem with using this medication in the parenteral form. Since it is very irritating to the muscle, with continued use, it can cause injection site complications as well as discomfort. Hydrooxyzine should be given orally whenever possible.

Diazepam (Valium^{R}) and chlordiazepoxide (Librium^{R}) are also used to treat anxiety and insomnia. Appropriate doses range from 2-10 mg. every 4 hours for diazepam while the dosage range for chlordiazepoxide is 5-10 mg. every 4 hours.

Phenothiazines such as chlorpromazine (Thorazine^{R}) are also effective in managing anxiety as well as nausea, and vomiting, and sedation for the severly agitated patient. Dosage ranges for chlorpromazine begin at 25 mg. every 4 hours and the medication is then increased as needed to control the patient's symptoms. Predominant side effects include over-sedation, extrapyramidal reactions, and mental confusion.

Antidepressant Medications

Reactive depression often accompanies chronic pain. Management of pain and anxiety usually diminishes the depression and as a result medications are not needed to treat it. When depression does become a problem, the cancer patient can be treated with tricyclic antidepressants (Elavil^{R}, Endep^{R}). The insomnia that often accompanies depression can be overcome by giving the tricyclic at bedtime and thereby exploit the sedative properties of the antidepressant. The antidepressant effect is usually seen two to three weeks after starting therapy at a dose of 75 mg. to 150 mg. per day. The side effects of the tricyclic medications are the "atropine like" problems such as dry mouth, blurred vision, tachycardia, constipation, urinary retention, and orthostatic hypotension.

Treatment of Pain: Background

When the treatment of chronic pain is begun, a "loading dose" of the narcotic should be administered. This is especially true if the patient is in excruciating pain. A blood level needs to be established that is above the pain relief threshold. The pain medication should be given on a schedule basis, around the clock so that the blood level never drops below the pain relief threshold. Thus, the patient will be in a pain free state. If the patient is started out with conventional doses of narcotics given on a prn basis, the pain may return after only a short period of time because the blood level of the drug has dropped below the pain relief threshold.

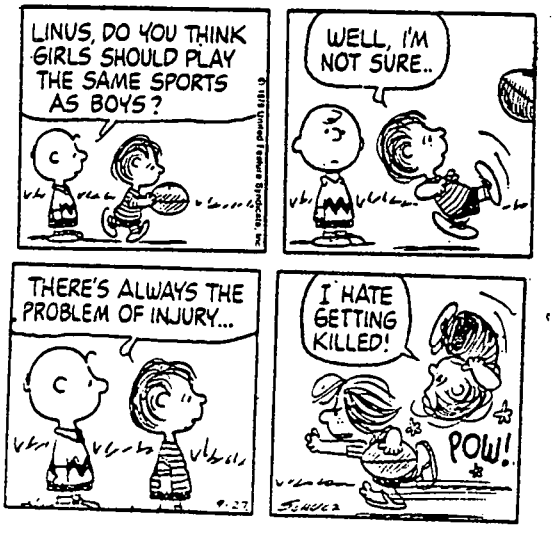
Using loading doses and scheduling pain medications are the best methods of pain control. These methods decrease the fear or expectation of pain, thereby decreasing the patient's pain still further. Many times the dose can be tapered downward over a period of time until the optimal dose and dosing schedule is reached. Once pain is under control, the patient's quality of life improves. Normal activity can then be maintained and the patient can develop a meaningful relationship with his family until death.

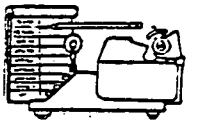
Patients in pain crave relief from it, not at psychological high from the narcotics. Should a patient start to demand seemingly

unreasonable amounts of narcotics, it means that that the pain control is inadequate. The patient is not becoming an addict. At this time the pain medication should be evaluated and the necessary changes should be made. With repeated daily doses, tolerance will eventually develop to the therapeutic effect of the medication as well as some degree of physical dependence. However, in terminal patients, development of tolerance and dependence should not prevent the patient's discomfort from being eased.

It is very important to have one person responsible for evaluating and regulating the patient's pain medication. This person can be a nurse, pharmacist, or physician experienced in treating cancer patients. This person works very closely with other members of the health care team so that everyone is aware of the patient's care plans. Furthermore, the cancer patient has only one person who regulates his pain medication and therefore has to deal with only one individual if there are problems with the pain control regimen. Thus the problem of having conflicting ideas on pain control are eliminated.

This individual also has to develop a close relationship with the patient so that he/she will gain the patient's confidence in his/her ability to control pain. Once this relationship is established, treatment goals can be set up with the patient and the patient's family.





We would like to thank Rachel Alexander for compiling the following list of resource books. Rachel is a librarian for the Worthington Library and the editor for the "Columbus Discovery"; the Newsletter for the Central Ohio Chapter of UOA Newsletter.

1. *The Ostomy Book: Living Comfortably with Colostomies, Ileostomies, and Urostomies. Barbara Door Mullen. Palo Alto, Calif.: Bull Publishers, 1980 (order directly from publisher or from United Ostomy Association). Accurate and lively account of why ostomies are necessary and how to live with them, from ostomates' experiences all across the country.*

2. *My Daughter, My Son. Inge Trachtenberg. A mother's true story of her son's and daughter's fight against ulcerative colitis and of her family's journey to freedom from illness and pain (finally, by way of ostomy surgery for both children). Told with humor and intense feeling.*

3. *Getting Well Again. C. Carl Simonton. A step-by-step guide to stress management is presented in an easy-to-read format. The underlying progress of the disease, so that "mind-therapy" (relaxation exercises) should be used in addition to the traditional therapies.*

4. *Cancer Care: A Personal Guide. Harold Glucksberg & Jack Singer. Case histories are used in this accessible handbook to illustrate the explanations of types of cancer, how they are identified and treated. Doctor-patient relationships are covered as well as problems related to pain, nutrition, and emotional adjustment.*

5. *A Private Battle. Cornelius Ryan and Kathryn Morgan Ryan. The four-year secret journal kept by a well-known author of World War II histories as he battled against cancer, is interspersed with his*

wife's own perspective.

6. *You Can Fight for Your Life. Lawrence LeShan. From his 20 years of research and psychotherapeutic work with cancer patients, the author presents evidence that the mind can make the body receptive to cancer, and that the mind is also capable of fighting back.*

7. *Sixty-Plus & Fit Again. Magda Rosenberg. Exercises for older men and women presented in a manner supportive even to those reluctant to push themselves toward fitness after surgery.*

8. *A Comprehensive Guide for Cancer Patients & Their Families. Ernest & Isadora Rosenbaum. Based on successful programs pioneered by the authors, the book considers both mind and body. Besides the expected descriptions of types of cancer, other areas covered include mental stress with relationships, role of nutrition (with recipes!), physical rehabilitation (with photo examples of exercises), going home and outside agencies, sexuality & cancer. Really written for the patient.*

9. *And a Time to Live. Rober Chernin Cantor. The author deals with the emotional impact of cancer, and strategies and perspectives through which individuals can maintain or regain their sense of personal authority and competence. While addressing iteself to patients and families, this title may be more appropriate to health care professionals.*

10. *Strike Back At Cancer. Stephen A Rapaport. This is a consumer-oriented sourcebook of cancer treatment, including specialists and treatment centers as well as information on major types of cancer. Describes organizations devoted to the rehabilitation of cancer patients and families, too.*

NOTE: I am confident that E.T.s can reach most people with the fundamentals of physical stoma management. Perhaps the suggestion of a book may carry your positive management spirit outside the bounds of the hospital over to the untamed area of self-image and life philosophy, where any life-threatening experiences take their toll. Many of the cancer titles could be useful in that case, even if the ostomy is the result of some other problem, as most of them deal with stress management, attitudes, looking at (i.e., accepting and supporting) the total person.

I would add a note of encouragement to check the local library for new relevant titles and suggestions from the librarians. Most public libraries are receptive to ordering material their community requests and virtually all are linked to an interlibrary loan system.

Rachel Alexander
Editor, Central Columbus Discovery (Central Ohio Chapter of UOA Newsletter

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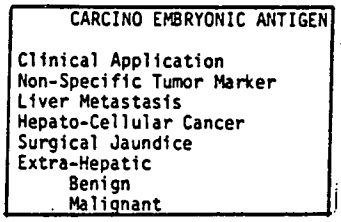
Murphy's Law №11:
The success of a good idea depends on knowing what to do with it!

"Some people strengthen the society just by being the kind of people they are."
—JOHN W. GARDNER

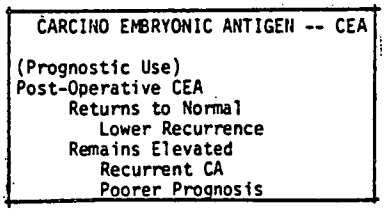


CEA

EDWARD W. MARTIN, JR., M.D.
ASSISTANT PROFESSOR
DEPARTMENT OF SURGERY
Junior Faculty Clinical Fellowship
ACS

Carcinoemebryonic antigen was first described by Gold and Freedman in 1965 and was so named because of its distribution in neoplastic and embryonic gastrointestinal tissues. Shortly thereafter, it was characterized as a protein polysaccharide complex. At first, the presence of carcinoembryonic antigen in the adult was thought to be a specific indicator for the presence of colorectal cancer. Since that time, there have been increasing data supporting the premise that CEA is elevated in many benign conditions as well as in nonentodermally derived tumors. Significant CEA positivity has been reported in inflammatory bowel disease, collagen disease, chronic lung disease, pancreatitis, chronic heavy smoking, liver disease, polypoid lesions of the GI tract, and in many non-digestive tract tumors including the bladder, lungs, head and neck, reproductive organ, breast, and neuroblastoma. In looking at colorectal tumors, in particular, in comparing the CEA elevation to the Duke's classification, Duke's A tumors rarely were elevated, Duke's B tumors elevated between 30 and 40 percent, Duke's C tumors elevated approximately 60 percent of the time, and distant metastatic colorectal cancer elevated almost all the time. To summarize this data, approximately 65 to 70 percent of colorectal tumors have elevated CEA levels above 2.5.

Although CEA is known to be a nonspecific tumor marker, it has much usefulness as a tumor marker in evaluating the effectiveness of surgical procedures, radiation therapy, chemotherapy, immunotherapy, and any other therapeutic modalities available to the physician for many tumors, and in particular, the gastrointestinal tumors. The limitation of our effectiveness with chemotherapy and other therapeutic modalities for gastrointestinal tumors should limit our enthusiasm for the tumor marker which does predict recurrent tumor or change in tumor burden often before any other diagnostic modalities available to the physician become abnormal.



The association of an increased CEA titer with colorectal and pancreatic tumors has been well confirmed in the literature. The diagnostic usefulness of the CEA determination has been studied in the high-risk, highly suspicious group. I think it is a diagnostic tool that has much merit, but as a screening tool for a general healthy population, it has little merit. It also has definite prognostic value in the absolute value can often be used to prognosticate the survival of the patients with the various GI malignancies. In otherwords, a patient with a high CEA level that does not change with any of the therapeutic modalities available to the physician, has a very poor prognosis, whereas a CEA that does change dramatically from an elevated level down to a more normal baseline level, often has a much better prognosis. A new "baseline" CEA value following a surgical resection is often reached somewhere between 7 and 30 days postoperatively. Any rise in this value indicates new tumor progression. An increasing emphasis is being placed upon the CEA determinations (the serial CEA determinations) in cancer patients in monitoring the effectiveness of the various

modes of treatment, i.e., surgical, chemotherapy, immunologic therapy, hormonal therapy, and radiation therapy. At Ohio State University Hospital, we have had increasing experience over the past 10 years in using CEA determinations and following colrectal carcinoma. CEA determinations in colorectal carcinoma shows a 65 percent increase in elevation with postoperative titers remaining elevated in the patients who had only a palliative procedure but fall into a more negative zone after a curative procedure (i.e., to a range approximately 2.5 ng/ml or lower). An excellent correlation exists between CEA levels in the greater tumor, i.e., more poorly differentiated tumors showing less CEA activity. Left-sided colon lesions show a significant higher titer than the right-sided lesions. The CEA values have been shown to be elevated in approximately 90 percent of pancreatic carcinomas, 9 percent of breast cancer, and 35 percent of other tumors such as ovarian, head and neck, bladder, kidney, prostate.

We have also used CEA to follow many of the benign processes and a new CEA, CEA III is now being evaluated. The known data with CEA levels in 35 patients with ulcerative colitis showed elevations during the exacerbations about half the patients which returned to a more acceptable normal level during a remission of the ulcerative colitis. In 6 patients following colectomy, the CEA fell to the negative zone and remained in the negative zone. We've also looked at adenomatous polyps and found that 40 percent of the patients with adenomatous polyps had elevated CEA's; between 2.5 and 10. We found no patients that had CEA levels above 10 ng/ml that did not have a frank malignancy. Preoperative and postoperative CEA determinations are important in assessing the effectiveness of all therapeutic modalities, and we suggest that serial determinations are important in the follow-up period and in the evaluation of the other therapeutic choices. We feel that a physician can definitely make therapeutic decion on changes in CEA activity and also it adds to the physician's prognostic insight as he observes the serial determinations and the trends in CEA activity.

CEA		
LEFT COLON TUMORS	82%	Elevated
Duke's A	50%	"
Duke's B	75%	"
Duke's C	100%	"
Duke's D (or distant metastasis)	100%	"

In summary, CEA levels followed serially, that's every six weeks to two months postoperatively, in many of the tumor problems whether it be gastrointestinal or other tumors has added to the physician's information and also to his early therapeutic decision-making. We've found that many of the other diagnostic modalities follow CEA elevation from anywhere to 3 to 18 months after a change in CEA activity and at this time, the tumor burden is so large that the other therapeutic modalities are less effective. Serial determinations are a key to using this nonspecific tumor marker in making therapeutic decisions.

EDITORS' NOTE

This article should clarify some of the misconceptions concerning the value of CEA levels. Many of your cancer patient may be followed periodically with CEA levels. I think it is important that we understand its purpose and usage.

overview

Highlights of CEA Article

1) *CEA levels can be elevated in benign disease.*

2) *It has usefulness as a tumor marker in evaluating effectiveness of different modes of treatment (surgery, radiation, chemotherapy, etc.) especially for GI tumors.*

3) *Little merit as screening tool for general public.*

4) *CEA trends can help physician prognosticate survival of GI malignancies.*

5) *CEA levels may be used to follow benign processes such as ulcerative colitis.*

6) *CEA levels followed every 6 weeks--2 months post-op adds to early therapeutic decision making.*

7) *CEA levels elevated:*

65-70%	-	*Colorectal CA*
90%	-	*Pancreatic CA*
9%	-	*Breast*
35%	-	*Head--Neck*
		Ovarian
		Kidney
		Prostate

Barbara Montgomery
Betsy Hewitt

PUBLICATIONS OF INTEREST

"The Differential Diagnosis of Impotence" Wasserman, Pollak, Spielman, Weitzman, JAMA, May 1980 Vol 243, pp2038.

"Intravenous Hyperalimentation", Eriksson, Douglas, JAMA, May 1980, Vol 243 pp 2049.

"Anorectal Gonorrhea", Felman, Nikitas, Modern Medicine, May 30, 1980, pp 109.

"Henri Hartmann and the Hartmann Operation", Sanderson, Archives of Surgery, June 1980 Vol 115, pp 792.

"On Writing and Writing Workshops", Hodgman, Nursing Outlook, June 1980 pp 366.

"Meeting the Challenge of Fistulas and Draining Wounds", Taylor, Nursing 80, June 1980, pp 45.

"Test your Knowledge of Cancer Prevention, Detection, Diagnosis", Wang, Kelley, Nursing 80, Feb 1980, pp 66.

"Pseudocommunication with Patients", Mercer, Nursing 80, Feb 1980, pp 105

"Mucocutaneous Reactions to Antineoplastic Agents", Ca-A Cancer Journal for Clinicians, Adrian, Hood, Skarin, May-June 1980 Vol 30, pp 143.

"Pain Management", Wolf (Editor) Topics in Clinical Nursing, April 1980, Vol 2.

"Treatment of Pressure Ulcer", Mikulic, AJN, June 1980, pp 1125.

"Coping with Cancer: a Guide for Health Care Professionals", Friedman, Cancer Nursing, April 1980, Vol 3, pp 105.

"Assessment and Treatment of Psychological Problems of the Cancer Patient", Freidenbergs, Gordon, Hibbard, Diller, Cancer Nursing, April 1980, Vol 3, pp 111.

"Nutrition and Cancer: a Review of the Literature", Butler, Cancer Nursing, April 1980, Vol 3, pp 131.

REPRODUCED FROM MID-ATLANTIC
REGION NEWSLETTER SUMMER 1980

EXCERPTS FROM IAET CONFERENCE

Nurses in the Political Arena by
Senator Marilyn Goldwater, R.N.
Elizabeth Hughes, PhD., R.N.

Elizabeth Hughes reminded the members that "nurses have timely insights into problems affecting health care today." She told us that each of us does make a difference. Nurses are in the minority but we are where the real action is & we should make our voices heard. She stated that the World Health Organization, which is composed of 134 countries, has as its object Health Care for all by the year 2000. Presently, health facilities are geographically unavailable to many pts. Economics prevent some persons from having care. Consumers must become involved in their care. Consider the issues of accessibility, availability and cost. Who should we see for services? How should funds be allocated? These are some of the questions that we should involve ourselves in. In the next decade, many opportunities will come for nurses. We must go out & seek these opportunities. They won't come by themselves. Health prevention is a major goal in the U.S. & also in other countries. Deinstitutionalization is focused on goals. Health states change. Health systems change. Health education & cost are important factors for consideration. Cost is very controversial. It has special relevance. National health expenditures have grown from 5% of the gross in 1950 to 10% in 1980. Cost containment is being looked at by congress. There is intense pressure to control inflation. Nurses, by way of their positions, need to meet the challenges of the 80's. We need a balance between economics & humanism. Nurses must become versed in the language of economics. We owe it to the pt.'s & to ourselves to become involved in health care issues. Activism by nurses is important. Many legislators have had no contact with illness. (either as a pt. or as a health worker.) Nurses who are practicing should blend their knowledge & their skill with those who are versed in health issues. Define goals & objectives. What are we striving for? Be where we need to be seen. To be an activist takes time, involvement & persistence. Develop a network of people & use them as resources. Exchange information with others. Read laws. Take a course in economics, legislation or political action. If you believe these things, you will become involved & you can affect the future of health care.

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Senator Marilyn Goldwater reminded us that Health Care is the 3rd largest industry in the country. There must be public acceptance of nurses as a group. This is a goal - not an achievement yet. We MUST take RISKS. Florence Nightingale was a political person for her time. Most medicine was then practiced in communities. Health care then became hospital based & institutionalized & so did nursing. Advanced knowledge & the women's movement is trying to turn this around. NURSING COMPLIMENTS THE SERVICES OF MEDICINE. The public needs to get this message.

There are new focuses on geriatrics, drug addiction, mentally handicapped & hospice care. Pt's & their families are becoming participants in care.

We must rely on a broader role for nurses. There is no legal restriction on independent nursing practice. There is only an economic one.

Senator Goldwater introduced a bill for third party payment. All health insurers in MD must now include benefits for reimbursement of nurse practitioners & midwives. The state board of nurses must maintain a list of these practitioners. Support for this bill in MD came from nurse practitioners themselves & from the MD Nurses Assoc. The bill did not pass in 1977. Senator Goldwater reintroduced it in 1978 as 2 bills. The nurse midwife bill passed in '78. Blue Cross discovered that it was cost effective to pay for the services of nurse midwives. Both bills are aware of the rights & responsibilities of nurses. Pt's must be referred to a doctor when necessary. A Calif. court ruled that nurse midwifery did not constitute the practice of medicine because pregnancy is not a disease. Nurse midwives need to refer 20% of patients to a physician.

Nurse clinician work is different from a technician. We can plan for health maintenance. One of the major objections federally to third party payment is that there is no standardization. The availability of high quality of primary care health personnel is lacking. This prevents achieving the goal of good health care for all. There are many gaps that must be filled. This cannot be done by a single bill or a single effort. Nurses do have political clout. We should not underestimate our power.

REPRODUCED FROM MID-ATLANTIC REGION NEWSLETTER SUMMER 1980

NURSES IN THE POLITICAL ARENA (cont'd)

It is our profession, our livelihood & our future. All of us, working together, can accomplish a lot. Support the risk takers. Nurses are becoming skillful about lobbying. Nurses are not as visible in Annapolis as doctors. Write & protest the media image of nurses.

One of the immediate things that ETs are encouraged to do is to write to their respective legislators regarding House Bill 7036. (This was formerly HR 1650 & then HR 3641.) It encourages providing a clearing house on digestive diseases & offering grants to strengthen pt. ed. programs Look up the address for your Senator & write a letter TODAY.

* * * * *

LEGISLATIVE NOTE: House Bill 1591, which encouraged third party payment for services of licensed health professionals was defeated, on a 10/11 vote by the House Economic Matters Committee. Nevertheless, MD Nurses' Assoc. is recommending that nurses in private practice file for coverage whether the pt. has Blue Shield or any other insurance that states it covers these expenses. If the nurse's claim is rejected by the insurance company, the nurse is requested to file a complaint with the MD State Commissioner of Insurance: Mr. Edward Birrane, Jr. Ins. Commissioner, Dept. of Licensing & Regulation, One S. Calvert St., Baltimore, MD 21202

Also send a copy of the above complaint to MNA. MNA will thus be able to monitor difficulties being experienced by nurses in this regard & will have data as an aid for discussion with legislators.

* * * * *

OHIO LEGISLATIVE BULLETIN

Nurses have stayed apolitical far too long! While we turn our heads the other way, decisions are being made about health care in this country--in State and Federal Legislation--with little input from the millions of nurses in this country.

Some rules concerning skilled nursing facilities and intermediate care facilities would shock you!!!!

--LPN's can be Directors of Nursing in these facilities.

--Registered nurse coverage can be waivered.

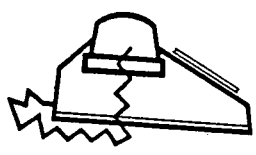
Senate S.B. 200 re: Nursing Homes was amended. The Bill consisted of lowering standards for nursing homes because of a "nursing shortage"!!

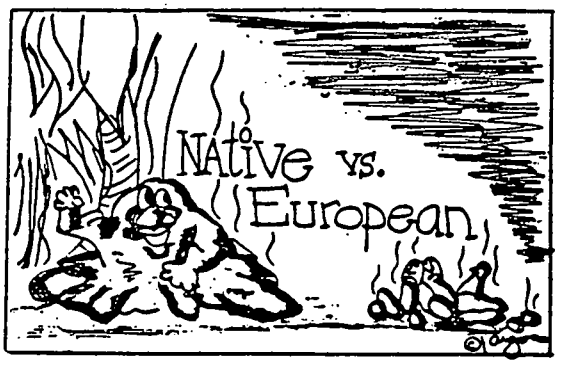
HOW CAN YOU BE EFFECTIVE IN CONTROLLING TRENDS IN NURSING AND HEALTH CARE?

1. *Find out who your representative and Senator is--get to meet them and let them know who you are.*
2. *Write or call your Legislator to express your views on the issues.*
3. *Join their campaigns--let them see you visibly active in politics.*
4. *Read newspapers, Nursing Journals, and newsletters about pending legislation.*
5. *Join your state/district legislative committee.*

Nurses need to take stock of their profession and help define its role not only in their own facilities but also in the political arena!

Bobbie Lindberg, R.N.
Member of Legislative Committee for ONA





DIET AND FECAL CARCINOGENS

It is recognized that from a functional standpoint, the colon may be divided into a proximal water-absorbing portion and a more distal reservoir portion. In light of this, it is interesting to note that the majority of colon carcinomas occur in the left colon, the storage site for fecal material. Though a definite cause-and-effect relation between fecal storage and carcinogenesis has yet to be established, some interesting points have been made.

Epidemiologic studies have fairly well established that the red meat-laden Western American diet carries with it a significantly higher incidence of colon cancer than does the more vegetarian diet of Nigerians or the traditional Japanese diet. From many animal studies, it appears as though the fat content of red meats rather than the meat protein itself is the important factor in colon carcinogenesis. Though no specific carcinogenic agent has been identified in red meats, analysis of fecal material in humans and animals fed high animal fat diets demonstrated significantly increased levels of bile salts, compared to stool specimens from control populations. This is in keeping with a function of bile salts, being to assist with absorption of dietary fat.

Bile salts, as you immediately recall from ancient chemistry lessons, have a Sterol configuration which, when acted upon by certain microflora, appears amazingly similar to a group of known carcinogenic agents, the methylcholanthines. These microflora, notably Clostridia, have been found in higher numbers in colon cancer populations compared to controls; stool assays for enzymes necessary for chemical breakdowns of bile acids to possible carcinogens demonstrate higher levels in cancer subjects.

If it can be assumed that fecal carcinogens act by direct contact with colonic mucosa, one would suspect that areas of prolonged exposure to such noxious substances would be involved more frequently with cancer. Many investigators believe this to be the prime reasons why the majority of colon cancer is located toward the distal colon--the reservoir or storage area. In a review of previously mentioned epidemiologic studies, it becomes apparent that the low-risk populations (e.g. Nigerians) had not only low animal fat diets, but also high fiber content. Further inquiries found that these populations generally have more bowel movements per day with a more rapid bowel clearing time than do their Western counterparts, all attributed to fiber. In vitro studies have shown that natural fiber binds bile salts quite readily. Quite possible, then, high fiber diet might assist in the decreased colon cancer rate by both shortening the transit time of gastrointestinal content (thereby reducing exposure time of mucosa to carcinogens) and by binding carcinogens and/or their precursors on their hurried way out (thereby not allowing time as exposure of carcinogens to the ravages of colon micro= flora).

From the aforementioned, one can conceptualize that the Western high fat diet somehow introduces potential carcinogenic materials to the colon. These substances are, in turn, modified by a unique colonic microflora into noxious cancer-inducing metabolites, which exert their effect by direct contact in the reservoir areas of the colon. There they will remain for prolonged periods of time without the urging by the bulk effect-fiber.

Between this entire concept and scientific fact, there lies a great deal of research to solve the multiple controversies therein.

However, such initial observations as summarized above are not being cast aside as circumstantial evidence, and it is the opinion of many that only in resolving this concept will a real advance in decreasing morbidity and mortality of colon cancer be achieved.

John Ferrara, M.D.
Clinical Oncology Fellow
Clinical Instructor in Surgery
Ohio State University Hospitals

EDITORS' NOTE

Certainly this current view of the cause-effect relation between the fat content in red meat--prolonged storage and colon cancer proposes interesting questions for us as enterostomal therapists:

1) *Should sigmoid colostomy patients irrigate every day instead of every other day. (Theory: increased fecal storage time = increase in carcinogens).*

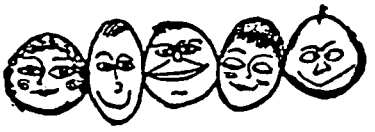
2) *Should we discourage red meats--animal fats in our high risk colon patients?*

SUGGESION: Try out this theory by making observations of your own. Interview your colon cancer patient for past bowel habits and diet. See if there is a relationship between high animal fat--low fiber in the diet and increase risk of colon cancer.

U.O.A. Visitor Trainers Workshop Held

After several months of planning the Ohio Division of the American Cancer Society and the Ohio U.O.A. sponsored an Ostomy Visitor Training Workshop in Columbus in June. Ostomates and E.T.'s from many cities in Ohio participated. Lou and Rita Wray were on hand to lend their support and leadership to this successful and interesting program. Cooperation was the key and will no doubt be exemplified in the skills enhanced by the visitor trainers that attended. Anita Epstien of the Ohio Division, American Cancer Society and Connie Freundlich of Columbus are to be commended for their dedication and expert guidance in this unique endeavor. I encourage all E.T.'s to involve U.O.A. visitors in the care of ostomates. This cooperation will definitely make care of the ostomate a team effort.

Judy Schaffer, R.N., E.T.
Cincinnati, Ohio



WCET REVIEW

Over 300 people from nineteen countries attended the third WCET in Cleveland, Ohio August 10 - 14th. There were representatives from Australia, Denmark, England, France, Germany, Hawaii, Ireland, Israel, Japan, Mexico, New Zealand, Norway, Singapore, Sweden, Switzerland, South Africa, and the Netherlands in addition to those from Canada and the United States.

As hostesses, we "Mideasterners" wore red, white, and blue plus straw hats and red shoulder sashes which provoked much comment, as we resembled people seen on T.V. at the Democratic Convention in New York.

There were fewer manufacturer exhibits than usual and the booths were open for the entire meeting.

On Monday morning, the manufacturer representatives introduced and discussed their products and presented some scientific material.

In the afternoon, there was a WCET Business Meeting and nomination of officers.

The poolside barbeque in the evening was held indoors because of rain.

At the all day program at Cleveland Clinic on Tuesday, physicians from different countries presented new concepts, evaluation of new procedures and different methods of management. Some of the products discussed are not on the market as yet, some are not available in the United States at present.

The speaker from Switzerland, a gastroenterologist, humorously recounted his experiences with surgeons and nurses in his push for better stomas and ostomy care for patients.

There were two very good presentations in Sexual Adaptation and the ostomates.

On Wednesday, a representative from each country gave a progress report on stoma care.

Following this, papers were presented by E.T.'s from different countries.

There were concurrent programs on Thursday. Program A--an all-day session especially for local nurses and non-WCET members. Program B for WCET members--for the morning there was a business meeting. The following officers were elected:

President: Prilli Stevens, S. Africa
Vice-President: Marie Burroughs, Canada
Treasurer: Marilyn McManus, S. Africa
Recording Secretary: Marilyn Spencer, U.S.
Corresponding Secretary: Lorraine Acworth, Australia
Our delegate: Mary Jane Koch, U.S.

It was decided that:

1. Dues remain at $10 per year.
2. The Logo will remain the same.
3. Meetings to be held every two years. (In 1982 it will be in England; in 1984 in South Africa.)

In the afternoon there were nine round table discussions, three of which could be attended by each person.

Cocktails that evening were by courtesy of the manufacturers. Afterwards the banquet was held followed by installation of officers and recognition of Norma Gill as instigator and outgoing president of WCET. Dancing capped the evening.

It would have been great if you could all have attended as this meeting provided much food for thought.

Betty Lowe, R.N., E.T.
Ann Arbor, Michigan

NEWSLINE CINCINNATI:

Greetings to all of our Mideast Region friends. We are boasting 12 E.T.'s in the Greater Cincinnati area. We meet monthly, rotating hospitals and also take turns going to U.O.A. meetings. The month that an E.T. is to attend a U.O.A. meeting she writes an article for the U.O.A. local newsletter. Our E.T. meetings are informal with one person who records minutes and another to select programs. Various physicians have provided lectures from time to time and covered current surgical and medical practices in our area.

We have found it helpful to have sales-representatives contact our program chairperson to schedule 15 minutes updating at our monthly meeting. This has provided a good audience for the rep and eliminates the time taken during the E.T.'s busy day to meet a rep. Our problem sharing and even "referral swaps" benefit our patients and generate ideas.

Our second annual picnic will be held at the scenic St. Walburg Convent in July. We have no plans to talk "shop"--its fun and a pleasant gathering.

We wish all of you well for a safe and sun-filled summer.

Judy Schaffer, R.N., E.T.
Cincinnati, Ohio

Dear Ettie:

Note of interest to those of you who work with Kidney dialysis--we have several patients who are on continous ambulatory peritoneal dialysis (CAPD) this is a new form of kidney dialysis, that offers patients freedom from a standard kidney dialysis machine. Nu-hope has a new CAPD support #2675 (1½) this pouch like support holds the empty plastic bag and holds it in place with a velcro hook tape. Our dialysis nurse has used this on several patients; both she and the patients really love this system.

Signed,
New Freedom

Dear Ettie:

We have been having problems with stoma-hesive with the curved edge (in the regula packaging not the new blister pack) not sticking. It doesn't lay down well and also has been lifting up on the edges. I understand this is not supposed to be a different formula but it just is not sticking as well as the regular stoma-hesive. Are any of you having the same kind of problem? If so, let us know--we've been in touch with the clinical research department of Squibb and they are also checking this out on their end.

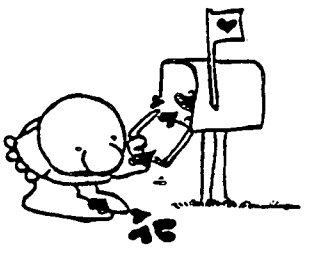
Signed,
Curled edges

Barb & Betsy

Dear Ettie:

Just wanted to share with you the success we are having with the "New" Hollister paste. It doesn't wash away easily and we have been using it with ileostomies & below skin level stomas and patients with draining wounds. We put it around the stoma or opening and when we apply the pouch we push it down flat and firm-to make the paste smash as flat as possible. The pouches have been staying on the "difficult stomas 5 to 7 days. (NOTE: I must tell you--try not to get it on your hands cause -- it's a bear to get off.)

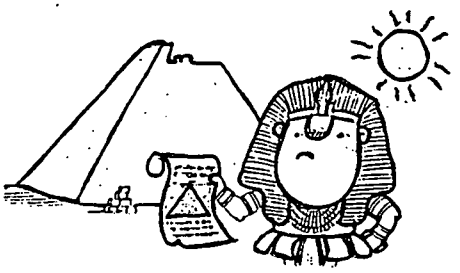
Signed,
Tight seal but sticky fingers



WE NEED LETTERS
"LOTS" OF LETTERS

Murphy's Law No 2:

Everything takes longer than you think it will!



HELP

We have lost the following E.T.'s. If anyone has information as to their whereabouts, please forward their new address to:

Barbara Montgomery, R.N., E.T.
Nursing Service, Room 221
The Ohio State University Hospitals
410 W. 10th Avenue
Columbus, Ohio 43210

1. *Sandra Gustwiller, LPN, E.T.*
2. *Anne Ward, R.N., E.T.*
3. *Elizabeth Hillard, R.N., E.T.*

We do not have current addresses for the above persons.

A BELATED THANK YOU

I recently had occasion to visit the Grand Rapids Hilton Hotel. It reminded me of the Great Lakes Regional Conference held there in April of this year. Well actually it wasn't the Hilton. In fact it wasn't in Grand Rapids. Truth be known it was in Cleveland at the WCET conference. The effect was the same any way.

The occasion brought to mind the fact that I must be getting old and forgetful. I'm sure that I said "thank you" in person to a lot of people. But the one thing I didn't do and should have, was to thank in public all the great Mideast E.T.'s that made our UOA regional what it was. I should have sent this in to the Dropper right away. But all of you who have chaired a conference know that it tends to make you temporarily senile. I'm not saying I'll ever be any better, but one thing is for sure! The Mideast E.T.'s can't get any better. Those of you who came from all over the region and helped me so much here in Grand Rapids probably don't know how special you are to me. You made a hard job easy and and enjoyable, so much so I hope to put together another educational program soon.

A special thanks has to go to Bonnie Bolinger Without her hours of work and strong support (in many ways) the conference would not have been as big a success as it was. She's one great lady.

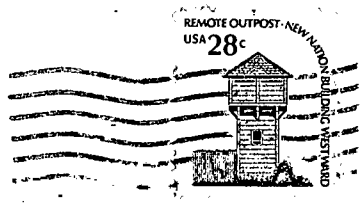
To all future Program chairpeople in the Mideast Region I would like to say one thing! Don't be afraid to take on the job, you have the best support team in the world.

Thanks to all,

Susan E. Buffin LPN E.T
Grand Rapids, Michigan

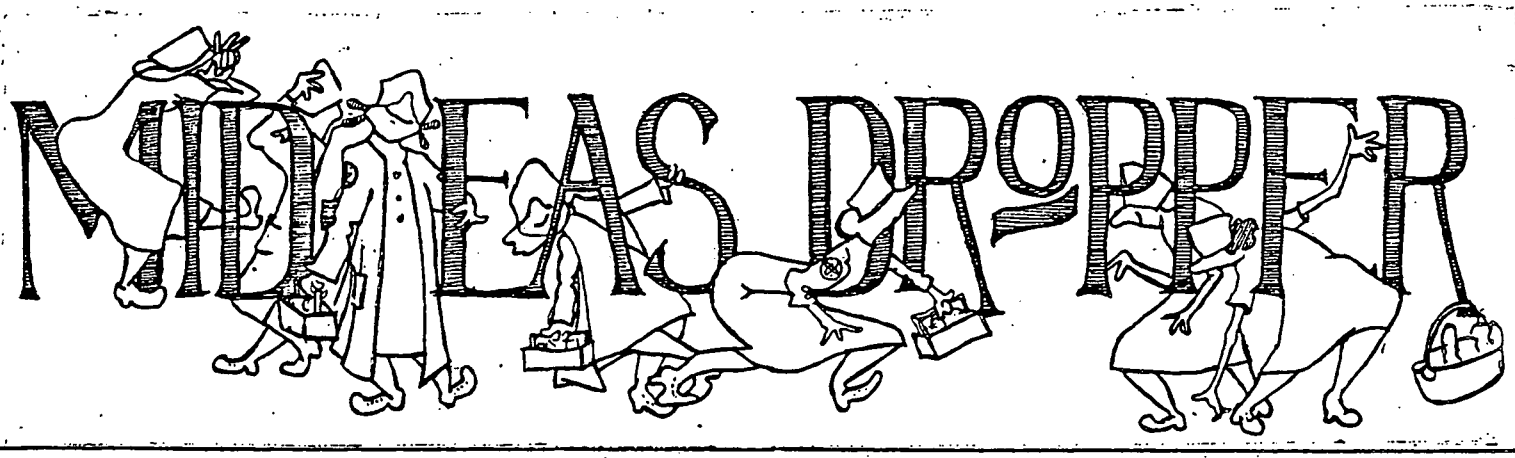
Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

COLUMBUS 5
SEP 19



MAUDE B. TIMMONS, RN ET
5319 Velle Vista Drive
Louisville, KY 40272

FIRST CLAS

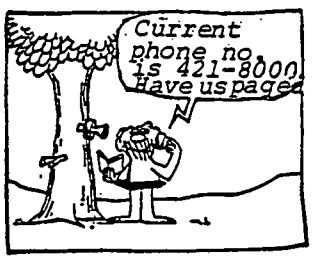


VOL. VIII December., 1980 NO. 4

EDITORS

Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

Notice



MIDEAST REGION I.A.E.T. OFFICERS

PRESIDENT:	*Joyce Hawley*
PRESIDENT ELECT:	*Sally Thompson*
SECRETARY:	*Rosemarie VanIngen*
TREASURER:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Jane Beerck*
REGIONAL TRUSTEE:	*Sue Hughes*
TRUSTEES:	*Ethel Pryor* *Barbara Montgomery* *Betsy Hewitt*
COMMITTEES:	
Membership --	*Jane Beerck*
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Education --	*Susan Cecil*
By-Laws --	*Ethel Pryor*
Publication --	*Barbara Montgomery* *Betsy Hewitt*
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THOUGHTS FOR THE NEW YEAR!

I will try to live through this day only, and not set far-reaching goals to overcome all my problems at once. I know I can do something for 12 hours that would appall me if I felt that I had to keep it up for a lifetime.

Just for today I will try to be happy. Abraham Lincoln said, "Most folks are about as happy as they make up their minds to be." He was right. I will not dwell on thoughts that depress me. I will replace them with happy thoughts.

Just for today I will adjust myself to what is. I will face reality. I will try to change those things I can change and accept those things I cannot change.

Just for today I will try to improve my mind. I will not be a mental loafer. I will force myself to read something that requires effort, thought and concentration.

Just for today I will do a good deed for somebody--without letting him know it.

Just for today I will do something positive to improve my health. If I'm a smoker, I'll make an effort to cut down. If I'm overweight, I'll eat nothing I know is fattening. And I will force myself to exercise--even if it's only walking around the block or up the stairs.

Just for today, I will be totally honest. If someone asks me something I don't know, I will not try to bluff; I'll simply say, "I don't know."

Just for today I'll do something I've been putting off for a long time. I'll finally write that letter, make that phone call, or clean that closet.

Just for today, before I speak I will ask myself, "Is it true?" "Is it kind?" If the answer is negative, I won't say it.

Just for today I will make a conscious effort to be agreeable. I will look as well as I can, dress becomingly, talk softly, act courteously and not interrupt when someone else is talking. I'll not try to improve anybody except myself.

Just for today I will have a program. I may not follow it exactly, but I will have it, thereby saving myself from two pests: hurry and indecision.

Just for today I will have a quiet half-hour to relax alone. I will reflect on my behavior and will try to get a better perspective on my life.

Just for today I will be unafraid. I will gather courage to do what is right and take responsibility for my own actions. I will expect nothing from the world, but I will realize that as I give, the world will give to me.

THE ABOVE IS A LIST I FOUND YEARS AGO WHICH I FELT MIGHT BE OF INTEREST TO YOU.

Barbara Montgomery, R.N., E.T.

from the "PRES"

Our 1980 Regional Program sponsored by the Columbus Enterostomal Therapists was outstanding. It was good that 43 of our regional E.T.'s were there.

Our E.T. business meeting held on Saturday had a much lower attendance. The outgoing officers did an outstanding job the past two years. It will be challenge to do as well. I do know were are all interested and concerned with the growth and cohesiveness of our region.

With the E.T.'s time at a premium, and some hospitals funding at a minimum, it may be more difficult in the future for some of us to attend International Conference. This means in order to keep up with new techniques and skills we may have to stay closer to home. "Closer to Home" is the Mideast Region of the I.A.E.T. Without the officers and committee members willing to work on future programs the continuing education in our field may be left to you. We need "new blood", new support, and more enthusiastic interest in our region.

Our business meeting on November 1, 1980, was extremely well conducted by Helen Arend. From 8:00 - 12:00 we had committee reports, new and old business, election of officers, and a sharing session (slide presentations on problem patients).

As I assume office as President of the Mideast Region, I hope to hear from many of you. This is your organization and I would like to know what <u>you</u> want from it. I am asking for your support, ideas, criticisms--just let me hear from you.

I know everyone must enjoy our Mideast Dropper. There is almost as much information in it as in our journal. Barbara and Betsy are begging for material for each issue. Share your knowledge and experience with us in the region by submitting materials to the newsletter publishers.

I ask you to support me by becoming active in our region. We need you. This is your organization and you can make it serve your best interest by becoming involved.

Our 1981 Regional Meeting will be held in Detroit, sometime in November. Put this in your budget and on your calendar. Hope to see all 153 (present) members there.

Happy Holidays.

Joyce

With affection and respect, we express our thanks to Helen, a longtime member of the Mideast Region, who has served as Secretary, as a member of the Board of Directors, and as President from 1978-1980.

With a special gift or orderliness, she has conducted business meetings in accordance with an agenda distributed beforehand to save time for everyone; with a keen interest in other groups, she has kept us informed of activities of national and regional scope. Because she is a warm, optimistic person she has welcomed newcomers and longtime members alike to her circle of friends, finds some good aspect in all situations, and has a ready and infectious laugh.

No job has been too small or too forbidding for her to tackle either as a volunteer or a leader. She has devoted countless hours to the Mideast Region, and has given us an example that will be tough to follow!

"Barbara Ann"

PLANNING AHEAD
by Susan C. Hawkins

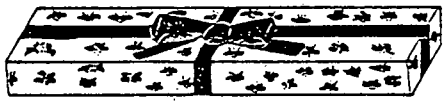
THE CONCEPT OF planning ahead has always intrigued me. I've been a life-long admirer of those who do, and only in the last decade have I been able to relate this concept to major issues of my life (like my job). Unfortunately, Christmas shopping I've never classified as a "major issue in my life"... although it should be.

For instance, it is not unheard of for me to send belated "Merry Christmas" cards and gifts. I have to have them specially printed, you know (the cards, that is)! Evidently, Hallmark does not consider us folks who shop right up until the last minute (and after) a worthy consumer group. Although, when one ponders it, there is more of an excuse, considering the rush of the season, to miss a Christmas salutation and gift than there is to miss a birthday.

Anyway, every year I intend to do things in an organized fashion. I make lists in November. I should make lists in July so I can budget. But, hang the budget on December 23, when I finally get around to shopping. Who cares if I pay a price equivalent to Elizabeth Tyalor's diamond for a set of matching tea-towels and napkins? It's the spirit of the season that overcomes you...or the crowds...I'm not sure which.

I do know that on December 23, 1978, the proximity of the coming holiday will reach an urgent status, and I will be forced to join the throngs of people like me in an uncontrollable rampage to find my mother a scarf in a certain shade of violet, to match the pin my sister is giving her.

I know that after parking three miles from the shopping center, searching through five stores containing thousands of people bordering on hysteria, that I will find a scarf in not quite the shade I was looking for.



I will search for a salesperson from whom to purchase the scarf. To find such a person, I will look for the largest mass of humanity and, in the center, I will surely find a cash register operated by a person who did all their Christmas shopping months ago, and takes no pity on those of us who did not.

I will finally find the end of one of the lines (the wrong one, of course) and patiently wait my turn. Only when I discover that the person at the head of the line wishes to send his purchase (a coat rack) to Egypt do I begin to lose hope.

I consider, fleetingly, stealing the scarf...and for a moment I calculate the time difference in stealing the scarf, going to trial, and "doing the time," as opposed to waiting in line. I'm not sure which would take longer.

Just when I've decided to try life at Alcatraz, another salesperson (dressed like Mrs. Claus in a room that must be 180°) opens another register. Ho! Ho! Ho! I trample over three elderly ladies and a child, and happily present my scarf to Mrs. Claus.

"Cash or charge?", she will snarl, at which point I will begin to write my check. "You'll have to get that OK'd by Mr. Zabilnikoski," she gleefully reports. "He's downtown at the main store," she adds. I will hand her the scarf and slink away in embarrassment.

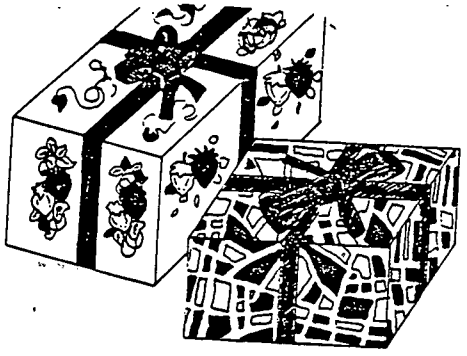
I will go through this procedure for 23 other items on December 24, 1978...only this time I will be accompanied by armed guards from Capone, Inc., as I will be carrying a large sum of cash.

Upon returning home, laden with packages, I will discover that I do not have enough boxes to wrap my purchases. Old-fashioned ingenuity will come into play as I wrap my sister's silk blouse in an oblong box marked "Kinney's." An empty Pupply Chow box will have to do for my brother's socks...but I will just put a bow on my nephew's tractor, as I have run out of wrapping paper anyway.

(I will not run out of paper due to lack of planning, though. I bought some on December 27, 1977, and carefully stored it in the basement. As it has now mildewed, I discard it and plan to purchase some only before the season next year.)

The shopping and wrapping having been completed, I will join my family. On the evening of the 24th, as I sit in front of the tree with twinkling lights, feel the fire burning, and sip on my eggnog, I will engage in conversation with my three-year-old nephew.

He will patiently explain to me the wondrous ways of Santa Claus, and my spirit will be renewed. The toughts of shopping for the whole world and delivering gifts via sooty chimneys will make me realize how fortunate I am to have to plan for relatively few. It will become once again apparent that Whoever is guiding us sends us only tasks that we can, with a little effort (and planning) accomplish.



SCHOLARSHIP INFORMATION-- WHERE TO WRITE AND WHO IS ELIGIBLE

In answer to your request for information regarding scholarships for Enterostomal Therapy education, please find the enclosed requirements for acceptance to educational programs, an application form and a listing of approved educational programs.

Due to the awareness of the growing need for certified enterostomal therapists throughout the world and our strong belief in the continued growth and sucess of enterostomal therapy, the International Association for Enterostomal Therapy has established scholarship grants. These scholarships will be awarded to deserving Registered Nurses who are interested in working in this specialty field and in improving the quality of nursing care for the ostomy patient.

The scholarship grants have been established for I.A.E.T. by manufacturers of ostomy supplies, the United Ostomy Association and other interested parties who share the same concern of members of our organization.

ENTEROSTOMAL THERAPY SCHOLARSHIP REQUIREMENTS

The applicants for this scholarship grant must:

1. Be a registered nurse with two years recent experience.
2. Be employed in a hospital, or other related health facility.
3. Have a sincere interest in the total rehabilitation of the ostomy patient.
4. Be utilized in his/her employment in direct patient care and in staff teaching.
5. Share his/her expertise and knowledge in the community.
6. Become familiar with all ostomy products, use what is best for each patient, and not endorse an individual product.
7. Become familiar with all resources which will truly benefit the ostomate.
8. Must remain in E.T. employment for two years and hopefully become a member of I.A.E.T.
9. Submit a progress report to the president of I.A.E.T. after six months and then after one year from the E.T.'s Director of Nursing and/or immediate supervisor.
10. Applicants for scholarships must have been accepted to a program and a zerox copy of their acceptance enclosed wi h scholarship application.
11. Scholarships recipients must enter a educational program within the fiscal year the scholarship is received.
12. Each applicant is responsible for seeing that a letter of recommendation from the Director of Nursing or immediate supervisor and two physicians accompany the application. Only complete applications will be reviewed by the committee. These should be mailed directly to I.A.E.T., 505 N. Tustin Ave., Suite 219, Santa Ana, California 92705

Special Considerations of the Scholarship Committee

1. To give consideration to applicants from communities without E.T. services and students with financial need as well as recognizing areas where the need for a second E.T. is imperative because of the increasing demand for services.
2. Accept those students who meet the criteria established for admission into educational programs, including international students.
3. Review all completed applications and notify each of committee's decision.
4. Deadline for receipt of application and its requirements is December 1st of each calendar year.
5. Applicants who are not chosen in a given year will be held over for consideration the next year. If, after two consecutive years, the applicants did not receive a scholarship, the applicants must reapply with statement of interest.

The above criteria have been established by the I.A.E.T. scholarship committee and is subject to revision.

Sincerely,

Nell H. Perry, R.N., E.T.
Chairman, Scholarship Committee for I.A.E.T.

We have a new addition to the Mid-Eas-dropper staff! Her name is Erin Elizabeth Hewitt born October 23, 1980, to Betsy Hewitt, R.N., E.T. (O.S.U. Hospital) one of the editors and publishers of our newsletter. Erin came on board weighing 8 lbs. 2 oz. Both mamma and baby are doing fine.

CHOOSING THE ANALGESICS IN TREATING CHRONIC PAIN OF MALIGNANT DISEASE

by

Randy P. Schad
Assistant Director of Pharmacy
Department of Pharmacy
The Ohio State University Hospitals

Some cancer patients can relieve their pain by taking simple aspirin or acetaminophen. However the mainstay of cancer pain control are narcotic analgesics. Although most of these drugs produce a similar quality of analgesia in equianlgesic doses, factors such as oral effectiveness, duration of action, metabolism, and individual variation in patient response should be considered in the selection of a specific analgesic.

Aspirin

Aspirin has analgesic, antiinflammatory, and antipyretic properties. It is the standard medication used for the relief of mild pain. Its analgesic and antiinflammatory actions are associated with its ability to decrease the formation of prostaglandins in the body. The usual oral dose for adults is 325 to 650 mg. every 3 to 4 hours. Side effects are usually limited to gastric irritation. Doses greater than three grams per day increase the bleeding time. Tinnitus is seen when high doses such as those seen in rheumatoid arthritis are used.

Acetaminophen (Tylenol^{R})

Acetaminophen has analgesic and antipyretic properties similar to aspirin. It is an effective drug for the relief of mild pain, but it should not be used alone in treating intense pain. In clinical doses, acetaminophen is not effective in pain caused by inflammation. The usual oral dose for adults is 325 to 650 mg. every 3 to 4 hours. If a dose of 650 mg. is ineffective, higher doses are of no benefit. The total daily dose should not exceed 3 gm. In patients with severe liver impairment, doses should be lower than normal. Therapeutic doses of acetaminophen are remarkably free of adverse side effects. However severe hepatotoxicity is associated with overdosage of the drug or when it is taken chronically in therapeutic doses (3-4 gms./day).

Codeine and Codeine Combinations (Tylenol No. 3^{R})

Codeine provides very satisfactory relief of mild pain especially when taken with a nonnarcotic analgesic such as aspirin or acetaminophen. These agents have a high oral efficacy. They are capable of producing all of the side effects of other narcotics. However when codeine is administered orally in doses of 32 to 65 mg. every 4 hours, the incidence of side effects is not high. It is a useful first drug or drug combination to be tried on cancer patients with mild pain.

Propoxyphene (Darvon^{R})

Propoxyphene products are used orally for the relief of mild to moderate pain. A 65 mg. dose of propoxyphene is no more and possibly less effective than usual doses of aspirin and acetaminophen. If used at all in treating patients with cancer pain, the combination products of propoxyphene and aspirin or acetaminophen should be used. The recommended dose of either of these combination products is one every four hours. Side effects include dizziness, drowsiness, and nausea and vomiting. Somnolence occurs only when it is used in large doses. It has low addicting properties. There has been much publicity lately to remove propoxyphene from the market because of the large number of fatalities with which it is associated. In most of the deaths, other drugs (including alcohol and tranquilizers) were also used and the patient died from multiple and massive drug use.

Pentazocine (Talwin^{R})

Pentazocine is structually related to morphine and is used for the relief of mild to moderate pain. However an oral 50 mg. dose has been shown to be less effective than 650 mg. of aspirin. The usual parenteral dose is 30 to 60 mg. every 3 to 4 hours, while the oral dose is 50 to 100 mg. every 3 to 4 hours. Talwin (12.5mg.) is also available in combination with aspirin (325 mg.). The analgesia produced by oral administration of pentazocine is not dependable because of poor absorption of the drug from the gastrointestinal tract and extensive metabolism of the drug when given orally. Side effects include nausea and vomiting, drowsiness, sweating, headache, dizziness, sedation, blurring of vision, constipation, and respiratory depression. There are also problems with psychotomimetic reactions after intramuscular and oral administration. These psychotomimetic effects include hallucinations, euphoria, delusions, depression, distorted body images and depersonalization. These problems reduce the value of the drug in the ambulatory patient. On long term use, parenteral pentazocine has caused fibrous myopathy. Pentazocine is also a narcotic antagonist, therefore it will precipitate withdrawal symptoms in patients who have been on narcotics for prolonged periods and who are switched to it. Pentazocine should be used cautiously, if at all in cancer patients.

Nalbuphine (Nubain®) and Butorphanol (Stadol®)

Nalbuphine and butorphanol are two synthetic agents with combined narcotic antagonist and analgesic properties. Both have been released with claims of producing a low degree of physical dependence, respiratory depression, and hemodynamic toxicity. Further studies are needed to support these claims. Both have proven effective in moderate to severe pain of differing origins. Butorphanol is recommended in doses of 1 to 4 mg. IV or IM every 3 to 4 hours, while Nalbuphine can be administered IV, IM, or SC in doses of 10 mg. every 3 to 6 hours. Side effects of both drugs include sedation, light headedness, nausea, vomiting, sweating, dizziness, respiratory depression, constipation, psychotomimetic effects, and physical dependence. Both agents will produce intense withdrawal reactions in patients who have been switched to them after receiving narcotic analgesics for prolonged periods. Neither drug has shown any apparent advantage over other narcotics when used appropriately.

Brompton's Mixture

In England, Brompton's Mixture consists of variable amounts of heroin, cocaine, alcohol, syrup and chloroform water. In the United States it usually consists of either morphine or methadone combined with cocaine in an alcoholic base. The medication is titrated to meet the patient's needs to control pain and is given on a scheduled basis. This mixture has gained much attention in recent years because of its use in controlling pain of the terminally ill as part of the hospice concept. Reports in the literature claim the combination of morphine and cocaine control pain in the majority of patients in doses of 5 to 20 mg. of morphine every 4 hours. Cocaine is usually administered as a constant 10 mg. dose. Cocaine is included in the solution in an attempt to counteract narcotic sedation and to potentiate the narcotic. Swishing the Brompton's Mixture in the mouth before swallowing may increase the absorption of cocaine when taken orally. Also, if the patient has any painful mouth ulcerations, the cocaine will numb these areas which many times enables the patient to eat and drink when he was not able to before. In some patients cocaine causes excessive CNS stimulation, hallucinations, and nightmares. Recent double blind crossover studies have showed no significant difference between the traditional Brompton's Mixture and a morphine syrup without cocaine. Twycross, a leader in the Hospice movement, has stopped using cocaine in his patients. Other side effects of the mixture include nausea and vomiting, confusion, constipation, and drowsiness. Since some patients experience some degree of nausea with oral morphine, prochlorperazine (Compazine) is given to patients on a regular basis. The medications are not physically mixed so that the Brompton's Mixture can retain its dosage flexability. Furthermore routine combinations of phenothiazines with narcotics should be used with caution because the phenothiazines can potentiate respiratory depression, sedation, and orthostatic hypotension.

"Bring ideas in and entertain them royally, for one of them may be the king." —MARK VAN DOREN

Morphine

Morphine is the standard analgesic against which other narcotics are evaluated. The analgesic effect of morphine is usually maximal within an hour of parenteral administration. Following subcutaneous or intramuscular injection, peak plasma levels occur within 30 minutes and analgesia may be maintained up to seven hours. Plasma levels after oral administration are only 1/5 to 1/3 of those obtained after parenteral administration. Thus large doses of morphine (i.e. 60 mg.) have to be given orally to achieve effective blood levels because morphine is rapidly metabolized by the liver during the first pass. The starting oral dose of morphine is 30 mg. every four hours. The dose is then titrated according to patient response. The literature reports doses as low as 2.5 mg. every four hours in elderly patients to control pain while other patients required 90 mg. or more. A number of patients in Hospice of Columbus have needed to take up to 210 mg. every 3 hours of morphine orally to relieve pain. There have been other case reports of giving continuous intravenous morphine to control cancer pain. Doses employed have ranged from 40 to 144 mg. per hour for periods of 30 to 70 days with virtually no escalation in the dose once steady state has been achieved. Patients have been coherent and alert. Side effects of both parenteral and oral morphine are sedation, mental clouding, inability to concentrate, lethargy, constipation, nausea and vomiting, tolerance, physical dependence, respiratory depression, dizziness, and anxiety. Most hospice organizations utilize morphine as their drug of choice in treating their patients.

Methadone (Dolophine®)

Methadone has the reputation for being a sinister drug and has been widely associated with drug abuse. However it is one of the best absorbed and most effective narcotics for analgesic purposes. Ten milligrams of methadone intramuscularly is as potent as 10 mg. of morphine. When administered orally, methadone retains about 50% of its analgesic potency. It is rapidly absorbed reaching peak plasma levels within 2 to 4 hours after administration. Even though the average plasma half life is 25 hours (range 13 to 47 hours) both the oral and parenteral dose of methadone is 5 to 10 mg. every four to six hours titrated to meet patient needs. Since the half life of methadone is prolonged, frequent dose escalations, and shortened dose intervals lead to an increase in methadone accumulation which may result in toxic plasma levels. Therefore, dose changes should be made very carefully. Side effects are the same as with the other narcotics previously mentioned. When methadone is first started on patients, extreme somnolence is seen in some patients. This disappears after the first 3 to 4 days and the patient can resume daily activities. Finally, methadone is considerably less expensive than other strong narcotic analgesics and should be considered a very useful drug to control chronic pain.

Meperidine (Demerol®)

Meperidine is the most often prescribed synthetic analgesic used in the hospital. A usual adult dose is 75-100 mg. intramuscularly every

three hours. This dose will be equivalent to 10 mg. of morphine. Meperidine has a short duration of action, 3 hours. When given by mouth, it has a 1/3 to a 1/4 oral-parenteral ratio. So in order to get the same analgesic effect as 100 mg. of intramuscular meperidine, the patient has to take between 300 and 400 mg. of the medication. Peak levels are not attained until two hours after oral administration, thus analgesia is delayed. A toxic metabolite, normeperidine builds up in the body of patients with renal failure. This build up can cause unwanted central nervous system excitation and even seizures. Meperidine has the same side effects associated with its use as other narcotics. For the treatment of the chronic pain of cancer, it offers little advantages over other available agents.

Hydromorphone (Dilaudid^{R})

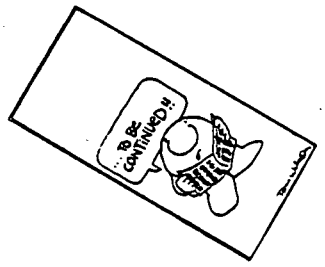
Hydromorphone is a semisynthetic analgesic related to morphine. The usual oral and parenteral dose is 2 mg. every 3 to 6 hours. The dose should be adjusted to meet the needs of the patient. It is also available as a rectal suppository (3 mg.) that can be used in those patients who cannot take oral medications and who have injection site complications. The side effects associated with its use are the same as other narcotics. As compared to morphine and methadone, it is a very expensive medication.

Levorphanol (Levo-Dromoran^{R})

Levorphanol is a highly potent synthetic analgesic with properties and actions similar to those of morphine. It is available as an as an injection and as oral tablets. The average adult dose is 2 mg. orally or subcutaneously. The dose is then adjusted to meet patient needs. The duration of action is about 4 hours. Side effects are similar to those of other narcotics.

Oxycodone Combinations (Tylox^{R}, Percodan^{R})

Oxycodone is a synthetic narcotic analgesic available only in combination with aspirin, phenacetin and caffeine (Percodan) or with acetaminophen (Percocet, Tylox). It is useful to control moderate to severe pain. The usual dose is 1 tablet every 4 hours titrated to meet the needs of the patient. Following oral administration, the analgesic effect is noted in ten to fifteen minutes and reaches a maximum in 30 to 60 minutes. The duration of analgesia is reported to range from 3 to 6 hours. Side effects are comparable to those seen with other narcotics. However the phenacetin in the Percodan has been implicated as a cause of renal papillary necrosis. This mainly develops over long periods of time in patients consuming large quantities of phenacetin. Acetaminophen can cause hepatotoxicty when taken chronically in therapeutic doses (3-4 gms/day).



PUBLICATIONS OF INTEREST

"Ulcerative Colitis: The Cancer Threat", Nugent, Surgical Roumds; Aug 1980, pp. 28-32

"Sexual Implications of Bowel Diversion", Wabrek, Wabrek, Burchelle, American Journal of Proctology, Gastroenterology & Colorectal Surgery; Aug 1980

"The Rational Use of Narcotic Analgesia for Controlling Cancer Pain", Houde, Drug Therapy; July 1980 #7 pp 63-68

"Preoperative CEA Level:a Prognostic Test in patients with Colorectal Carcinoma", Kohler, Siminowitz, Paloyan, The American Surgeon; Aug 1980, pp 449-451

"Non-narcotic Alternatives for Controlling Cancer Pain", Houde, Drug Therapy; Aug 1980 #8, pp 59-64

"Management of Patients with Ileal Resection", Levine, Practical Gastro-Enterology; June 1980, pp 7-14

"Ileostomy Diarrhea", Achkar, Practical Gastroenterology; June 1980, pp 16-19

"In Search of an Effective Antiemetic: a Nursing Staff participates in Marijuana Research", Seipp, Chang, Shiling, Rosenberg, Cancer Nursing; Aug 1980, pp 271-276

"The New USA Stapling Apparatus (EEA-131) for a low anterior resection of the Rectum", Fain, American Journal of Proctology & Gastroenterology & Colorectal Surgery; Jul 1980, pp 20-26

"Sexual Function after Abdomino-perineal Resection of the Rectum", Pluchinotta, Fabris, AJP, GE, CR Surgery; Jun 1980, pp 18-21

"Decubitus Prevention through Early Assessment", Taylor, Journal of Gerontological Nursing; July 1980, pp 389-391

"Why Preop Stoma Planning is a Must", Lerner, Harsh, Eisenstat, RN; Aug 1980, pp 48-51

"Cancer Chemotherapy: Those Dreaded Side Effects & What to do about Uhem", Levitt, RN; June 1980, pp 53-56

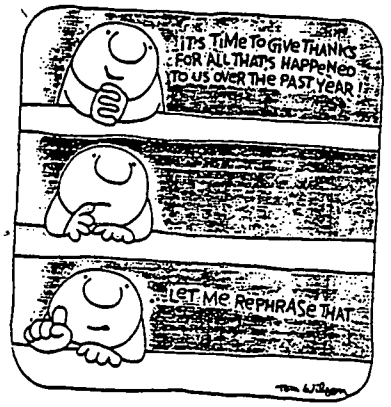
"Reference Sources for Nurses", Nursing Outlook; July 1980, pp 444-448

"Influencing Food Acceptance in Anorexic Cancer Patients", Gormican, Post-Graduate Medicine; Aug 1980, pp 145-152

HELPFUL HINT

Some nurses use commercial cotton balls. Be certain to check labels--many are not cotton. They are nylon or others that are very irritating to skin.

Judy Schaffer



Since Betsy's sharing with you about her 1st total body Cancer Screening Day in 1979, we have had several inquiries about how to start a program so we had the 1980 chairpersons share the following information with you.

THE OHIO STATE UNIVERSITY HOSPITALS

1980 Cancer Screening

The Cancer Screening Day

On Saturday, June 7, 1980 from 8:30 A.M. to 4:30 P.M., 212 employees and their adult, immediate family members attended the Cancer Screening. All particioants were given the following information from the American Cancer Society on the most prevelant cancers related to their sex:

Males:	Females:
Listen to Your Body	Listen to Your Body
Facts on Lung Cancer	Facts on Breast Cancer
Facts on Colon-rectal Cancer	Facts on Colon-rectal Cancer
Facts on Prostate Cancer	Facts on Uterine Cancer

Each participant completed a questionnaire which asked specific questions about high risk factors related to his or her sex. Individual explanations about their high risk factors for particular cancers were given to participants by physicians and nurses. Then, participants chose among the following exams and laboratory studies:

Head and neck, including oral
Breast
Abdomen
Pelvic with pap smear
Testicular
Rectal
CEA
Alkaline Phosphatase for males over 40

Participants could also choose to attend any or all of four educational sessions lasting 10-15 min. each: Risks of Smoking- Lung models, ACS brochures; BSE -Film, Betsi Breast Model, ACS brochures; TSE - Film, Testicular Model, ACS brochures.

Posters on prevention and early detection of cancer were displayed on walls in the lobby, hallways, exam rooms, and teaching rooms.

The objectives of the committee for the Cancer Screen this year were:

1. To offer a comprehensive screening exam to employees and their adult immediate family members.
2. To provide cancer information and instruction to interested persons.
3. To evaluate various cancer screening tests.
4. To collect data for use in medical, nursing, and epidemiological research.

The staff who were responsible for successful operations during the Cancer Screening to meet these objectives were:

20 Nurses
6 Physicians and 1 Pathologist
3 Secretaries/Ward Clerks
2 Lay persons from ACS
2 Medical Technologists
2 Physicians' wives
1 Nursing attendant
1 Epidemiologist
1 Lay person from OSU Volunteer Services
38 Total Volunteers

Publicity for the Cancer Screening included two letters to each employee with their paycheck on the first and last pay periods on May. Posters were placed in the enclosed bulletin boards the week before the screen. Fliers were sent to all mailing stations and posted by all elevators. Table cards were placed on all tables in the dining rooms and vending areas the week of the screen.

Findings from the Cancer Screening

Attendance at the 1980 Cancer Screening was 212 employees and family members. (This was down considerably from last year's attendance of 700). Of those participating this year, 28 percent were male and 72% were female. Seventy-one persons or 33% of the participants had one or more abnormal physical findings. The list below crudely summarizes these findings:

23 Pelvic abnormalities
12 Breast masses
12 Suspicious moles and skin lesions
10 Head and neck abnormalities
9 Rectal abnormalities
9 Enlarged lymph nodes
6 Thyroid abnormalities
3 Testicular masses
2 Enlarged prostates
2 Abdominal masses
2 Aortic abnormalities
1 Hypertension
1 Abnormal weight loss

Obviously, all of these findings will not necessarily prove to be a malignancy. All persons with abnormal findings were encouraged to seek further medical attention on the day of the screening. When appropriate, some participants were referred to specialists. All persons with abnormal findings were sent an individualized letter reinforcing the advice given them the day of the Cancer Screening to seek further medical attention. A carbon copy of the letter was sent to the physician identified by the participant as his or her family doctor. (Dr. Martin personally dictated all these letters). All persons with abnormal findings will be followed up in the next few months to determine rates of malignancy or other serious illness related to abnormal findings.

Regarding the lab tests taken, the CEA levels and pap smear results have not yet been received. All the Alkaline Phosphate results were negative.

All participants with no abnormal findings were sent form letters reinforcing their normalcy and their positive health behavior in attending the Cancer Screening.

Follow-Up Data Collection

As a follow-up to the Cancer Screening, Molly Moran, R.N., M.S., Elaine Glass, R.N., M.S. and Nancy Reiches, Ph.D. are collecting additional data. All participants with abnormal physical findings and 105 participants (30 male and 75 female) will be sent a one page survey asking their reasons for coming for the Cancer Screening. Another survey will be sent to a random sample of the 3,100 hospital employees (200 males and 200 females) who did not attend the Cancer Screening. This questionnaire will reveal information on these employees' high risk factors and their reasons for not attending the free Cancer Screening. All data collected is being computerized for multiple factor analyses.

Summary

Collaborative voluntary efforts and financial assistance from The Ohio State University Hospitals and Clinics. The Ohio State University Comprehensive Cancer Center, and The Franklin County Unit of the American Cancer Society resulted in a relatively successful Cancer Screening Program. The major weakness of the program was the poor attendance. The planning committee had prepared the facilities to accommodate 800-1000 participants. The follow-up data collection should reveal some possible solutions to remedy this problem next year.

Submitted by:

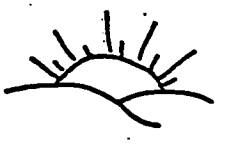
Elaine Glass, R.N., M.S.

Elaine Glass, R.N., M.S.

Molly Moran, R.N., M.S.

Molly Moran, R.N., M.S.

How often
we kneel
to our weakness...
when
we might rise
to our strength.



SEMI-ANNUAL BUSINESS MEETING

MID EAST REGION IAET

COLUMBUS, OHIO

Helen Arend, President, called the meeting to order and welcomed everyone. Each person attending introduced herself and stated where she was from. New members were recognized and asked to stand.

There were forty-five members present, therefore, a Quorum was established.

It was announced that motions should be sent in writing.

Roberts Rules of Order were presented and reviewed by Helen Arend. Joan Van Neil moved that these be adopted. Kathleen Wood seconded the motion. The motion was carried unanimously.

The secretaries' minutes were submitted and approved. Angie Lamb moved that the minutes be accepted. Norma Gill seconded the motion. The minutes were accepted.

Jane Beerck, Treasurer, read and presented the Treasurer Report. The Treasurer Report was received and is to be audited. Jane reported that our income is from our dues and from educational programs. Copies of the proposed budget were distributed and it was read by Jane.

Sue Brady moved that the proposed budget be accepted. Sister Consolata seconded the motion. The motion was carried unanimously.

Committee reports were then given. Membership Committee Chairman, Nancy Rioux, reported on postcards being sent to welcome new members and to locate old members. Nancy asked for help in how we could be notified of new potential members. A questionnaire was given to each of us to be filled out and returned to the Membership Committee. Any suggestions or ideas in which to contact potential new members is appreciated by the Membership Committee.

A breakfast for new members at our next regional meeting was discussed.

Joan Van Neil of the Education Committee reported that there were eight Education Programs reported to the Education Chairman during the last year.

Barb Montgomery, Trustee, reported on the Newsletter. A problem she is having is due to change of addresses of some of the members. She needs to be notified of these changes. Barb also asked that all of us send her articles, names of new members, and new ideas for the Newsletter. She asked for input from all of us. She also announced that Betsy Hewitt, Trustee, has a Baby Girl-8 lb. 2oz.!

Ethel Pryor reported on the By-Laws. The By-Laws revisions will be in the Newsletter. A Pre Conference report will inform members of the revisions and will clarify certification. This will be discussed at our National meeting in Chicago in June.

Helen introduced Maude Timmons, Historian, who has made a remarkable recovery from a serious auto accident and is back working and "going strong". Maude asked that we turn in more information and pictures for our Mad East Region Historian Book.

Sue Hughes, Regional Trustee, then gave her report. Sue reported on her duties as the Regional Trustee. She announced that the National Conference will be June 17, 18, 19, 1981, in Chicago, and that the Certification Exam will be given on June 20th.

Sue reported that the IAET Directory will be sent to each member, probably in January.

The U.O.A. Visitor Program Booklet will be available to us. This is endorsed by the U.O.A. and the A.C.S. The IAET was asked for input in the Education Program.

The Standards of Enterostomal Therapy Nursing Practice was then discussed. A copy will be sent to each member with their new membership cards. Sue then reported on the Hollister Outreach Program. The ET's have been recognized in these programs. The concerns of the membership regarding these programs will be taken to the National Conference.

Sue stated there are guidelines for IAET Educational Programs available through the National Office.

Discussion followed regarding the Youth Rally. Sue read a letter from Jan Jestor, Youth Rally Chairman. The Youth Rally will not be sponsored this year by the IAET and the U.O.A. Legal implications of the Youth Rally were discussed. Many concerns regarding the need for a Youth Rally were presented. Helen suggested that the parents of the "kids" attending the Youth Rally be legally responsible for action of the youths and not the total responsibility of the IAET and the U.O.A.

Ethel Pryor made a motion that the Mid East Region supports the concept of a "Youth Rally". We ask that the "IAET re-examine their position and explore alternatives that will allow involvement in another Youth Rally without legal responsibility for the behavior and conduct of the youth participants." Kathleen Wood seconded the motion. The motion was carried unanimously.

Sue advised all the members to take their swim suits to the National meeting in Chicago in June!

Barb Montgomery then reported on the Educational Program on Friday. 230 people attended with 18 companies exhibiting. All went well with two-three thousand dollars profit being made for the Mid East Region.

Norma Gill reported on the World Council of Enterostomal Therapists which was formed by Norma in 1976. The first conference was in Milan, Italy and the second in Dussoldorf, Germany. She stated that there were 300 people present at the W.C.E.T. held in Cleveland in August, 1980, with 22 countries represented. The new president, Pearlie Stevens, is from S. Africa. The next meeting will be somewhere in England in May, 1980. The United States representative is Mary Jane Kock, Hollister.

The Norma N. Gill Foundation was established by the W.C.E.T. This is to be used to assist foreign countries in sending E.T.'s to school and to help them to get schools started. Norma stated that this foundation may be used anywhere to get Enterostomal Therapy started.

Joyce Hawley made a motion that the Mid East Region be the first to contribute to the Norma Gill Foundation in the amount of $250.00. Trudy Blied seconded the motion. The motion was passed unanimously. The $250.00 will be banked in the United States. The written plans for the money are to be written by Norma Gill.

Norma Gill thanked the group for the contribution.

Helen then reported on our Tax Exempt Status, which is being worked on. She also discussed Communication Problems. She encouraged us to notify the membership chairman of members which may have not been notified by the region or the IAET.

As New Business, Helen announced that there will be no Regional Booths at the National Conference.

Helen then asked Ethel Pryor to report on the next Mid East Regional Meeting to be held in Detroit, Michigan, 1981.

Discussion followed regarding preferences of weekdays vs. Saturdays for the meetings. A straw vote was taken to determine how the majority of the group felt about this. The majority requested Friday and Saturday meetings.

Norma suggested that we not only stress the Business Meeting but the Educational Program also.

Joan Van Neil was elected Chairman of all the Enterostomal Therapy School Directo She reported that there will be a refresher course at the Cleveland Clinic with tentative dates being May 1-2. She also reported that the Certification Exam will be given on June 20, 1981, in Chicago. Notifications of the above will be sent to all Mid East Region members.

Norma announced an all-day program being given at the Cleveland Clinic by the physicians there, sponsored by the Cleveland Ostomy Association on February 1, 1981. The program may be attended by ostomates, R.N.'s, ET's, etc.

Pat Hurd commented on some type of certificate or card being sent to those people who have taken and passed the Certification Exam.

Joyce Hawley suggested that we do something to update our Mid East Region Banner. Angie Lamb agreed to "work on the banner."

Joyce Hawley made a motion to purchase a tape recorder to be used by the Secretar Angie Lamb seconded the motion. Sue Hughes will be in charge of the purchase of the tape recorder and to decide on the cost. The motion was carried unanimously.

We then had election of officers. The nominating committee included Phoebe Alfke, Sue Buffin, and Juanita Jenkins.

Phoebe Alfke, Nominating Committee Chairman, presented the slate for those nominated for President Elect, Kathleen Wood and Sally Thompson. There were no nominations from the floor. Ethel Pryor moved the nominations be closed. Angie Lamb seconded the motion.

Helen introduced Sally and Kathleen to the group. She stated that as President Elect, the person has two years to prepare for being president.

During the counting of the votes for President, Sue Hughes suggested that we form a committee within our Mid East Region to pursue a Youth Rally. Discussion followed and this will be presented to the National Conference in June.

Sally Thompson was elected President Elect.

Susie Cecil and Rosemarie Van Ingen were nominated for Secretary. Sue Hughes moved that the nominations for Secretary be closed. Olga Ramas seconded the motion. Rosemarie Van Ingen was elected our new secretary.

Trudy Blied, Ehtel Pryor, and Nancy Rioux were nominated by Phoebe for Trustee. Kathleen Wood moved the nominations be closed. Sue Brady seconded the motion. Ethel Pryor was elected.

Helen then introduced the new officers and turned the meeting over to Joyce Hawley, President.

Joyce presented Helen, the out going President a charm bracelet from the Mid East Region. She also thanked the other out going officers for serving the past two years.

Joyce announced that at out Regional meeting in Detroit next year, we will be electing a new Regional Representative, 2 Trustees, (for the Newsletter), and a Treasurer.

Helen Arend then moved that the meeting be closed. Angie Lamb seconded the motion. The motion was carried, the meeting closed.

Respectfully submitted,

LeAnn Hartley, R.N., E.T.
Secretary, Mid East Region
IAET

MIDEAST REGION

INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY, INC.
Indiana Kentucky Ohio Michigan West Virginia

To: Mideast Region Members
From: Nancy Rioux, R.N.E.T., Mideast Region Membership Chairman
Date: December 3, 1980
Subject: Questionnaire

The Mideast Region Membership Committee would like to establish a "Buddy System" to welcome new E.T.'s to our region. Your help in completing the attached survey would be most appreciated, especially by our potential new members. Please return the questionnaire to me as soon as possible.

Sincerely,

Nancy Rioux, RN.ET.
Chairman Mideast Region Membership Committee

MID EAST REGION
(Membership Committee Questionnaire)

DIRECTIONS: Please complete each item by checking the most appropriate block or by entering the requested information. Your immediate attention to this survey will be most appreciated.

I. GEOGRAPHICAL STATUS:

A. Are you the only Enterostomal Therapist in your . . .

- ☐ Hospital
- ☐ City
- ☐ Other

B. If Hospital is checked in "A," how large is the institution you are affiliated with . . .

- ☐ <200 beds
- ☐ 200-350 beds
- ☐ 350-600 beds
- ☐ >600 beds

C. If "Other" is checked in "A," describe specifically:

II. ENTEROSTOMAL MEETINGS:

A. Do you meet with other Enterostomal Therapists?

- ☐ Yes
- ☐ No

B. If "Yes" to the above question, how often do you meet?

- ☐ Monthly
- ☐ Other

C. If "No" to "A" . . .

- ☐ Are not interested
- ☐ You are too busy

III. NEW THERAPIST:

A. Would you be willing to contact a new Enterostomal Therapist in your area if you were notified?

- ☐ Yes
- ☐ No

B. How would you suggest the Mid East Region welcome new Enterostomal Therapists (Describe below) . . .

Signed: _____
Name City

Return to: Nancy Rioux RN. ET. Grant Hospital, 309 E. State St., Columbus, Ohio 43215

NOVEMBER 1, 1980 SEMI-ANNUAL BUSINESS MEETING
MID EAST REGION IAET

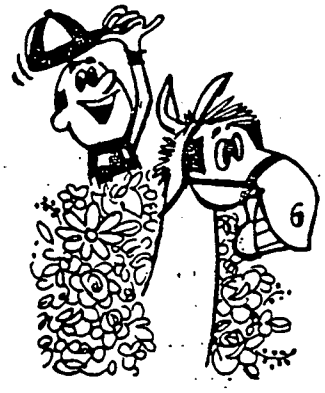
Those attending:

1. Susan L. Brady
2. Mary Angela Lamb
3. Sr. Consolata Wolking
4. Joan Van Nail
5. Catharine M. Jeffords
6. Sherry Birdsall
7. Pat Hurd
8. Nancy Rioux
9. Norma Gill
10. Sally Thompson
11. Olga Ramus
12. Gladys Smith
13. Darlene F. Murphy (Lexington, Ky. non member)
14. P. E. Freeman
15. JoAnne Aldrich
16. Lena Smith
17. Olga Ramas
18. Phoebe Alfke
19. Rosemarie Van Ingen
20. Ethel Pryor
21. Lynne Bieberitz
22. Charlotte Gerbig
23. Sara Crawford
24. Maude Timmons
25. Joyce Morris
26. Marie Lonz
27. Barbara Montgomery
28. Leona Mandich
29. Helen Van Sweden
30. Lois Jean Halloway
31. Kathleen Wood
32. Joyce Hawley
33. Jill Kundtz
34. Ruth Barley
35. Helen Arend
36. Jane Beerck
37. Trudy Blied
38. Marjorie Rose
39. Jean Jenkins
40. Patricia Zollars
41. Norma Guesman
42. Mary Bowling
43. Susan Cecil
44. Susan Muench
45. Markey Kriete
46. LuAnn Hartley

MISCELLANEOUS INFORMATION

Are you aware that there is an association called "The American Liver Foundation"? This group is working hard to increase liver research and to increase public knowledge of the danger these diseases present to all of us. This year, they have funded seven postdoctoral Research Fellowships and ten Student Research Fellowships. Volunteers have established groups in MD, Texas, Chicago, Northern California, Cinn. & New York. More are needed to help educate the public & to raise funds. If you would like to be on the mailing list, to receive information on liver disease, write to: AMERICAN LIVER FOUNDATION 30 Sunrise Terrace, Cedar Grove, NJ 07009 They are happy to send information to nurses & all interested persons.

Hot Tips



NEW PRODUCTS - FILTER FOR GAS & ODOR

Coloplast is featuring a new gas filter with activated carbon. They claim it helps to absorb odor for up to 24 hrs. The new product goes by the name of filtrodor. It can be adapted to any type ostomy pouch. Ask your local representative for samples if you have not already done so.

SKIN CARE PRODUCT

DECUBITEX is an easily applied ointment that the company states has multiple actions to encourage rapid healing of topical ulcers. It contains solubilized scarlet red to promote epithelialization & encourage new granulation tissue. A free sample is available by writing to W.F. Merchant Pharmaceutical Co., Inc., P.O. Box 6, Mt. Rainier, MD 20822

INCONTINENCE PRODUCT

Proctor & Gamble has developed a new type or incontinence system. They state that it has a unique, soft, pliable liner that pulls urine away from the skin. It has unique vented side panels that allow air to circulate and strong adhesive tapes for a secure fit. It goes by the name of "Attends".

MIDEAST REGION PROPOSED BUDGET
January 1, 1981 - December 31, 1981

REVENUE

Membership Dues	
New & Renewal dues 155 x $10	$1550
Education Seminar (net)	100
Interest earned	50
Total Revenue	$1700

EXPENSES

Newsletter-4 issues	$ 450
Telephone	90
General printing/typing	30
Conference expense	800
General postage	30
Miscellaneous	200
	$1600
REVENUE OVER EXPENSES	$ 100

MIDEAST REGION FINANCIAL REPORT

CHECKING ACCOUNT

Balance as of 5/15/80		$ 760.64
Transferred from Savings Acct.		400.00
Expenses:		
Postage	$189.66	
Printing/Typing	128.89	
Conference Exp.	395.00	
Phone	19.36	
Miscellaneous	73.17	
Total Expenses	$806.08	
Balance as of 10/27/80		354.56

SAVINGS ACCOUNT

Balance as of 5/15/80	$1,416.20
Interest earned	34.90
	$1,451.10
Transferred to checking	400.00
Balance as of 10/27/80	$1,051.19
Certificate of Deposit 288914 (in Louisville)	$1,074.32
Total Assets	$2,480.07

REGIONAL TRUSTEE UPDATE

The IAET Semi-Annual Board of Directors meeting was held October 24-26 at the Marriott Hotel, Downtown. It was a most productive and sharing Board Meeting. The Board of Directors of IAET is composed of the National officers and a trustee from each region. Besides being a liaison between National and their region all Regional trustees are appointed Chairmanship of a committee.

he amount of work these people accomplished since our annual conference is phenomenal. I will share some of the highlights with you.

I. Standards of Enterostomal Nursing Practice has been finalized. A copy of the Standards will be sent to all members and to new members as they join the IAET.

II. Hollister is continuing there outreach program through 1981. These programs generate revenue for IAET.

III. The IAET is financially stable. All debts to past management have been paid.

IV. Several scholarships are available to perspective Enterostomal therapists. Information about scholarships can be obtained through central office or the Chairman of the scholarship committee.

V. The IAET and UOA have agreed not to support a youth rally in 1981. This was a difficult decision but because of problems which existed at post youth rallys the IAET feels it was wise to withdraw at this time.

However, the future is open for programs for the youth and we need to consider alternate ways to meet this important need.

VI. A proposed Visitor Training Manual Standard to be utilized by: United Ostomy Association ACS and the IAET

was submitted by Bobbie Brewer the UOA/IAET liaison for consideration and approval by the IAET. This manual will be reviewed and a final decision submitted at the Annual Conference in June.

VII. A proposed Grievance Procedure for IAET inc. was submitted. The purpose of these rules adopted by the Board of Director's of the IAET. Inc. is to establish procedure by which the concerns of the members of the association may be given a fair hearing and to insure that any result and action, disciplinary or otherwise may conform with established principles of due process of law.

VIII. These are a few of the major highlights of the meeting. You must plan to attend the annual conference in June for a complete update. The tentative dates of the Annual Conference are:

June 16th-17th--Board Meeting
June 18th-19th--Conference & Business Mtgs.
June 21st--Certification of Examination

As I receive more information about the conference, I will generate the information to you.

Sue Hughes, RN, ET, Regional Trustee

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We were asked to get an "official definition of a certified E.T., board certified E.T. and how the Grandfather clause affects both the old and new members. After talking to both Bonnie Bollinger and Sue Hughes we were informed there will be a bylaws change to be voted on at the National Meeting in June that will comply with the privacy act and there will not be a list as far as who is and who isn't certified (a member in any category will not be excluded).

APPLAUSE! APPLAUSE! APPLAUSE!

The Mid -East Region has been very active this fall with two very successful workshops. The Mid-East Educational Program: "Skin Care--What Do We Do Next"--Part II had 230 participants and 18 companies present displaying their products.

And at Bronson Methodist Hospital in Kalamazoo Michigan, Mary Ann Ver Steig presented "Sexuality Adaptation for Irreversible Health Limitations."

"A conference is just an admission that you want somebody to join you in your troubles." —WILL ROGERS

To assure that you continue to receive the Newsletter during the trauma of a move, please fill out and return to Barbara Montgomery, R.N., E.T.

PRESENT: Name _____

Address _____

NEW: Name _____

Address _____

COMMITTEES OF MID-EAST RECION OF IAET

November 1, 1980

Membership:
Chairperson: Nancy Rioux RN ET
1. Sherry Birdsall RN ET
2. Susan Brown
Term of Office: 11-79 to 11-81

Program:
Chairperson: Susan Cecil RN ET
1. Joan Baptie RN ET
2. Mary Bowling RN ET
Term of Office: 11-80 to 11-82

Publications:
Chairperson: Barb Montgomery RN ET
1. Betsy Hewitt RN ET
2.
Term of Office: 11-79 to 11-81

Nominating:
Chairperson:
1.
2.

Budget & Finance
Chairperson: Jane Beerck RN ET
1. Joyce Hawley RN ET
2. Luann Hartly RN ET

Parliamentarian: Trudy Blied RN ET
By-Laws: Ethel Pryor RN MN ET
Historian: Maude Timmons RN ET
Term of Office: 11-80 to 11-82

OFFICERS OF MID-EAST REGION OF IAET

November 1, 1980

President: Joyce Hawley RN ET
Grandview Hospital
405 Grand Avenue
Dayton, Ohio 45405
Work # (513) 226-3200
& page
Term of Office: 11-80 to 11-82

President Elect: Sally Thompson ET
Worldwide Ostomy Center
926 E. Tallmadge
Akron, Ohio 44310
Work # (216) 633-0366
Term of Office: 11-80 to 11-82

Officers of Mid-East Region IAET (Cont.)

Secretary: Rosemarie VanIngen BS ET
Providence Hospital
16001 W. Nine Mile Rd.
Southfield, Mi. 48075
Work # (313) 424-3435
Term of Office: 11-80 to 11-82

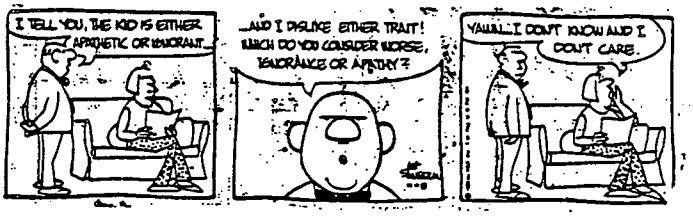
Treasurer: Jane Beerck, RN BSN ET
St. Elizabeth Medical Center
601 Miami Blvd W
Dayton, Ohio 45408
Work # (513) 223-3141
Term of Office: 11-79 to 11-81

Regional Trustee: Sue Hughes RN BSN ET
Jewish Hospital
217 East Chestnut Street
Louisville, Ky. 40202
Term of Office: 11-79 to 11-81

Trustees: Betsy Hewitt RN ET
O.S.U. Hospital Rm. 221
410 W. 10th Avenue
Columbus, Ohio 43210
Work # (614) 421-8000
421-8447 leave message
Term of Office: 11-79 to 11-81

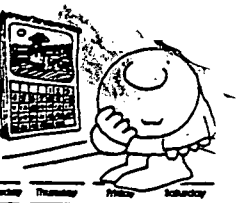
Barbara Montgomery RN ET
O.S.U. Hospital Rm. 221
410 W. 10th Avenue
Columbus, Ohio 43210
Work # (614) 421-8000
421-8446 leave message
Term of Office: 11-79 to 11-81

Ethel Pryor RN MN ET
Henry Ford Hospital
2799 W. Grand Blvd.
Detroit, Mi. 48202
Work # (313) 876-2492
Term of Office: 11-80 to 11-82



What's happening ?

Fill in the calendar with your special programs we'll share with everyone



FEBRUARY 1981

MARCH 1981

APRIL 1981

MAY 1981

JUNE 1981

JULY 1981

AUGUST 1981

SEPTEMBER 1981

OCTOBER 1981

NOVEMBER 1981

DECEMBER 1981

JANUARY 1982

Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

MAUDE B. TIMMONS, RN ET
5319 Velle Vista Drive
Louisville, KY 40272

FIRST CLASS