VOL. IX MARCH, 1981 NO. 1

EDITORS

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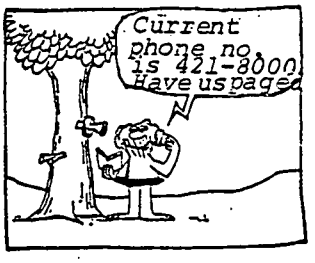
Columbus, Ohio 43210



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*
Budget & Finance --	*Jane Beerck*
Education --	*Susan Cecil*
By-Laws --	*Ethel Pryor*
Publication --	*Barbara Montgomery* *Betsy Hewitt*
HISTORIAN:	*Maude B. Timmons*
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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"

Conference time will soon be here. We are hopeful the entire Mideast Region will meet in Chicago. According to the program, in the March - April Journal, the I.A.E.T. Regional meetings will be held at 5:30 p.m. on Thursday, June 18, 1981. I will post the meeting place (if not pre-arranged) at the Hyatt for all to see. The Conference agenda looks as though it will be very educational.

The National office has seen a 1980 membership list. 1981 membership dues, prorated, will make yearly billing easier for Central office. Our Regional Treasurer, Jane Beerck, will also feel more financially secure. We are just now receiving regional rebates for 1980.

An update from Bonnie has been received stating 'Adler and Droz will be donating $100.00 to each region to further our work. It was a very nice gesture on their part and I will be sure and thank them in advance.

Also we are in receipt of the newsletter from Northeast Region. The 1982 Conference will be at the New Grand Hyatt in New York, June 23-25. Please plan ahead if you wish to attend this conference.

The 1981 Regional U.O.A. Conference will be in Youngstown, Ohio, at the Ramada Inn, April 3, 4 and 5. Hope many of you will be able to attend.

Looking forward to time to share, and getting acquainted with new members and renewing old friendships in Chicago.

See you there.

Joyce

FLASH FROM COLUMBUS!!!!!!!!
CONGRATULATIONS TO US!!!!!!

Our final figures are in from our October Skin Care Workshop and the Mid-East Region has a profit of $1930.00.
Thanks to all who made this program such a success.

DIANE DEROCHER IS A CLINICAL ONCOLOGY SPECIALIST AT OSU. SHE HAS HAD A GREAT DEAL OF EXPERIENCE WORKING WITH PATIENTS AND FAMILIES LIVING WITH CANCER.

WE APPRECIATE HER COMMENTS AND LOOK FORWARD TO HER WRITING ADDITIONAL ARTICLES FOR THE NEWSLETTER.

COMMUNICATING WITH CANCER PATIENTS AND THEIR FAMILIES

By Diane Derocher, RN, MS

The cancer experience can be devastating for all those whose lives are touched by it. Nurses, with their repeated interactions with patients and families, have the unique opportunity to assist individuals by helping them identify their fears, conveying needed information, and providing comfort and caring. The following is a brief description of a few of the communication techniques I have found useful in my work with cancer families.

When the diagnosis is first made, patients may not be able to call the disease "cancer". They may refer to their illness as "my tumor, malignancy, or growth". Follow the patient's example. Use their terms. It is essential to always work at the patient's emotional level. Forcing people to look at something they do not want to acknowledge will only cause further anxiety.

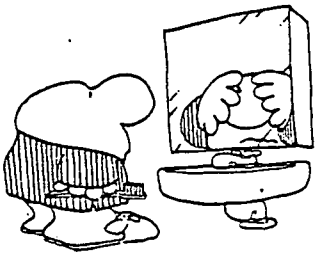
Fear often stems for lack of information and/or experience. Many questions will arise about diagnosis, prognosis, and treatment. Answer in easy to understand terms geared to the patient's level of understanding. Do not go into details unless they are requested. Pictures and diagrams may help simplify descriptions. It is difficult for individuals to synthesize a large volume of new information at once, especially if it is a stressful situation. Be patient if the same questions are asked repeatedly.

Many oncology families must cope with repeated hospitalizations. There are communication techniques that may help minimize the depersonalization so often associated with institutions. Set the tone of the admission by greeting a family with a statement like: "Hi, I like to be called _____, what do you like to be called". Individuality is immediately being acknowledged. When talking with people it is best to be at their eye level. It may be necessary to crouch down, kneel, or pull up a chair with the bed ridden individual. This eye contact validates the importance of their communication. Actively listen to what is being said. Lean toward the person who is speaking, use nonverbal cues (such as nodding the head) to encourage them to continue and ask for clarification when there is confusion. These techniques help relay concern. An individual's sense of worth and personal identity can be further enhanced by encouraging them to share their inner world: their concerns, likes and dislikes. Get to know your patients and their families as people.

Caring, the essential component of oncology nursing, needs to be open communicated. If someone has been important to you tell them. You might be the only person who ever said, "I'll never forget you". It may add a note of immortality to a seemingly ended existence.

Caring must also be communicated nonverbally. A gentle tone of voice, a patient calm manner, an accepting attitude, and a willingness to listen are but a few of the essential ingredients. Do not be afraid to comfort with touch. Gently stroking a person's arm, offering a supportive hug, or simply holding hands often relays more meaning than any words can impart. Tears are yet another way to express caring. There are certain instances when it is very appropriate to express emotions with tears. Silence relays a special caring. Although there may be no words left to say, sitting quietly vividly demonstrates the desire to comfort and care.

This brief description has only highlighted a few hints for communicating with cancer patients and their families. It is essential to remember that our communication can help others live very successfully through their cancer experience.



NEED A ROOMMATE FOR THE CHICAGO CONFERENCE?

We are again offering our services to coordinate roommates so you won't miss the big event!

We all need to reduce our expenses and this will help.

Please send your name, address, and telephone number along with smoking or other preferences to:

Nancy Rioux, R.N., E.T.
Chairman of the Membership Committee
Mideast Region
c/o Grant Hospital
309 East State Street
Columbus, Ohio 43215

The membership Committee will do their best to locate someone for you.

CERTIFICATION EXAMS for 1981 will be given on June 20th in Chicago at Conference time and also on Nov. 14th. Watch the Journal for more details of locations, etc.

Deadline for applying to take certification test is extended for 10 days after Cleveland workshop for those who still want to register.

WILL YOU CHECK MY FIGURES ? I'M EITHER A PENNY SHORT OR $642,000 OVER."

THE OUTREACH PROGRAM has been costing Hollister $50,000 a year. IAET has to decide if they can fund this themselves or find other means of generating revenue on a continuing ed. level. Hollister has approved 4 programs for 1981.

"... I can't go bowling tonight, Freddie, I'm cramming for an IQ test tomorrow..."

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* _____

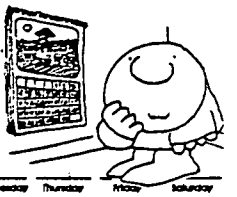
Address _____

NEW: *Name* _____

Address _____

What's happening ?

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



April 9-10th:
Ostomy Workshop, sponsored by St. Mary's Hospital and Marshall University School of Nursing Continuing Education.

May 1, 1981:
Colon--Rectal--Ostomy Conference at St. Clair Community College, Port Huron, Michigan

May 1 and 2, 1981:
Enterostomal Therapy Update Seminar--1981, sponsored by the Center for Continuing Medical Education at Bunts Auditorium, which is located in the Education Building of The Cleveland Clinic Foundation.

APRIL 1981

MAY 1981

JUNE 1981

JULY 1981

AUGUST 1981

SEPTEMBER 1981

OCTOBER 1981

NOVEMBER 1981

DECEMBER 1981

JANUARY 1982

The Cleveland Clinic Educational Foundation

Center for Continuing Medical Education
9500 Euclid Avenue
Cleveland, Ohio 44106

FRIDAY, MAY 1, 1981
Morning Session

8:00 a.m. **Registration**

8:50 a.m. **Welcome**
PENN G. SKILLERN, M.D.
Director of Continuing Medical Education
VICTOR W. FAZIO, M.D.
JOAN VanNIEL, R.N., B.S.N., M.A., E.T., *Presiding*

9:00 a.m. **Review of Pathology of Inflammatory Bowel Disease**
FRANK L. WEAKLEY, M.D.

9:20 a.m. **Diagnostic Tests for Colon and Rectal Patients**
NELSON MOZIA, M.D.

9:40 a.m. **Overview of Colon Cancer**
DENNIS FRIED, M.D.

10:00 a.m. **Complications of Inflammatory Bowel Disease**
PAUL ANSELINE, M.D.

10:20 a.m. **Question and Answer Period**
NELSON MOZIA, M.D.
DENNIS FRIED, M.D.
PAUL ANSELINE, M.D.
Moderator — FRANK L. WEAKLEY, M.D.

10:45 a.m. **Coffee Break**

11:00 a.m. **Nutritional Review**
FRANCES TYUS, R.D.

11:20 a.m. **Parastomal Skin Problems**
NORMA GILL, E.T.

11:40 a.m. **Skin Barriers/Odor Barriers**
OLGA RAMOS, R.N., E.T.

12:00 noon **Parastomal Problems Encountered in the Community**
RICHARD BLACK, R.N., B.S.N., E.T.

12:30 p.m. **Luncheon — The Clinic Inn**

FRIDAY, MAY 1, 1981
Afternoon Session

MARILYN SPENCER, L.P.N., E.T., *Presiding*

2:00 p.m. **Fluids and Electrolyte Balance**
EDWIN FENDEL, M.D.

2:25 p.m. **Pharmacology Review of G.I. and G.U. Drugs**
MICKIE HELBEY, B.S., R.Ph.

2:50 p.m. **Patient Education**
JOAN VanNIEL, R.N., B.S.N., M.A., E.T.

3:10 p.m. **Coffee Break**

PEDIATRIC CONSIDERATIONS

3:25 p.m. **Congenital Colorectal Anomalies**
IAN LAVERY, M.D.

3:25 p.m. **Problems in Pediatric Urology**
ROBERT KAY, M.D.

4:05 p.m. **Care of a Child with a Stoma**
SALLY THOMPSON, E.T.
JUDY CLANCY, B.S.N., E.T.

• • •

4:35 p.m. **Short Bowel Syndrome**
EDGAR ACHKAR, M.D.

5:00 p.m. **Reception — The Clinic Inn**
Spouses cordially invited
(Courtesy of The Cleveland Clinic Foundation)

SATURDAY, MAY 2, 1981
Morning Session

NORMA GILL, E.T., *Presiding*

8:00 a.m. **Surgical Procedures Review**
FRANK L. WEAKLEY, M.D.

8:20 a.m. **Stomal Complications**
TED ROSS, M.D.

8:40 a.m. **Sexual Dysfunction**
IAN LAVERY, M.D.

9:00 a.m. **Cause and Course of Fistulae**
VICTOR W. FAZIO, M.D.

9:20 a.m. **Question and Answer Period**
FRANK L. WEAKLEY, M.D.
TED ROSS, M.D.
IAN LAVERY, M.D.
Moderator—VICTOR W. FAZIO, M.D.

9:40 a.m. **Coffee Break**

10:00 a.m. **Techniques of Management of Problem Patients**
CAROLYN TAMER, R.N., E.T.

10:25 a.m. **Alternate Methods of Fistula Care**
KAREN WELSH, R.N., B.S.N., E.T.
CRINA FLORUTA, R.N., E.T.

10:45 a.m. **Ileal Lavage**
PAMELA FEASTER, R.N., B.S.N., E.T.

11:00 a.m. **Patient with Pelvic Exenteration**
DENISE KEATING, R.N., B.S.N., E.T.

11:20 a.m. **Penile Implants**
AGNES YOST, R.N., E.T.

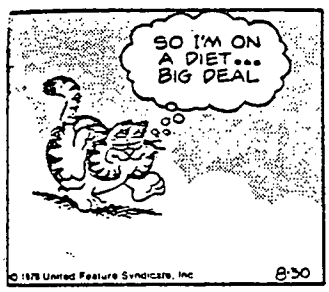
11:35 a.m. **Colostomy Irrigation**
BONNIE BLACKBURN, R.N., E.T.

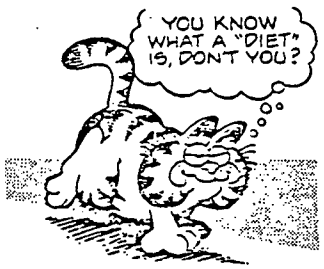
11:55 a.m. **Continent Ileostomy**
VICTOR W. FAZIO, M.D.

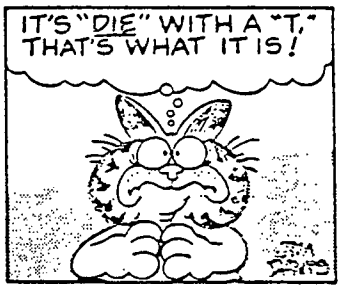
12:15 p.m. **Question and Answer Period**
CAROLYN TAMER, R.N., E.T.
KAREN WELSH, R.N., B.S.N., E.T.
CRINA FLORUTA, R.N., E.T.
PAMELA FEASTER, R.N., B.S.N., E.T.
DENISE KEATING, R.N., B.S.N., E.T.
AGNES YOST, R.N., E.T.
BONNIE BLACKBURN, R.N., E.T.
VICTOR W. FAZIO, M.D.
Moderator — NORMA GILL, E.T.

12:45 p.m. **Test Your Recall**
JOAN VanNIEL, R.N., B.S.N., M.A., E.T.

1:00 p.m. **Adjournment**







PSST! BERYL'S SERENDIPITY:

While browsing through magazines, the following article impressed me enought to copy, but, sorry I missed the author's name.

"I sincerely wish you will have the experience of thinking up a new idea, planning it, organizing it, & following it to completion, & then have it be magnificently successful. I also hope you will go through the same process & have something "bomb out."

I wish you could know how it feels "to run" with all your heart & lose—horribly.

I wish you could achieve some great good for mankind, but have nobody know about it except you.

I wish you could find someting so worthwhile that you deem it worthy of investing your life.

I hope you become frustrated & challenged enough to begin to push back the very barriers of your own personal limitations. I hope you make a stupid mistake & get caught redhanded and are big enough to say those magic words "I was wrong."
I wish for you a magnificent obsession that will give you reason for living and purpose and direction and plan and life. I hope you give so much of yourself that some days you wonder if it's all worth it.

I wish for you the worst kind of criticism for everything you do, because that makes you fight to achieve beyond what you normally would.

I wish for you the experience of leadership, self respect, & living.

Serendipity:

The faculty of finding valuable things not sought for: The gift of making happy & unexpected discoveries by accident.

If there comes a little thaw,
Still the air is chill and raw,
Here and there a patch of snow,
Dirtier than the ground below.
Dribbles down a marshy flood;
Ankle-deep you stick in mud
In the meadows while you sing,
"This is Spring."

C.P. Cranch *Spring Growl*

AGENDA

THURSDAY, APRIL 9, 1981

12:30 - 1:00	Registration
1:00 - 2:00	Colon-Rectal Surgery Dr. Kenneth Scher
2:00 - 3:00	Urinary Diversions Dr. Tara Sharma
3:00 - 3:15	Break
3:15 - 4:15	Psychological Impact Sharon Ambrose, R.N. M.S.N.; Oncology

This program for RNs and LPNs will provide a comprehensive view of management of patients requiring an ostomy. Content includes pathophysiology, diversionary procedures and rehabilitation. During the workshop sessions, participants will be introduced to equipment, supplies and ostomy application techniques.

FRIDAY, APRIL 10, 1981

8:00 - 9:00	Colostomy Teresa Chaffins, CRNET
9:00 - 10:00	Urinary Diversion Juanitia Jenkins, RNET
10:00 - 10:30	Break and exhibits
10:30 - 11:30	Ileostomy Nancy Martin, RNET
11:30 - 1:00	Lunch and exhibits
1:00 - 1:45	Workshop
1:45 - 2:30	Workshop
2:30 - 3:15	Workshop
3:15 - 3:45	Panel Discussion Ostomy Patients
3:45 - 4:00	Evaluation Certificate of Attendance

GENERAL INFORMATION

FEE: $25 (includes materials, lunch and breaks)

DEADLINE REGISTRATION: Thursday, April 2, 1981. No refunds after deadline, however substitutions may be made.

CREDIT: Application has been made to WVNA & WVLPNA for contact hours. C.E.U.'s will be granted by Marshall University.

LOCATION: Holiday Inn Gateway
6007 US Rt. 60 East
Huntington - Barboursville
Phone: (304) 736-8974

ACCOMMODATIONS: Reservations are the responsibility of the participant.

This program carries no academic credit

REGISTRATION FORM

MAKE CHECKS PAYABLE TO:
Inservice Education

MAIL TO:
Inservice Education
St. Mary's Hospital
2900 First Avenue
Huntington, WV 25701

NAME_____SOC. SEC. NO._____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____

EDUCATION_____( )RN ( )LPN ( ) OTHER_____

POSITION AND AREA OF NURSING SPECIALITY (be specific)_____

_____

EMPLOYING AGENCY_____

January 12, 1981

SUBJECT: Outstanding Membership Forms

While attending the W.C.E.T. Congress in Cleveland some of you indicated your interest of fecoming a member by paying dues for 1980. Regrettably, there were too few application forms to meet the demand. In order to complete the membersnip directory and insure the delivery of all communications, please complete and forward the enclosed membership application to Marylyn McManus.

Sincerely,

Marilyn Spencer, LPN, ET
Recording Secretary, W.C.E.T.

MEMBERS

There shall be two categories of members - full members and associate members.

A FULL member shall be either

a) a nurse who has undertaken a recognised course in stomatherapy, OR

b) a person who was accepted into full membership as of August 14, 1980.

A full member may attend meetings of the World Council and stand for election to office and act as an international delegate.

An ASSOCIATE member shall be any person, not fulfilling the criteria for full membership, but having an interest in and a commitment to the activities of the World Council. An associate member may attend meetings of the World Council but shall not stand for election to office of the World Council.

Where a country has no persons who are eligible for full membership, the country may send an individual to attend the meeting in the capacity of a voting delegate, such a person will not be a full member and may not stand for office.

Mail to : Marylyn McManus
Treasurer : WCET
P.O. Box 2000
Johannesburg 2000
Republic of South Africa

Drafts/Postal Orders payable to W C E T.

1981 COLON - RECTAL - OSTOMY CONFERENCE
MAY 1, 1981
ST. CLAIR COMMUNITY COLLEGE - PORT HURON, MICH

8:00 - 8:30	REGISTRATION	AUDITORIUM
8:30 - 9:00	COMMON & UNCOMMON ANAL & RECTAL DISORDERS	DR. CHE SONG PARK M.I
9:00 - 9:30	THE INDICATION FOR, AND TYPES OF ILEOSTOMIES	DR. D. JAGELMAN M.D.
9:30 - 10:00	I CAN COPE PROGRAM	PAT. STEWART R.N.
10:00 - 10:15	UNITED OSTOMY ASSOCIATION	CINDY MONROE, PRES.
10:15 - 10:30	BREAK - COFFEE COMPLIMENTS OF DIAMOND -SHAMROCK CORP.	
10:30 - 11:00	PEDIATRIC OSTOMIES	BERNICE HUCK RN ET
11:00 - 11:45	PANEL, QUESTIONS FROM AUDIENCE	
12:00 - 1:00	LUNCH ON YOUR OWN	
1:00 - 1:30	DEALING WITH EMOTIONAL TRAUMA	DR. K. LEPARD M.D.
1:30 - 2:00	THE CORRECTIONS OF ILEOSTOMY COMPLICATIONS	DR. D. JAGELMAN M.D.
2:00 - 2:30	STOMAS - FISTULAS - DECUBITUS	ROSEMARIE VAN INGEN I
2:30 - 3:15	PANEL, QUESTIONS FROM AUDIENCE	

SPEAKERS:

DR. D. JAGELMAN M.D.	DEPT. OF COLON & RECTAL SURGERY CLEVELAND CLINIC OHIO
DR. CHE SONG PARK M.D.	DEPT. OF COLON & RECTAL SURGERY SAGINAW HOSPITAL
DR. K. LEPARD M.D.	DEPT. OF PSYCHIATRY SINAI HOSPITAL DETROIT
BERNICE HUCK RN ET	DEPT. OF ENTEROSTOMAL THERAPY CHILDRENS HOSPITAL DETROIT
ROSEMARIE VAN INGEN BS ET	DEPT. OF ENTEROSTOMAL THERAPY PROVIDENCE HOSPITAL SOUTHFIELD

NAME _____ ADDRESS_____

CITY _____STATE _____ZIP_____ REGISTRATION: $10.00 no later than April 20, 1981
MAIL TO: DONNA HOFFMAN LPN ET RIVER DISTRICT HOSPITAL 4100 S. RIVER RD. ST. CLAIR, MICH 48079

Additional Factors to be Considered When Treating the Chronic Pain of Malignant Disease

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

Naloxone (Narcan)

Occasionally when giving the narcotics on a scheduled basis, the patient will develop respiratory depression. This can be treated by stopping the medication and then waiting for the effects of the narcotic to dissipate. If the respiratory depression is severe, naloxone, a narcotic antagonist, can be administered. The dose is 0.4 repeated as needed to control the symptoms. If the entire amount is given in one bolus dose, the patient will experience narcotic withdrawal symptoms. The naloxone should be diluted in 10 to 25 ml. of normal saline and then administered slowly intravenously at a rate sufficient to counteract the narcotic depression.

Morphine Equivalance

Morphine equivalences are the equivalent doses of the narcotics that must be used when switching the patient from one narcotic to another. Switching is necessary when the patient starts to experience bothersome side effects. When changing, an equivalent dose of narcotic must be administered in order to maintain the narcotic blood level above the pain threshold and prevent the patient from experiencing excruciating pain. Table 1 lists the standard morphine equivalences. These doses should be used as a guide, they are not absolute doses. Many times they will vary from patient to patient. Also if the patient is taking the medication by mouth, the dose will have to be decreased if changing to a parenteral form. If the patient is changed from an

Table 1: Morphine Equivalents

Morphine 10 mg. IM or SC Equals

Hydromorphone	1.5 to 2 mg.
Levorphanol	2 mg.
Methadone	8 to 10 mg.
Meperidine	75 to 100 mg.
Codeine	120 mg.
Pentazocine	50 mg.

injection to an oral form, the dose will have to be increased in order to overcome the first pass effect. The first pass effect refers to the phenomenon that is seen whenever a medication is taken orally. The medication is absorbed from the intestine and then taken to the liver where it is metabolized into inactive metabolites. Thus higher than normal doses have to be given to overcome the first pass effects so that an effective analgesic dose is administered.

Side Effects

Constipation is one of the biggest problems associated with the use of narcotics. It is caused by a decreased dietary intake, dehydration, inactivity and by the medication which decreases the gastrointestinal mobility. Whenever the patient is placed on scheduled narcotics, he should also be placed on scheduled laxatives and stool softeners. Usually one Peri-Colace^{R} capsule, two to three times a day is sufficient.

Nausea and vomiting is caused by the narcotic stimulating the chemotrigger zone in the brain. If these side effects become a problem, the patient should be placed on a scheduled antinausseant in doses sufficient to control symptoms. Occasionally the antinausseant doses used will have to exceed the regular recommended doses in order to control the nausea and vomiting.

A transient sedation occurs for the first two to three days in many patients when they are first placed on scheduled narcotics. This is due to the direct depressant effect of the drug on the central nervous system. It can also be due to the lack of sleep the patient may have been experiencing for a prolonged period of time. Both the patient and family members should be cautioned about this side effect so that they will not worry that the patient is receiving too much medication. After two days, the patient will be alert and oriented, but the pain symptoms will be under control. If the sedation is too great or prolonged, the narcotic dose may have to be decreased.

Other central nervous system side effects include disorientation, bizarre feelings, hallucinations, and respiratory depression. If any of these occur and become very bothersome for both the patient and family, the narcotic dose should be decreased. However if the patient's pain cannot be controlled by the decreased dose, the medication should be switched to an equivalent dose of another narcotic.

Less frequent side effects included tachycardia, hypotension, itching, sweating, and urticaria. Again, if these problems become too bothersome, changing the drug to another potent narcotic should be tried.

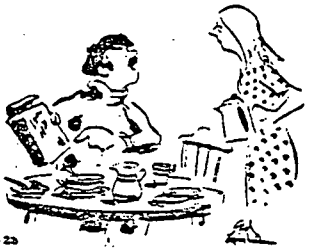
As the patients are kept on the narcotic for extended periods, the patient will have to receive increasing amounts of the narcotic. This is due to either the patient's pain increasing or to the patient becoming tolerant to the drug. In both cases, the patient will need to increase the dose or frequency of administration. Higher than normal dose should not be a concern for the patient, family, or health professional. The important point to remember is that the patient should be kept comfortable. There have been case reports of patients receiving intravenously 90 mg. of morphine sulfate per hour for several months and never suffering any side from it. Health professionals have always been taught about the problems of addicting the patient to potent narcotics. This side effect should not be even considered if the patient is terminal.

Drug Interactions

Drug interactions are mainly due to the additive central nervous system effects of the narcotics with other drugs. When barbiturates, phenothizines, and alcohol are used in combination with narcotics, the patient should be cautioned to be aware of excessive sedation.

Summary

With the proper ordering of medications, the patient should never experience so much pain as to make his life miserable and so that he wishes for death. When used properly, medications permit the patient to enjoy a meaningful and productive life for as long has he may have left.



"They list the adult daily requirement of protein—but what about of honesty, concern, faith, leisure, idealism, humor, love?"

EDITOR'S NOTE **********

Recently Barb and I attended a Workshop titled Pain: Assessment and Intervention in Nursing Practice. It was an excellent presentation with many helpful suggestions for non-invasive pain relief. The instructor was Marge McCaffery, R.N., M.S., F.A.A.N. She presented the prejudices that hamper pain relief, suggestions for specific pain relief, analgesics, narcotics, potentiators in the treatment of acute and chronic pain.

I highly recommend this Workshop for your hospitals and schools.

The following is a short piece from the workshop dealing with specific pain relief methods.

I have already instituted some of her suggestions with great success!

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

PREJUDICES THAT HAMPER ASSESSMENT OF PAIN

--MaCaffery, 1980

1. *AUTHORITY: HEALTH TEAM VS. PATIENT*

   Definition of pain in clinical practice: Pain is "whatever the experiencing person says it is, existing whenever he says it does" p. 11.2. This includes verbal and nonverbal behavior and assumes the nurse makes the effort to observe and obtain the information.

   Believe the patient!

   There are very few malingerers, i.e. people who fake pain.

2. *KNOWN PHYSICAL CAUSE OF PAIN VS. UNKNOWN CAUSE*

   The cause of pain cannot always be determined. Calling such pain imaginary serves no purpose.

3. *ACUTE PAIN MODEL VS. ADAPTATION*

   Misconception: All expressions of pain fit the acute pain model. That is, if the patient has pain there will be visible signs of discomfort, physiological and/or behavioral.

   Correction: Physiological and behavioral adaptation occur, leading to periods of minimal or no signs of discomfort. This may be due to cultural values, fatigue, distractions, or other factors.

   Lack of pain expression does NOT mean lack of pain!

   How would this person have to act for me to believe he has pain?

4. *PAIN SENSATION: PREDICTABILITY VS. VARIABILITY*

   Severity

   Misconception: Everyone perceives the same intensity of pain from the same stimuli (e.g. Uniform pain perception threshold).
   Correction: Comparable stimuli in different people do NOT produce comparable sensations of pain.

   Duration

   Misconception: Pain fits the acute pain model in that all subsides over a relatively short period of time as healing takes place.
   Correction: Pain may last years and may exist without tissue damage.

   Multitude of factors that result in variability of severity and duration: endorphin level (endogenous + morphine = endorphin). CNS activities (e.g. gate control theory) include psychological and cultural factors.

5. *HIGH VS. LOW PAIN TOLERANCE*

   Definition of pain tolerance: that duration or intensity of pain that a person is willing to endure.
   Problem: We tend to value a high pain tolerance and to lack acceptance of the person with a low pain tolerance.

PART II. Suggestions for Practicing Specific Pain Relief Methods

A. *Distraction (pp. 89-115)**

   Effect on pain: By focusing the patient's attention and concentration

on other stimuli, pain is placed on the periphery of awareness. Usually this results in an increased tolerance for pain that lasts only during the time the distraction is being used.

1. *Visual concentration point and rhythmic massage. Keep your eyes open and stare steadily at a stationary spot. The skin is massaged somewhat firmly in a slow and rhythmic or circular manner. A lotion or powder to the bare skin is ncessary if massage is prolonged. The nurse may do the massage initially and then take the patient's hand, helping him do it for himself. Usually massage is done on or near the painful area, but for distraction purposes other areas of the body may be massaged. If this is not distracting, add slow rhythmic breathing*

2. *Slow rhythmic breathing. Take a slow, deep breath before and after using this. The rate is 0 to 9 breaths per minute, i.e. slowly inhaling and exhaling. Whether these are shallow or deep, chest or abdominal inhalation is "in, 1, 2;" for exhalation, "out 1, 2." This rhythm should be adjusted to the patient's comfort. Initially the nurse chants the rhythm aloud for the patient or breathes in unison with the patient. Eventually the patient may learn to maintain the constant rhythm for himself by counting silently. Tell the patient to take a deep breath whenever he feels the need.*

   Try increasing the complexity of this distractor by adding one or more of the following: concentration point or close eyes and picture breathing, rhythmic massage, inhalation through the nose and exhalation through the lips, or raise a finger with inhalation and lower finger with exhalation.

3. *He-who rhythmic breathing. Take a slow, deep breath before and after using this. For the he-who breathing, take very shallow "throat" breaths through the mouth. Inhale; whisper "he" upon exhalation; inhale; whisper "who" upon exhalation--repeat. Do not force exhalation; exhale naturally as you whisper the words. DO NOT speak as you inhale. The rate of breathing begins slowly, accelerating as pain increases and decelerating as pain decreases. It helps if the nurse initially breathes and whispers in unison with the patient. Instruct the patient to take a deep breath whenever he feels the need.*

   Try varying this distraction and increasing its complexity by adding one or more of the following: concentration point or close eyes and use imagery of "choo choo" train going faster and slower in coordination with the rate of breathing or open eyes and turn head to side as "he" is whispered and turn head forward for "who;" rhythmic massage; nodding of head in rhythm with breathing. Effectiveness may be enhanced if the patient is in a comfortable position and tries to remain relaxed.

   With rapid breathing patterns done for longer than a few minutes, remind the patient to report the first signs of hyperventilation--tingling or numbness around the lips or in the finger tips. If they occur, have him breathe into a paper bag. Correct the origin of the problem, usually forced exhalation and/or rate too rapid.

   When pain is inflicted for this method, increase and decrease the intensity of pain.

4. *Sing and tap rhythm. Ask the patient to select a song he knows and likes. Have him emphatically mouth the words to the song as he sings it silently in his mind. Also have him emphasize the rhythm by slapping the thigh, nodding the head, or tapping a finger in rhythm. He may keep his eyes open, use a concentration point, or close his eyes and focus on the imagery suggested by the song. The pace of the song may change in accordance with the pain, singing fast for intense pain and slow for mild pain.*

5. *Auditory stimulation via earphone. The patient selects a comedy recording or a musical recording that he likes. Music for pain relief is usually loud*

and fast. Listen to the recording through the earphone. Adjust the volume to match the intensity of pain, increasing the volume as the intensity of pain increases. Use a concentration point or a mental image suggested by the recording. For music, tap out the rhythm in some way. (Obtain cassette, tape recorder, earphone.)

B. *Relaxation (pp. 137-155)**

Effect on pain. Generally it is thought that relaxation enhances the effectiveness of other pain relief measures such as imagery or a narcotic. Therefore, for best results relaxation is combined with other pain relief measures. (in the practice session it may be difficult to observe any positive effects of relaxation alone on acute, inflicted pain. If so, try combining relaxation with another noninvasive technique, e.g. menthol. If a relaxation technique is used alone and produces relaxation but no pain relief, this should still be considered a successful attempt.) Efforts to relax may aid sleep or act as a distractor from pain. Relaxation may decrease painful stimuli directly by relaxing tense muscles that are causing pain. Regular daily use of relaxation techniques reduce fatigue and anxiety associated with chronic pain. To test effect of relaxation, take P rate before, during and after.

1. *Slow rhythmic breathing plus combination of personalized techniques. (See previous discussion of slow rhythmic breathing, #2 under distraction.) The patient may lie down with support under the knees and neck or he may sit in a chair with both feet flat on the floor and hands loosely in his lap. Describe the possible techniques (such as progressive relaxation, etc. included below) and have him select those he wishes to try. Ask him to describe in detail a place, situation, or scene that is expecially relaxing to him (include a description of all possible sensory stimuli involved when you suggest in the following technique that he remember a peaceful place). The following is an example of instruction to the patient (may be taped):*

"Close your eyes and take a slow deep breath. As you breathe out, feel yourself relaxing, going limp. Feel the tension draining out of your body. Begin to breathe slowly, comfortably, and quietly; breathe from your abdomen if you wish to feel a bit more relaxed. Each time you breathe out, you may allow yourself to feel that you are becoming limp, or feeling heavy or light or weightless. If you wish you may think about your breathing. You can feel the air enter your nose and lungs. You can feel the air go out of your lungs and feel yourself relaxing as you breathe out. As you breathe out, perhaps you will want to say silently to yourself the word 'peace' or 'relax.' You can perhaps, if you wish, allow the tension to flow from your body as the air flows from your lungs. If you desire you can help yourself concentrate on your breathing by saying silently to yourself as you inhale, 'in, 1, 2;' as you exhale, 'out, 1, 2.' I will pause now to let you focus on your breathing in any way you like and to let you focus on your breathing in any way you lie and to let you feel yourself relaxing more and more each time you breathe out. (Pause for about 15 seconds.) Now if you wish, you may remember a place or a time when you felt very peaceful and relaxed. If you wish you may allow yourself to go there in your imagination. You can look around, look above you, feel and see this lovely place. Perhaps you can find a very comfortable place to sit or lie down. In this relaxing, peaceful place you can continue to breathe slowly, relaxing more each time you breathe out,

When you are ready to end this relaxation experience, you may count very slowly and silently to yourself from one to three. At the count of one, begin to move your lower body, legs and feet, slightly. At the count of two, move your trunk slightly. At the count of three, breathe in deeply, hold your breath for a second, open your eyes, and say silently to yourself, as you breathe out, "I feel relaxed and alert." Begin moving about slowly."

2. *Music. See discussion of auditory stimulation via earphone (above) except use slow, familiar music that the patient likes, have the patient remain inactive, and suggest closing the eyes and using image of whatever is suggested by the music, e.g. sunset, ocean waves.*

3. *Relaxation with a trainer. Position the patient comfortably. If he is lying down, support the knees and head with small pillows. Have the patient use a concentration point or close his eyes and use a peaceful image. Tell the patient to breathe in deeply, tense his muscles, and "go limp" as he exhales slowly. Gently move the extremities and neck to determine if the patient has relaxed. If a body part is not sufficiently relaxed, try gentle movement of the part, a deep breath, a yawn, and/or instructions to inhale and contract the muscle and then exhale and relax the muscle. After a few minutes, end the practice period by telling the patient to take a deep breath. Practice for period of a few minutes until relaxation is achieved.*

4. *Quick and easy relaxation techniques. Tell the patient, "Take a deep breath and begin yawning." Or, tell him, "Breathe in deeply and clench your fists at the same time, hold it, then breathe out naturally and let your body go limp."*

C. *Cutaneous stimulation (pp. 116-136)**

Effect on pain: Ideally the pain is eliminated or the intensity is decreased, relief lasting during and/or for hours following cutaneous stimulation. Sometimes relief lasts as long as stimulation is done. Some patients report that relief takes the form of distraction or increased pain tolerance rather than decreased pain intensity.

Cutaneous stimulation techniques: Select from the following.

- *a) Methods of producing various qualities of sensation--pressure, cold, menthol rubbing agent, massage.*
- *b) Intensity--moderate or just below the level that produces pain.*
- *c) Duration--intermittent, continuous (depends upon effect).*
- *d) Areas of stimulation--skin over pain, skin around pain, between pain and brain, contralateral (skin on opposite side of body corresponding to pain site), trigger point or acupuncture points, unrelated areas of body (feet, hands, back).*

NOTE: In the practice session, inflict sustained pain for a few seconds then apply cold or menthol or determine if they relieve pain. The effects of cold and menthol last for some time, so it is difficult to determine their effectiveness by stopping them and experiencing the pain without them. Skin test with menthol. To hasten the effect of menthol, use an area that absorbs well, e.g. forearm, not hand, and warm the area by wrapping it in a plastic sheet. If at all possible use menthol on someone who actually has pain.

**Page numbers in parentheses indicate where the topic is discussed further in the book NURSING MANAGEMENT OF THE PATIENT WITH PAIN, ed. 2, Philadelphia, J. B. Lippincott, 1979, by Margo McCaffery.*

REFERENCES

1) McCaffery, M.: Current misconceptions about the relief of acute pain. In Crue, B.L., Jr. (ed.): Chronic Pain, Jamaica, N.Y., 1979.

2) McCaffery, M.: Nursing Management of the Patient with Pain. ed. 2, pp. 10-21. Philadelphia, J. B. Lippincott, 1979.

The past two years as scholarship chairman I have been in a unique position to assess the funding of scholarships in relationship to meeting the needs in areas where Enterostomal Therapists are few and far between.

I am concerned that while we are growing, we also need to look at Regional areas who could use a little boosting to identify their own needs and give some encouragement to the issue.

This could be done most effectively, I believe if we could establish a Regional scholarship & the following ideas could be explored:

1. *Regions with a comfortable working budget could allocate monies to be specified for their Region or they might consider sponsoring someone from another Region.*
2. *Those Regions who could not make a sizeable contribution could pool the monies to make a joint scholarship with another Region.*
3. *A third possibility could be any Region wanting to contribute to a Regional Scholarship fund could be donated as such & held in the Foundation with only a certain amount to be allocated each year.*

The scholarship would be awarded at the annual banquet as are those from manufacturers.

I realize that each Region carries responsibility pertinent to their areas & I also believe each Region has been the recipient of many gracious efforts from the manufacturers who are also giving large amounts of monies for scholarships.

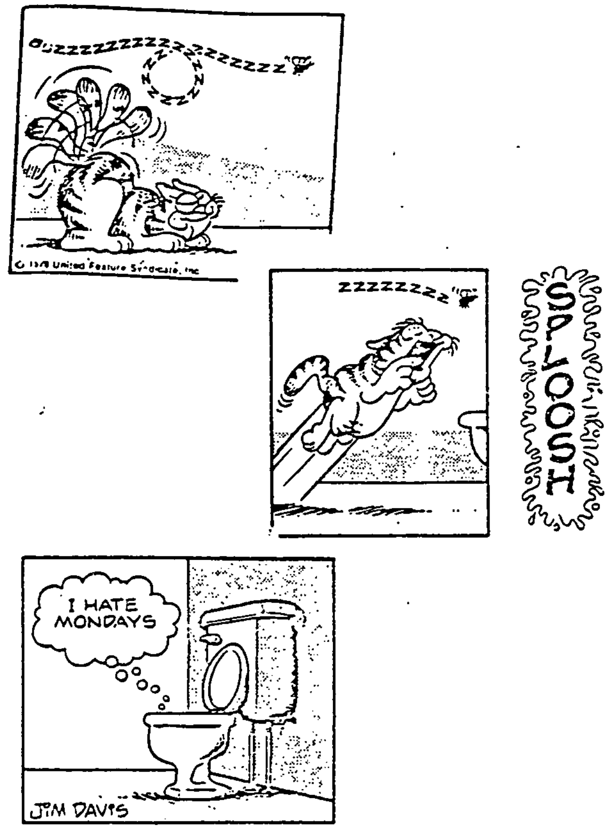
Since ultimately our concern is for educating the public & adding quality to the life of the ostomy client it would behoove us to initiate a cooperative effort in the same direction as the manufacturers of ostomy supplies. This would more than likely enhance their decisions to continue their scholarships.

Another consideration is the economy. Scholarships offered now are not set in cement.

This information comes during a busy time of the year, please don't put it aside. In fact I ask that you include it on your agenda for your next meeting or better still in a questionnaire via your newsletter.

I'm confident of the cooperation from each of you ladies & I look forward to the Regional responses.

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



You may not always feel like it, but try wearing a smile more often! If you do, there's a good chance you'll see a lift in your spirits.

"You smile, in part, because of the way you feel, and you feel a certain way, in part, because of the way you behave," says Gary Schwartz, professor of psychology at Yale University.

"While laughing on the outside won't eliminate crying on the inside, it helps you create a 'happiness pattern,' "Schwartz continues. The more you smile, the more likely you are to experience happiness.

Smiling not only makes you feel better, but can produce tangible benefits as well. Statistics point out that company sales, productivity and morale go up when executives are trained to smile more. And it's even been shown that doctors who smile frequently face fewer malpractice suits.

Dr. James McConnell, a psychology professor at the University of Michigan, notes that when you smile, the whole world does seem to smile with you: "An insecure individual may think others just don't like her, when they're actually responding to the infrequency of her smiles."

So, if you want a better feeling, take time to put on a happy face!

February, 1981

ging Positions - Norma N. Gill

I have heard of many people who, at the age of their 40's, 50's and 60's, decide to retire from one position only to start another career. It always seemed like a frightening idea.

Well, guess who decided to do just this? Me! After 22 years at the Cleveland Clinic Foundation, where I have experienced many, many new adventures, I am leaving!

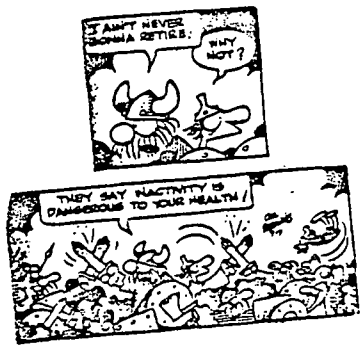
As close as the personnel of Cleveland Clinic are, to me and the wonderful opportunities which still exist, I want to try something different.

So, now, I am returning to Akron, the family and a new career. Although I will be part of World Wide Ostomy Center, Inc., managed by my daughter, Sally Thompson, I will have my own separate office. I will be available, as a consultant, for patients, manufacturers, to lecture to ostomates, nurses, physicians and related medical personnel and will be able to assist in many, many other areas.

Also, I would like to help the small hospitals in the vicinity in ostomy care. Last, but not least, whatever I can do in helping establish enterostomal therapy internationally.

With this radical change, comes monetary changes, too.

But, you know what? I can't hardly wait to meet these new challenges.



TO WHOM IT MAY CONCERN:

Norma N. Gill will leave the Cleveland Clinic Foundation (CCF) on May 1, 1981. She will join her daughter, manager of World-Wide Ostomy Center, Inc., in their family business as a consultant.

Mrs. Gill will continue to be closely associated with CCF as a consultant.

In Akron, Ohio, she will be available for:

- patient consultation
- lecturing -
  nurses, physicians, related medical personnel
- ostomy associations
- enterostomal therapy
- consultant to manufacturers and in helping with protocols
- national and international lecturing in enterostomal therapy
- consultant to area-wide hospitals on ostomy care re: general nursing
- international consultant on enterostomal therapy in -
  lecturing, schools, patient care, and related information

Further information available upon request.

After May 1, 1981, you may contact Mrs. Gill at:

World Wide Ostomy Center, Inc.
926 East Tallmadge Avenue, Suite C
Akron, Ohio 44310
(216) 633-0366

International Association for Enterostomal Therapy, Inc.
505 North Tustin, Suite 219, Santa Ana, California 92705 (714) 972-1720

December 29, 1980

MEMORANDUM

TO: Regional Presidents

FROM: Fred Droz

SUBJECT: Notice of Trainee Completion for the 1980 calendar year

Enclosed are copies of all the "Notice of Trainee Completions" for the 1980 calendar year. There are 2 stacks of notices;

1. Those "trainees" who have joined the I.A.E.T.
2. Those "trainees" who have not joined the IAET. These trainees have all been sent letters and applications inviting them to join.

I felt that you should receive copies of the entire list of graduates for the 1980 year.

We will be reinforcing and instituting some new procedures in order to make your job as President easier. The following procedures will be instituted;

1. Notice of trainee completion forms will be sent to you as they are received in our office.
2. The central office will send a letter to all graduates inviting them to join.
3. A new membership list print out will be sent to the President, membership chair, and newsletter editors on a quarterly basis.
4. Sets of "self-adhesive" labels of the members of your region will continue to be offered at 2¼ cents per label or $2.50 per hundred. These can be used for regional mailing, newsletters, etc.
5. Notices of new members and inter-regional transfers will be sent to the Regional President.
6. The Central office will design, produce and print flyers and brochures for regional meetings and educational offerings at cost.
7. The quarterly membership list print out will include information as to member dues payments. This information will be substantially simplified as we go to a January dues billing for everyone.

We want to help the flow of communication between the National Elected Leadership and the Regional Leadership. We also want to make it easier for the IAET leadership to do its job.

If you have any suggestions as to how procedures and communications with the central office can be improved, please feel free to call me or write.

Today's Chuckle

Most hospitals have the recovery room in the wrong place. It should be in the cashier's office.

Important Notice

Respond ASAP !

Get it Together.

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

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

All mid-east region members & Potential members please fill out and return to Nancy Rioux !!!

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:

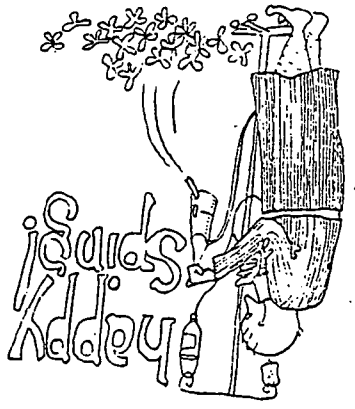
A. Would you be willing to contact a new Enterostomal Therapist in your area if you were notified?

- ☐ 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



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Barbara Montgomery, RN, ET
Room 221
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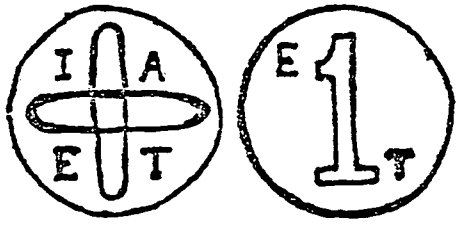
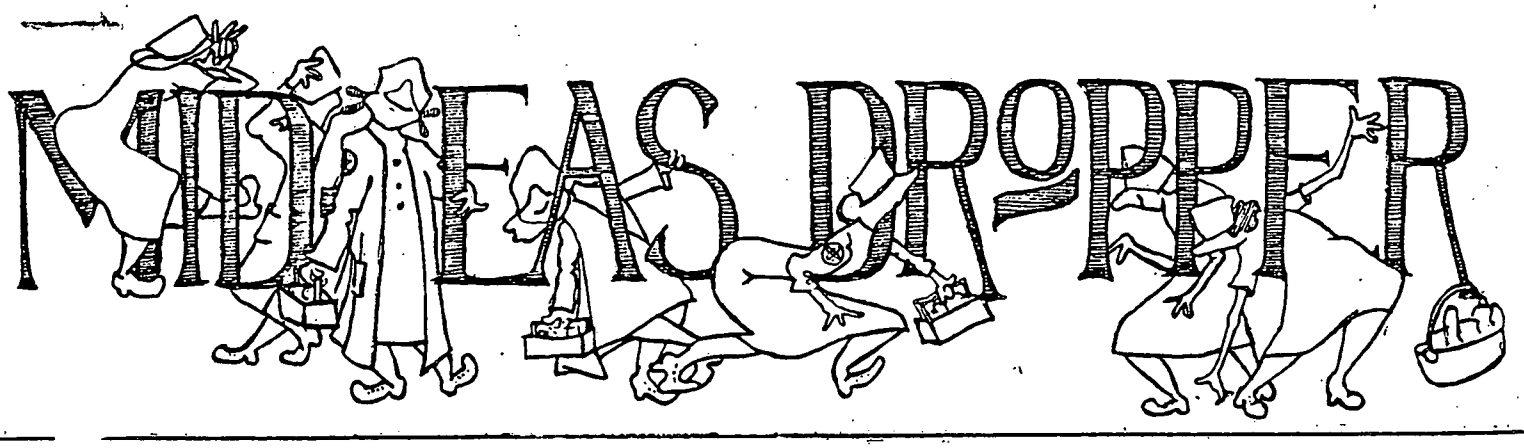


MAUDE B. TIMMONS, RN ET
5319 Velle Vista Drive
Louisville, KY 40272

FIRST CLASS



VOL. X JULY, 1981 NO. 2

EDITORS

Betsy Hewitt, RN, ET
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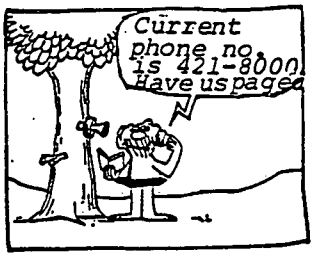
Notice



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:	
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Budget & Finance --	*Jane Beerck*
Education --	*Susan Cecil*
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	Joseph Rinaldo Jr., MD *Providence Hospital* *Southfield, MI*

from the "PRES"

The IAET Conference in Chicago was well attended by the Mid-east region. We had 134 sign in at Regional Meeting. Great Support and I really appreciate it!

On Monday, June 15, Squibb sponsored a management seminar for the Regional Presidents and National Officers. It was an excellent program. The Regional Presidents meeting on Wednesday, June 17, was very educational.

The election of Sue Hughes (our regional representative to IAET) to Vice-President of IAET was exciting. Sue will serve us well at that level and I feel I can speak for our region in saying -- "Good luck Sue, we're proud of you."

Helen Arend (past president of Mid-east Region) was elected to fill Sue's term. Helen will also represent us well at the National level.

It was good to see everyone and know that we are growing in number, knowledge and cooperation.

Our new Mid-east Banner made by Angie Lamb is beautiful. We'll hang it proudly at our next regional meeting in Detroit (November). Hope to see you all there.

Joyce

REGIONAL TRUSTEES REPORT

By way of introduction for those of you who were not at the Chicago Conference, I was elected Mideast Region Trustee to fill the unexpired term of Sue Hughes, who was elected Vice-president of the International Association For Enterostomal Therapy. This office will be up for reelection at our annual membership meeting in November.

We are all proud of Sue, who has worked so long and hard as our representative the past several years, and has made the commitment to continue to do so as Vice-president.

And---are we ever proud of the record of Bonnie B linger who just finished a two year term as national President. From the beginning of her term, she was responsive to the needs of all members. We are all grateful for her contributions to the growth of our organization and for the changes she implemented. She has been a great president and we thank her!

Our new president is Debra Broadwell from Atlanta. From my association with her thus far, she is great. I look forward to working with her.

Now, to the future. Your regional trustee is your representative on the national board of directors of the I.A.E.T. To be effective in this position, I will need communications from you. Please contact me directly with any ideas and concerns. I will make every effort to deal with them appropriately.

I attended the post-conference board meeting in Chicago. Because I am the new kid at the table, I did lots of listening and digesting.

My major assignment at the national level is U.O.A. liason, and I will start by attending the U.O.A. Conference in Minneapolis. (I am still looking for a roommate for August 12-15 and would welcome anyone to share.) The North Central Region has prepared an exhibit booth representing I.A.E.T. and I will be helping with that project.

Some of the issues discussed in Chicago are as follows, in brief form. Contact me directly for more information about any of these.

1. Canada has voted to form a national organization. They are looking to the I.A.E.T. for much help as they begin. The board has pledged to be very supportive to them.
2. The semiannual board meeting will be in New York, November 14-15, 1981.
3. The ET Journal will soon be published by the Mosby Company with Victor continuing as editor.
4. The communications committee is working on a new E.T. brochure which will improve visibility.
5. There is much interest in proxy voting and House of Delegates. These structures are being investigated.
6. There will be changes in the certification process with regard to testing dates and more communication with the regions.

Hopefully I will have more information later. I assure you that I will work hard to be your "linking pin" with the I.A.E.T. Please, please, let me hear from you.

Helen Arend
Bronson Methodist Hospital (Work)
252 East Lovell Street
Kalamazoo, Michigan 49007
(616) 383-8641
2135 Banbury Road (Home)
Kalamazoo, Michigan 49001
(616) 349-8522

Richard Edgin, M.D.
Fellow Division of Gastroenterolory
Dept. Internal Medicine, OSU Hospitals
Undergrad Education, University of Texas, Austin. Medical School - Texas Tech
As a fellow Dr. Edgin is involved as an endoscopist and consultant in his fellowship at the Ohio State University Hospitals.

SURGERY FOR CROHN'S DISEASE

Whereas operative therapy is considered curative for ulcerative colitis, surgery generally is a palliative procedure for Crohn's disease. The reason for this is the high rate of reoccurrence after surgery. This figure approaches 85% during the first 10 years follow-up after intestinal resection for Crohn's disease of the small bowel. The risk of reocurrence after proctocolectomy for Crohn's colitis is also substantial, being around 20-50% during 10 years follow-up. Thus, it is easy for one to see that surgical therapy of Crohn's disease should be reserved for serious complicatious of this disease.

The most common reasons for surgery with Crohn's disease are obstruction, internal fistulas, persistent enlarging inflammatory mass, severe perianal disease, perforation, uncontrolled hemorrhage, strictures (multiple) obstructive uropathy, and intractability to medical therapy.

Less commonly surgery is undertaken for toxic megacolon, unremitting extra-intestinal complications, growth retardation, corticosteroid therapy complications, or to exclude carcinoma. Rarely surgery may be necessary with so called acute regional enteritis to exclude acute appendicitis.

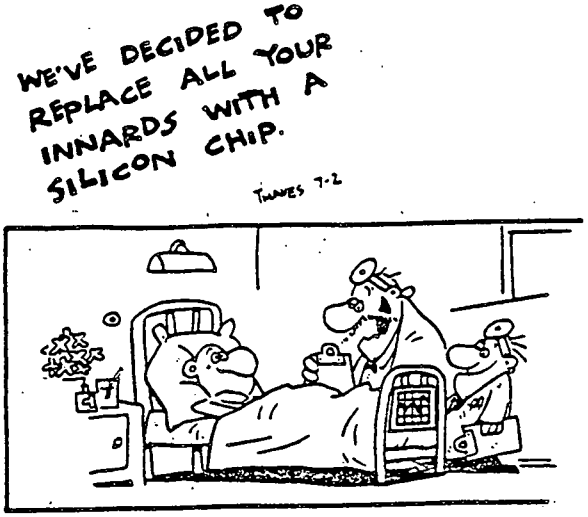
Several important factors must be considered if surgery is to be success-full with Crohn's patients. Adequate wide drainage of abscesses is a must and only after institution of antibiotic therapy and supportive care. Avoidance of these principles may result in enterocutaneous fistulas or wound infection. In addition, the maximal amount of intestinal absorptive surface must be preserved so as not to result in short bowel syndrome. Also anastomoses should be avoided in the presence of acute infection. Lastly, vigorious supportive nutrition should be under taken in any patient with Crohn's Disease undergoing surgery.

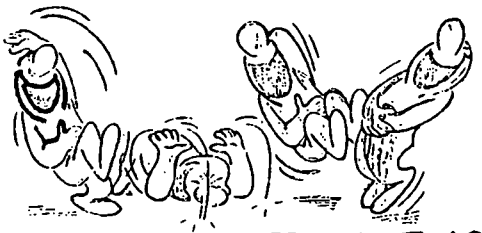
When surgery is done resection is the procedure of choice. Rarely bypass procedure are undertaken in isolated cases. A final reminder is placed as to the chronic nature of this disease and the high reocurrence rate after surgery.

References

1. *Clinics in Gastroenterology Vol. 9: 419-438, 1981.*

2. *Schacter H. and Joseph B. Kirsner Surgery in Crohn's Disease of the Gastrointestional Tract John Wiley & Sons, New York, Pages 154-168, 1980.*



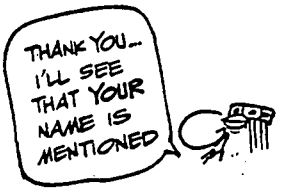


YOU WANT IT WHEN?!

Dead line Dates for YOUR input into Mideast Dropper.

August 24
November 23
February 15

Please
We must have input from you to make this your newsletter. We like hearing from you-- questions -- asking for certain information or articles, sharing ideas -- Help us -- Help you.. . . . . .



"Point of Interest" to those E.T.'s who work with pressure sores. Barbara Montgomery R.N.E.T. (one of our Mideas-Dropper editors) has written an article with 7 Podiatrists available thru your Armour Pharmaceutical rep. or by writing Armour Pharmaceutical Co., Scottsdale, Arizona 85251 & ask for "Management of Dermal Ulcers & Wound Complications". Also, she has assisted in writing & "starring" in a 20 minute teaching film on a "Systems Approach to Wound Therapy" (in 7 languages) available thru your Pharmacia Rep.

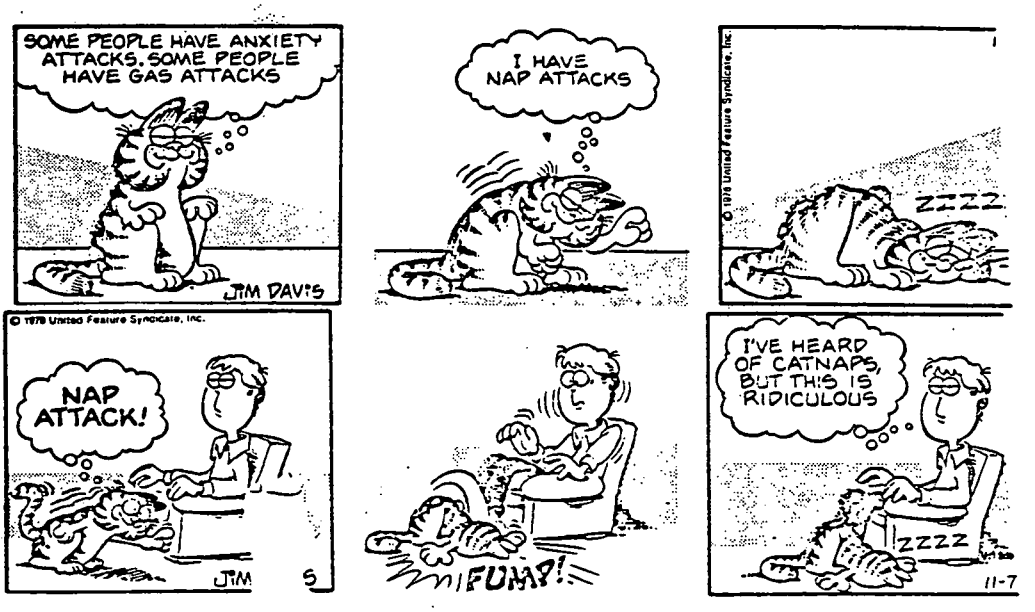
Dear Joyce & All Mid-east Members:

I am so greatful that my roots within I.A.E.T. are from this region. My Santa Claus will always remind me that seeing the world through the eyes of a child can erase many scars and blemishes. Thank you for caring about me. Thank you for being near when times seemed impossible. Thank you for making my years as President rewarding. These feelings are for our region and you as my friend.

With love,

Bonnie

The Mid-East Region surprised Bonnie Bollinger with a gift of a porcelin Santa Claus as she handed over the Presidency of the IAET to Debbie Broadwell at the Chicago meeting.



PROTOCOL FOR ABDOMINAL TUBES

By Betsy Hewitt, RN, ET

The following is a tube protocol that I developed while functioning as Head Nurse on a General Surgery unit. There are a lot of misconceptions concerning abdominal tubes. This article should clarify their purpose and give helpful hints for care.

The ostomy patient frequently requires a variety of tubes. I am in hopes the following might be helpful to you or staff nurses in your hospital.

Please note when reading this article that the protocol was developed for nurses at OSU.

Some of the standards may not be acceptable practices in your institution.

Nasogastric Tubes

1) NG -- used for decompression.

a. Check NG for patency at least every 2 hours.
b. Record amount and color of drainage in chart.
c. NG's may be irrigated with air at any time. If no drainage from NG, check for proper placement before irrigating with NS.
Placement check:
--Place stethoscope over stomach. Instill 20 cc air with toomey syringe. Listen for gurgle of air in stomach.
--Aspirate with toomey syringe from NG to check for gastric contents.
--If patient can't speak, NG is in lungs!
d. NG's may be routinely irrigated with 20-30 cc NS. If NG is not to be irrigated, the doctor will order this and a sign stating this should be placed above bed in room.
e. If after irrigation NG continues not to function, i.e., patient complains of nausea, vomiting, R.N. should reposition NG unless surgery would contraindicate this. Example, esophageal varices, esophageal anastomosis, gastric stapling. If NG is not to be repositioned, doctor will order this and sign stating this should be placed above patient's bed.
f. Change NG tubing and bottle prn if unable to distinguish color and type of drainage because of discolored tube.
g. Record NG drainage on I & O Sheet and board at the end of every shift. Before recording, subtract PO ice chips and maalox given by pharm tech. for accurate drainage.
h. Use adhesive or silk tape to secure NG's to patient's nose. Check nose every day for pressure sore due to tube, and tape accordingly. NG should also be secured to patient's gown with safety pin to prevent pulling on patient's nose.
i. Doctor may order brilliant blue and mineral oil after surgery to determine if patient is moving his bowels, or to check patency of anastomosis and NG should be clamped at least 20 minutes afterward. After this time period, unclamp tube, irrigate NG and record passage of brilliant blue.
j. NG tubes are not to be repositioned on any patient with gastric surgery.

2) G-Tubes --Used for decompression.

a. May use same policy for irrigations as with NG tubes.
b. When patient returns from OR, baby nipple should be placed over GT site to help secure tube.
c. GT dressings should be changed routinely every day. (No need for order). Clean technique.
1. Cleanse around tube with hydrogen peroxide, rinse with NS. Apply betadine ointment or neosporin to tube site.
2. Use soft-wick dressing, 1 under, 1 over nipple to secure tube.
3. Tape edge of dressing and nipple so there will not be any tension on tube.
d. If GT is ordered to straight drain, change drainage bags PRN to determine type, color, amount of drainage. Record this information in nursing notes.
e. If G tube is clamped, disconnect tube from drainage bag to prevent extra pulling on tube.
f. If G tube is to straight drain and patient c/o nausea, irrigate tube and try to relieve nausea. If tube

continues not to drain, notify doctor to change the tube.

g. If G tube is clamped and patient c/o nausea or vomiting, unclamp tube and check for residual from the tube.

h. If doctor orders GT to be clamped with every 4 hour residual checks; clamp tube initially, record every 4 hour schedule on kardex, aspirate contents from tube at end of 4 hours. If tube is patent of greater than 100 cc, notify charge nurse or doctor. If patient can't tolerate tube being clamped this long, unclamp before patient vomits.

i. After GT is discontinued, check site every day for drainage, cleanse as above if drainage and cover with topper.

3) Jejunostomy Tubes

a. Usually used as feeding tubes to bypass patient's stomach or as decompression tubes.

b. Dressing change: use same policy as with G tube dressings. Clean technique.

c. These tubes should also be nippled to prevent tension on the sutures.

d. If patient is receiving tube feeding, i.e., osmolyte, vivonex, TB tubing should be changed daily, labeled, and dated. Connection site should be taped.

e. If J-tube is used for decompression, use the same technique as G tube.

4) Chaffin Tube

a. Most common function is an irrigation tube to flush out cavity or abscess.

b. Chaffin tube is double lumen tube. One side of tube is used as the airway and the other side is most commonly connected to suction. Never clamp the side of tube used as airway--or suction will be cut off. If airway is draining, irrigate tube--it is probably plugged or suction not working.

c. Chaffin tube site is frequently bagged, but may be covered with dressing. If the tube site is covered with dressing, change daily. Clean technique. Use same protocol as with G & J tube sites. If the tube is bagged, the bag should be changed at least every week and PRN as needed for leakage, or especially foul drainage. At the end of each shift the drainage should be recorded in the appropriate column on the I & O Sheet and board and the drainage bag should be rinsed out with warm water to cleanse bag. Use banish as needed for odor in the bottom of the bag.

d. Chaffin tubes are occasionally used to keep a cavity open and the tube may be clamped. If so, use protocol as above for dressing change. Always tape tube to skin to keep tension off of skin.

5) Cecostomy Tubes

a. Used for decompression of the bowel until small bowel opens up and is functioning.

b. Used only for low anterior resection or if appendix is blown out.

c. May help decompress bowel, relieve pressure on suture line.

6) Red Robinson Catheters

a. Most commonly used as irrigation tubes to flush a cavity or abscess. May be inserted in fistula or cavity.

b. Frequently bagged, but may have tube site dressed. If the tube is being used for drainage of a cavity, it is usually bagged. If the tube is used for irrigation purposes it's usually dressed.

c. For dressing changes, use clean technique and same protocol as with chaffin tube.

d. If the tube is to be irrigated, the doctor orders the irrigation solution and frequency of irrigations. If the doctor doesn't order the amount of solution to be used, the nurse should use enough to clear the cavity. Record amount, kind, and odor of drainage in nursing notes.

e. Always tape tubes to prevent tension on sutures.

7) Miller-Abbott Tube

a. Used to decompress the small bowel and break up adhesions. This tube has a mercury end which will gradually advance with peristalsis.

b. Tube may be irrigated the same as on NG tube with Ns, but tube frequently does not irrigate well. MA is a

small lumen tube that may collapse when attempting to aspirate.

c. Frequently MA will not be taped as an NG because it is slowly advancing. After MA is in right portion of bowel, tape as an NG tube.

d. For decompression the MA will be connected to low gomco. Always connect the side of the tube marked suction to low gomco. Never connect the end marked balloon to suction!

e. Record amount and kind of drainage from tube in nursing notes.

8) T-Tubes

a. Intraoperative procedure, only put in OR.

b. Used to drain bile until swelling in common bile duct is relieved and bile can be redirected in patient's system.

c. Sutured in place in OR and connected to transhepatic bag for drainage.

d. T-tube dressings: sterile procedure.
   1. Dressings should be changed every other day, labeled and dated.
   2. Use 2 betadine swabs to cleanse around t-t site. Apply betadine ointment. Use 1 soft-wick dressing around 5-tube, then cover top of dressing and apply tape to make occlusive dressing. Also tape tubing below dressing to patient's skin to prevent tension on tube.

e. If dressing is ever found loose, it should be changed, not just retaped. Chances are the tube site will become contaminated if the dressing is loose and the patient could become septic.

f. Never irrigate T-tubes! If they are to be irrigated, the doctor will do so.

g. T-tube bags should be changed every week. Mark in the kardex the day they are to be changed.

h. Pin t-tube bags to patient's gown below t-tube insertion site. Gravity drain please!

i. T-tubes are latex, rubber catheters.

9) Transhepatic Catheter

a. Inserted percutaneously under fluoroscopy.

b. Used to drain bile from patient's system. Usually inserted on jaundiced patients to relieve their jaundice such as chronic obstruction from tumor mass.

c. May be irrigated per doctor's order. Irrigation is to be done under sterile technique with NS. The amount of irrigation fluid varies depending on patient. Insert irrigation fluid then withdrawal gently--do as a flushing method. Reinsert new irrigation fluid and allow to drain back by gravity. This procedure tests the tube and removes sludge.

d. These catheters are black or gray metal with discs sutured to patient's skin.

e. Dressing change every other day. Sterile technique. Use same technique for changing dressings as for t-tubes.

f. Transhepatic Catheter will be connected to the same type drainage bags as t-tubes. Should be changed every week and marked in kardex, day for change.

g. Frequently patients will go home with these catheters because their tumor is inoperable and this drainage tube will relieve some of their discomfort.

h. Home management of THC.
   1. Teach patient clean technique when changing the dressing.
   2. Drainage bags should be changed every week.
   3. Teach patient to irrigate tube as prescribed by the radiologist.

10) Hepatic Arterial and Venous Catheters

a. These catheters are broviac catheters inserted in OR for the purpose of chemotherapy infusion.

b. Catheters will be connected to prn adaptors and need to be flushed every shift with 1:1,000 cc at heparin to keep patent.

c. When chemotherapy is started, use IVAC pump or IMED to force solution in against pressure of hepatic artery.

d. Dressing changes. Sterile technique.
   1. Should be changed Monday, Wednesday, and Friday by IV nurse.
   2. Use occlusive dressing and TPN dressing kit.

11) Hepatic Catheters

a. Intra-arterial infusion of chemo-drug

infusion via major artery to a localized tumor mass. 20" long catheter inserted near the rapidly dividing cells.

b. Placed in hepatic artery or vein percutaneously under fluoroscopy. Sometimes placed in bracheal artery for better mobility of the patient.
c. Used for infusion of chemotherapy.
d. Patient remains on bed rest with leg straight if placed in hepatic vessle.
e. Dressings are done the same as hepatic arterial and venous lines! Sterile technique.

12) Penrose Drains

a. Used to drain intra-abdominal cavity.
b. May be used to keep a cavity open or drain purulent drainage from abscess. Example, drainage from pseudocyst.
c. If penrose drain is saturating dressing, patent of more than 30 cc/ shift the penrose should be bagged.
d. If penrose is to be bagged, should use bongort or urinary bag with stomadhesive. Never use closed end bag because it can not be emptied.
e. Penrose dressings--sterile technique. Drain probably inserted into sterile cavity if patient is fresh post-op.
   1. Use betadine swabs (2) around drain site.
   2. Apply betadine ointment.
   3. Use soft-wick dressings with 4 x 4 over top of incision, tape to make occlusive dressing.
f. If the penrose is bagged, the sterility cannot be maintained because the drainage is contaminated by the bag as it drains from the site. Use clean technique when changing or emptying the bag.
g. Record amount and kind of drainage in nursing notes.

13) Nephrostomy Tube

a. Used for drainage of Kidney--usually chronic obstruction due to tumor.
b. Teflon cathether--#7 french
c. Usually not irrigated by nursing staff.
d. Sterile technique required for changing dressing or drainage bag.
e. Normally connected to transfer pack--change drainage pack every week.

Carla Powell, R.N.
Chris Regan, R.N.

Nutrition Support Services Nurses
Ohio State University

HICKMAN CATHETERS

There are two groups of patients identified who require chronic venous accessibility those with severe chronic intestinal disease unable to substain a normal nutritional intake and those oncology patients requiring intermittant infusion of blood products, medications and drawing of blood.

Heparin wells or lockes have been used in patients in the ambulatory and institutional setting. These peripheral IV's have been used for drawing blood and intermittent delivery of medications. However, their suceptibility to infection, phlebitis, and infiltration have made this method of venous access for long term home or out-patient use impractical.

In 1973 Broviac et al reported on the development and use of an indwelling right atrial catheter. This all silastic catheter is used primarily for the delivery of nutritional fluids.

However, while the Broviac catheter provided ready venous access for fluid delivery it is difficult to maintain its patency if blood drawing is done.

In 1975 the Broviac catheter was modified making the inside diameter larger to facilitate blood drawing through the catheter without causing it to clot off. This modified catheter is call the Hickman Catheter

At O.S.U. the majority of patients utilitizing the Hickman catheter are the Home Parenteral Nutrition patients and the oncology patients. The H.P.N. Patient can receive nutritional fluids or have blood drawn through the line. The oncology patient can receive chemotherapy, have blood drawn or fluids administered. The obvious advantage for the oncology patient is not subjected to repeated needle insertions for his treatments. Both groups of patients can have this catheter remain in place at home.

A third group of patients utilitizing the Hickman catheter are patients with poor venous access. These are generally in house patients who will require long term fluid administration and blood drawing. The catheter is generally removed before discharge.

The patient selection depends on the individual patient's physician. After selection the patient is then seen by either the oncology clinical specialist or the nutrition support services nurse to determine the exit site. The optimum site should be a point at which the patient can easily see to do dressing changes. If the catheter is placed in a woman a site is selected to avoid interference by her bra. The type of clothing she wears is also considered such as low cut dresses and blouses to avoid the exit site being seen.

Placement

This is a surgical procedure performed in the operating room. Local anesthesia can be used but most patients have preferred general anesthesia.

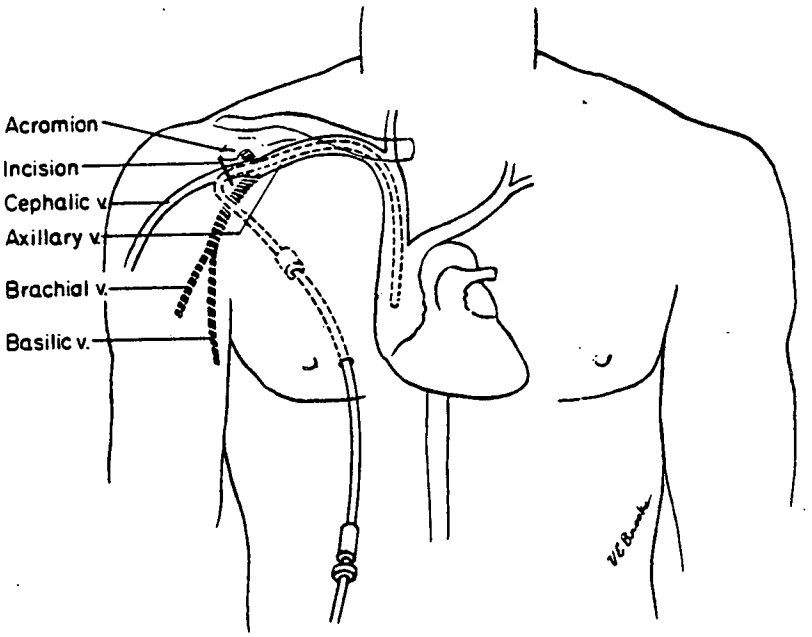


FIG. 1. Ideal position of catheter and site of incision.

Procedure

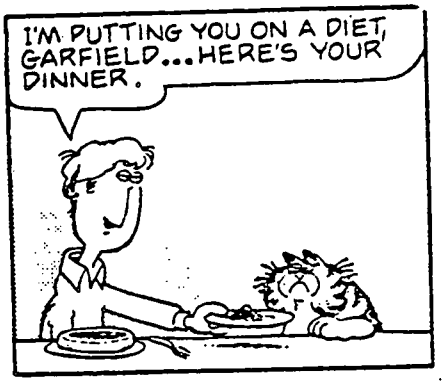
The incision is made near the clavicle to expose a vein leading to the subclavian vein. The tip of the silastic catheter is inserted into the right atrium with the position checked by fluroscopy. A small incision is made at the selected exit site. The distal end of the catheter is drawn through subcutaneous tissue with a pair of long nose clamps to exit at the selected site. The incision at the clavicle and around the catheter exit site is sutured.

Training

Teaching begins the day after surgery. We generally like 3-5 days to work with the oncology patients and two weeks for the H.P.N. patients. The patient is taught to be very defensive of their catheter. They are taught strict sterile technique. Anyone handling the line including hospital personnel must be meticulous when withdrawing blood.

The discharge teaching includes:

1) *Dressing changes*
2) *fluid administration (HPN)*
3) *Irrigation of line*
4) *Changing PRN adapter (plug)*
5) *resources for obtaining supplies*
6) *identifying community resourses.*

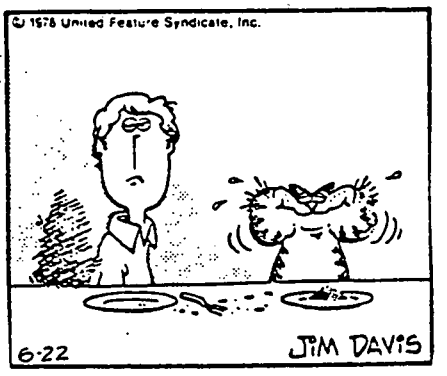


Follow-Up

Catheters placed in patients receiving treatments for cancer are seen in the oncology clinic on the out-patient basis and followed by the oncology nurse clinicians when hospitalized.

Patients on Home Parenteral Nutrition program are followed by the NSS on a monthly or bimonthly schedule as out-patients in the O.S.U. clinic and followed by the NSS when hospitalized.

Both groups of patients with any readmission are ask to redemonstrate their dressing change and heparinization technique to make sure they are maintaining sterile procedures. We feel this has been a very good policy as we have had only one incidence of catheter site infection since starting to use the Hickman catheter.

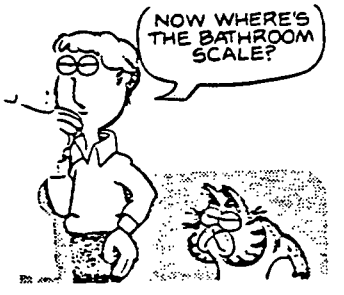


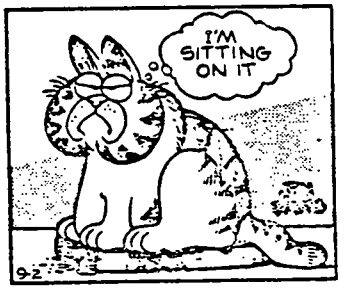
Conclusion

In our experience with about 50 centrally placed catheters, nine placed for home parenteral nutrition, forty-one placed in oncology patients, we have had few complications.

In general, life is made easier for both patient and hospital personnel by providing a painless accessible route for administering medications and withdrawing blood.

The Hickman catheter appears to be a positive step towards helping the chronic patient live comfortably with his disease.





COMMUNICATIONS

BURN-OUT FINAL SEGMENT

The Enterostomal Therapist is a High Risk professional for Burn-Out. To deal with this potential CRISIS we <u>all</u> must recognize the importance of looking after our own physicial and mental health. If we allow ourselves to enter into the process of burn-out, we endanger the well being of ourselves, of those we care for, of our families, as well as the quality of the profession we believe in. Recognition of the problem can be your first stumbling block. Do more than listen to comments of peers, <u>HEAR</u> what they are actually telling you.

What to do-

For Stage I Burn-Out
Treat yourself to that something you just haven't or didn'- take time for.
Eg.(A) New hair style
(B) Leisurely tub
(C) Hard cover book
(D) Banana split

No matter how big or small <u>you deserve it.</u>

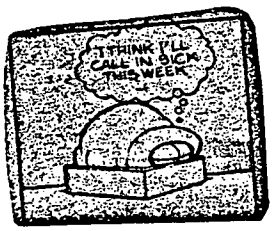
2. *Break up the daily routine*
   e.g. (A) Take in a movie
   (B) Take lunch out one day a week
   (C) Try new techniques for teaching
   (D) Walk in the park

3. *Identify and change what you can, become realistic with what you can't change.*

For Stage II Burn-Out

1. *Find a peer professional, you use as an unloading zone, a good listener may be all you need.*

2. *Engage in some type of organized social outlet, e.g. sports, ceramics, cooking classes.*



3. *An extended weekend or days off are a must for Stage II*

For State III Burn-Out
This is the most critical

1. *Professional advice would be advised. e.g. psychologist*

2. *Longer period of time off vacation, or take a leave of absence*

3. *If all fails you must decide if this is the time to move on to something new.*

N.B. NEVER FELL GUILTY ABOUT DOING SOMETHING FOR YOURSELF.

TRY THIS TEST 1. List 10 things you have done for others in the last week.
2. List 10 things you have done for yourself in the last week.

If you have trouble completing the second list, read through Stage I again.

From: Canadian Newsletter "the Link"
November, 1980

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VOL. XI SEPTEMBER 1981 NO. 3

EDITORS

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Barbara Montgomery, RN, ET
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Columbus, Ohio 43210

Notice

MIDEAST REGION I.A.E.T. OFFICERS

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MESSAGE FROM THE PRESIDENT

Doesn't seem possible it's time to think of fall and our Annual regional conference (Detroit - November 6-7). Know that our education part will be excellent. I will try to have the business part organized and brief as possible.

One item of business will be to discuss the possibility that West Virginia may secede from our region. I bring this up now, in the newsletter, for the West Virginia E.T.'s. We would hate to lose you individually and as a state, but if joining with another region you feel you could be more active this would be to your benefit.

I would ask you to reach an agreement as a state and have a decision for us in Detroit. We want to have a Regional E.T. pin and want the states of our region on the pin.

I have heard nothing from an individual E.T. in West Virginia -- heard this at national level prior to conference. Forgive me if it's rumor- we certainly want to keep you as part of Mid-East Region.

Hope that the membership will be cooperative with the Nominating Comittee as they call upon you for November election.

Let us all be grateful to Betsy and Barb for offering to continue publication of the Mideas Dropper. Please help them by providing news.

I'm writing this on August 17 (and the deadline isn't until August 24) because I'll be off from August 27 until 31 moving into my new house. I'm so excited! Even though it doesn't come with a yard man as I requested.

Enjoy the remaining summer days - see you in Detroit.

MIDEAST REGION

INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY, INC.

Indiana Kentucky Ohio Michigan West Virginia

SEMI-ANNUAL MEMBERSHIP MEETING

Chicago, Illinois
June 18, 1981

TIME: 5:30 p.m.

PLACE: Chicago Marriott Hotel
Chicago, Illinois

PRESIDING: Joyce Hawley, President

MEMBERS PRESENT:

Phoebe Alfke
Charlene Hutchinson
Ethel Beckwith
Anne E. Ward
Ethel G. Pryor
Joyce Hawley
Jill Kundtz
Nancy Rioux
Trudy Blied
Helen VanSweden
Sue I. Brady
LuAnn Hartly
Alice Basch
Norma Huesman
Patricia Martin
Barb Boylan
Pat Lewis
Brenda Kinder
Leona Mandich
Margaret Temin
Olga Cameron
Lynne Bieberitz
Beverly Wallace
Eleanor Higginson
Harriett May
Betty Gerth
Chris Walsh
Rita Kuschner
Kathleen Wood
Lois Jean Holloway
Rita Stromick
Faye Overby
Marlene Brockmeir
Ruth Baily
Janice Pitre
Gertrude Bevier
Cheryl VanHorn
Helen Arend
Sally Thompson
Shirley Dungan
Norma Gill
Janet Luber
Joan VanNeil
Eva Caudill
Jane Beerck
Mary Angela Lamb
Mary Jour Walker
Sr. Consolata Wolking
Helen Meyers
Maude Timmons
Nancy Robb Ellis
Sherry Birdsall
Susan Brown
Joan Baptie
Margaret Milem
Pat Hurd
Pat Freeman
Bette Lowe
Bernice Huck
Barbara Davis
Teresa Chaffins
Sue Hughs
Barbara Montgomery
Monica DeYoung
Jo Marion
Rosemarie VanIngen

Total: 66 members present

ORDER OF BUSINESS

Joyce Hawley, President, welcomed all members to the meeting. All new E.T.s and the E.T.s who were attending their first conference were asked to stand and identify themselves and their place of employment. Officers were introduced to the membership.

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

Joyce Hawley made apologies for the inadequacies of the room our meeting is being held in. She was not consulted as to the needs of our large region. The room was small, very warm, and not enough chairs or seating room was available.

SECRETARY'S REPORT

The minutes of the last Semi-Annual Membership Meeting held in Columbus, Ohio, were read by Secretary, Rosemarie VanIngen. The minutes were accepted as read. In the future, all minutes will be published in the Region Newsletter in order to conserve time during our Membership meetings.

TREASURER'S REPORT

The Treasurer's Report was read and explained by Jane Beerck, Treasurer. In the future, the region will receive rebate monies from I.A.E.T. in January and June of each year. The regions tax exempt status has as yet not been approved. I.A.E.T. tells us this is coming soon. Presently, our bank account requires a social security number on it, and our treasurer's social security number is on it which presents an unnecessary burden on her personnel tax accumulation. We were the first region to apply for tax-exempt status and it looks like we are the last region to obtain it.

The Treasurer's Report was accepted as read.

MEMBERSHIP

According to dues paid by I.A.E.T., we have 134 legal members in our region. Last years count showed 126. I.A.E.T. office will have ready by next June a new Membership Booklet that is computerized and will be up to date. I.A.E.T. states any member who is delinquent in their dues 30 days will be removed from Membership List and will not receive any mailings from I.A.E.T.

EDUCATION

No report given.

PUBLICATIONS

225 Newsletters sent out every issue. Barb Montgomery requests help in keeping mailing list current and correct. Barb Montgomery and Bettsie Hewitts term as Trustees expires in November. It was decided that Trustees do not necessarily have to be the editors of the Newsletter and since Barb And Betsy have volunteered to continue inthis capacity, they will be in the future the PUBLICATION COMMITTEE. All the region members are requested to keep the editors up-to-date on any news items that are important to our region. Our Newsletter is a communication tool rather than an educational journal. Let us all help and get news worthy items to Barb and Betsy.

BYLAWS

Ethel has nothing to report at this time.

HISTORIAN

Maude Timmons reports she has recieved only 2 letters in the past year to place in the historian book. She requests help in getting more material for the book. Joyce Hawley promised to send her some appropriate pictures.If any member has some good prints of the Chicago Conference, please send copies to Maude Timmons.

REGIONAL REP. REPORT

I.A.E.T. is in the process of interviewing publishing companies for the E.T. Journal. A publishing contract will be awarded to a company who is truly interested in our association. Mosby Company appears very promising at this time but no final decision has been made as of this date.
Fred Droz has been contacted by a T.V. Satelite Health Network (Cable) to prepare a program on our speciality of Enterostomal Therapy. We are the first nursing specialty to be approached, which is very encouraging. This opens up the possibility of future education programs via Cable T.V.
The subject of Proxy voting was discussed. Sue Hughes will report back to the board of I.A.E.T. that our region supports a thorough investigation of Proxy Voting.This will be discussed at the post-conference I.A.E.T. Board Meeting and Sue will write a report on findings for the next Newsletter.
There has been no change in the policy of the Certification Examination.
In closing, Sue thanked the membership and her campaign manager, Joyce Hawley, for all the support in her quest of Vice-President of I.A.E.T. Voting will take place tomorrow. Sue presented Joyce with a gift of appreciation.

OLD BUSINESS

Angie Lamb presented the membership with the new banner she made. The old banner was made of felt and became unsightly from transporting it to meetings. The new banner is made of all polyester material and can be packed and transported without the fear of displaying an unsightly banner. We can be proud of this project.

Joyce assures us the tax exempt status is coming soon according to I.A.E.T.

Barb Montgomery reports that the Skin Care Program of last fall at Columbus Ohio had 255 attendees, 18 exhibitors, and earned $1973.35 for the Region.

We have had 3-4 people in our region who have been published recently. Lets all share the talent in our region. Whenever you have anything published, please send the imformation to Barb Montgomery in order to have the imformation made known in the newsletter.

Joyce reports the communications between region and national are getting better. She as president of the region recieves any & all communications from national. She then has to feed out this imformation to the appropriate people in the region.
Joyce also sends a note of welcome to all new E.T.s in the region.
Joyce asks that we all work to keep our region strong and active. We are #1....

Examples of new stationary and new badges were presented. Both items coordinate with the region states illustrated and identifying lettering. The motion was made and passed to have Sue Hughes and Helen Arend proceed with the purchase of stationary and badges. Every member will be responsible for wearing their badge at all regional functions.

A Sony tape recorder has been purchased and is being used at this meeting.

Betty Gerth and Helen Arend opened the question of reviewing our procedure for retired members of the region. In the past, the retirees membership dues were paid on the region level. It was requested that the region board work on this project and make a report at the November meeting in Detroit.

Action is required if Sue Hughs is elected as I.A.E.T. Vice-President at election tomorrow. The motion is made if Sue Hughes is elected Vice-Presedent of I.A.E.T.,she can no longer be regional rep. of our region, Helen Arend will fill the term of regional trustee until November 1981, at which time the office of regional trustee will expire and office of regional trustee will be up for election. Motion passed.

Bonnie Bolinger opened discussion of next years annual conference in New York City. Package tours were discussed. A suggestion was made to have meetings earlier in day so we could have time to see the city we are in by late afternoon and evening. Ideas on conferences should be directed to Terry Hauf, New York Conference chairperson. Mary Jane May is in charge of writing conference guidelines for I.A.E.T. Please send your ideas to her also.
Our region prefers our meetings in the morning, possibly a breakfast meeting, with larger facilities than we have had in the past, as we are a very large region.

Ethel Pryor reports the Semi-Annual Regional Conference will be in Detroit, Michigan November 6 & 7, 1981. The educational day will be all day Friday, with the program Long Term Management of Ostomies. The program is directed to E.T.s and the nursing community who deals with the ostomate who has their stoma 5, 10, 20 years or more. Our keynote speaker will be Geraldene Felton, Ed.D., R.N. F.A.A.N. who is presently Professor and Dean of The University of Iowa. Dean Felton formerly was Professor and Dean of Oakland University School of Nursing, Rochester, Michigan. Dean Felton will present the findings of the research project:OUTCOMES OF EDUCATIONAL REGIMES FOR STOMA CLIENTS
Saturday's half-day program will be for E.T.s only. A region board meeting and an educational segment will be included.
The educational programs will be at Henry Ford Hospital with housing facilities at the St Regis Hotel. This is located in the New Centre Area of Detroit which is easily assessable by expressways and the airport. The mailings for this conference will be out in early September.

The nominating commitee, consisting of Betty Gerth, Chairperson, Sherry Birdsall and Carrie Gramby and Angie Lamb will be looking for candidates to run for office of 2 Trustees, Treasurer, and Regional Rep. for the November election. If you are contacted by one of the commitee members, think it over.....get involved. It's a great experience.

The two candidates running for President of I.A.E.T., Debbie Broadwell & Ellen Linn were each given 5 minutes for political oratory.

The motion to adjourn was made and seconded.

Respectively submitted,

Rosemarie VanIngen B.E.E.T.

Rosemarie VanIngen Secretary

9-9-81

Dear Barbara,

At the New York conference in 1982, we must have two candidates or more for each office of Secretary and Treasurer.

We know we can depend on Mid-East Region!!

Best Regards,

Mary

MEMORANDUM

To: Regional New Editors

From: Mary Phillips, R.N., E.T.
Chairperson, Nominating Committee

Date: August 8, 1981

RE: Nominees for IAET Office

I would like every member of each region to have the opportunity to place a name before the membership as a nominee for the office of Secretary and Treasurer.

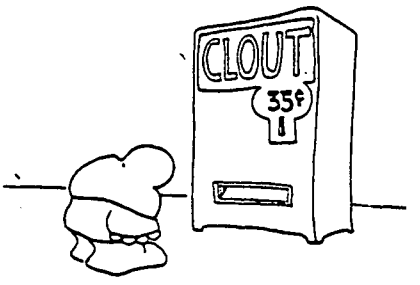
When selecting such a person, please give much thought to the qualifications and leadership abilities of that individual. With capable leaders and a working, cooperative membership, we can have an organization that we can be proud of.

A nominee must meet the qualifications as printed in the IAET By-Laws Article V, Section 2. In Section 5 a reference is made to those persons appointed to fill a vacancy. The duties of Secretary and Treasurer are described in Article V, Sections 9 and 10.

Editors, please give your region this information in your next newsletter. Thank you.

cc: Debra Broadwell
Jan Jestner
Phoebe Jo Alfke
Philip Pressel

MP:rp



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

FROM THE REGIONAL TRUSTEE

Representing the I. A.E.T. with liason to U.O.A.duties, I attended the annual conference of the United Ostomy Association in Minneapolis from August 12-16. The U.O.A. president, Albert Wallace, had invited me to sit in on the Board of Directors and the House of Delegates meetings. I marveled at the diligence and hard work of the members of that organization.

Our president, Debra Broadwell was also there for two of the days. She asked for assistance from the U.O.A. in the Bard Research Study which was explained to us in Chicago. That project is scheduled for completion sometime next year. Watch the newsline in the J.E.T. for a detailed explanation.

A highlight of the conference was the arrival of Mike Komlos--on foot. The 33 year old elementary school teacher ran 880 miles from Ambridge, Pa. to the conference site at the Leamington Hotel in downtown Minneapolis. The incredible part of this story is that Mike has undergone 23 operations and had last rites 14 times. Since recovering from ileostomy surgery in 1971 he has run in six marathons. This run raised $10,000 in pledges for the Pennsylvania chapter of the American Cancer Society.

The Mideast Region members will be happy to know that both the I.A.E.T. and the U.O.A. are working hard on the Youth Rally. Hopefully I will have more information on that for the November meeting.

Both organizations have approved guidlines for co-sponsored conferences and meetings. The last issue of J.E.T.published those in the newsline section.

Another recently completed project is a new U.O.A. Visitor Manual. Each local ostomy association president has received a copy.

Hollister will be sponsoring an outreach program in Mideast Region in Detroit on September 21. E.T.s from Mideast will attend and be introduced as resource people in the area. The new beautiful Mideast banner (made and presented by Angie Lamb in Chicage) will be there along with a display prepared by Rosemarie VanIngen for her ostomy association.

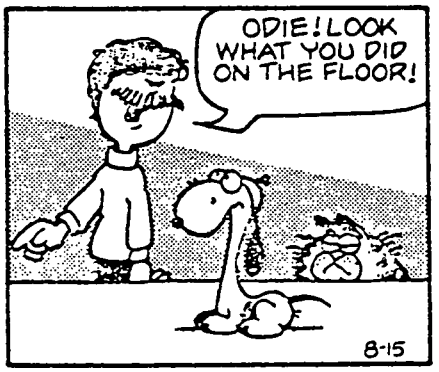
The National Cancer Institute has completed an Ostomy Education Bibliography which is available.

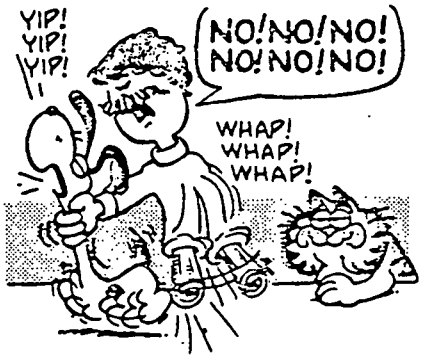
"Patient and Professional Educational Materials for Ostomates"

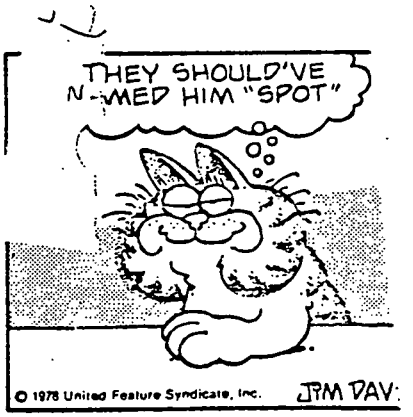
from Office of Cancer Communication
National Cancer Institute
Building 31 Room 10A 18
Bethesda, Md. 20205

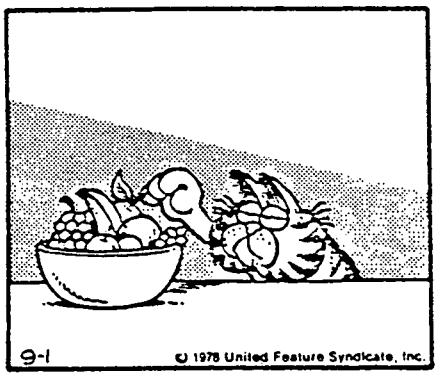
Please contact me if you have any concerns or questions concerning I.A.E.T.

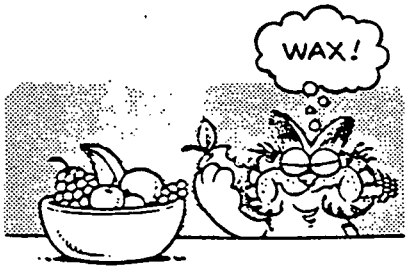
Helen Arend
Home 616-349-8522
Office 616-383-8641

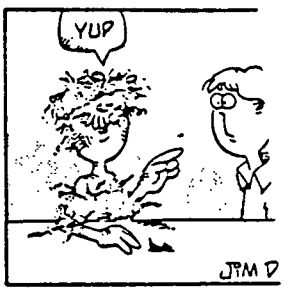












RULES FOR CONSTRUCTION OF A SATISFACTORY STOMA

Luther M. Keith, M.D.

I'm sure that each of us has been faced with a less than satisfactory stoma. We understand the management problems created when the patient has to deal with a problem stoma.

Barb and I approached one of our surgeons who has been noted for creating well placed - matured stomas. We asked him to write an article listing important considerations when creating a stoma. Dr. Keith believes there are 7 commandments a surgeon should follow. The first commandment is pre op marking of the stoma site. The following is a summary of the other steps.
This has been an area which we as Enterostomal Therapist have been "hazy". We understand the basic principles, but I think few of us have really had concrete steps that we can offer our surgeons. Perhaps it is time we became more involved in the actual procedure.

I hope this article helps you as much as we feel it has helped us. Save this article -- Xerox it, and offer it to the appropriate people. Good Luck!

Luther M. Keith, M.D.

Professor and Vice Chairman, Department of Surgery, The Ohio State University; Chief, Division of General Surgery; Associate Medical Director of Surgical Services. On Attending Staff at University Hospitals for many years.

There are several technical and anatomic considerations that the surgeon must rigidly follow to construct a functional permanent ileostomy or colostomy that is acceptable and manageable by the patient.

The segment of ileum or colon that is destined to become the stoma must be adequately mobilized to achieve sufficient length to traverse the abdominal wall and matured allowing final protrusion of 3 - 4 cm. above skin level without tension. The fascial opening thru which the intestine passes should be large enough to avoid constriction or pressure. The bowel should lie parallel to the long axis of its mesentery to avoid twisting. The mesentery of the bowel should not be denuded for more than 1 cm. from its terminal end to avoid ischemia or infarction. Assesment of the future viability of the eventual stoma area can be accurately predicted by use of Doppler ultrasound testing. Maturing of the stoma must be performed by meticulous approximation of the bowel wall to the edge of the skin opening to avoid future stenosis or stricture. The site of the skin opening should be appropriately placed to avoid abdominal wall folds and skin creases and should be visible to the patient even in a sitting or standing position. Observation of these principles will ensure a functional colostomy that can be successfully managed by most patients.

MID-EAST REGION MEETING

Item I

"Long Term Management of Ostomies" is the central theme of the 1981 regional program to be held November 6 and 7 in Detroit, Michigan at Henry Ford Hospital.

The educational sessions planned for Friday (November 6) are open to registered nurses and practical nurses as well as enterostomal therapists. A special effort is being made to publicize the conference among those professionals who care for ostomy patients in their homes, nursing homes, extended care facilities or schools.

On Saturday morning (November 7) E.T.'s will attend a regional business meeting. The final session will feature Dr. George Trichow, Colon and Rectal Surgeon at Henry Ford Hospital. Dr. Trichow will discuss recent advances and innovative techniques used in intestinal surgery as well as review the methods of preparing the bowel for resection and closure of a colostomy.

E.T.'s who wish to share extraordinary clinical problems and solutions with colleagues will have an opportunity to do so on Saturday morning following Dr. Trichow's presentation.

The conference ends Saturday at noon.

Ethel M. Pryor, R.N.E.T.
Planning Committee

Item 2

Out of towners attending the regional meeting November 6 and 7 in Detroit may wish to make reservations at the

St. Regis Hotel
3071 W. Grand Blvd.
Detroit, Michigan 48202
Phone: (313) 873-3000
Telex 235-500
Rates: Single $49.00
Double $59.00

The St. Regis is located three and one-half blocks east of Henry Ford Hospital. An easy distance for walking or busing to the meeting.

The famous Fisher Building and Fisher Theater is a half-block west of the St. Regis Hotel. There are also several good restaurants in the area.

NOTE

Friday's Educational Program will be followed on Saturday, November 7, by our business meeting and an educational session. This meeting will be from 8 A.M. to 12 noon at Henry Ford Hospital, 2799 West Grand Boulevard, Detroit, Michigan 48202

FLASH

ATTENTION ATTENTION

Mid East Board Members

There will be a Board Meeting in Joyce Hawleys room at the St. Regis Hotel at 9 p.m. November 5, 1981.

Elections

The Mid East Region nominating committee has prepared a slate for the offices of Regional Representative to the IAET, Treasurer, and two trustees for the Mid East Region.

The slate to date is as follows:

Regional Representative to the IAET
Helen Arends, R.N.E.T. (Kalamazoo)

Mid East Region

Treasurer
Jane Beerck, R.N.E.T. (Dayton)
Brenda Kinder, R.N., M.S. E.T. (Cincinnati

Trustee
Ruth Baily, R.N.E.T. (Cincinnati)
Sister Consotata Wolking, R.N.E.T. (Cincinnati)

"LONG TERM MANAGEMENT OF OSTOMIES"

November 6, 1981

Sponsored by:
International Association for Enterostomal Therapy -- Mideast Region

Hosted by:
Henry Ford Hospital

AGENDA

Thursday, November 5, 1981

8:00 p.m. Wine and Cheese Reception -- St. Regis Hotel

Friday, November 6, 1981

8:00 a.m. Registration & Coffee
Exhibits

9:00 a.m. Introductory Remarks
Ethel Pryor, RN, MSN, ET

9:10 a.m. Keynote Address: "Outcomes of Educational Programs for Ostomy Patients"
Geraldine Felton, RN, Ph.D
Dean of School of Nursing
University of Iowa

10:20 a.m. "Urinary Diversion Management"
Moderator -- *Vicki Rakowski*, RN, ET
- Overview of Urinary Diversion
  Vicki Rakowski, RN, ET
- Non Hospitalized Management of the Ileal Conduit
  Rosemarie Van Ingen, BS, ET
- Management of Urinary Diversions in Non Hospitalized Children
  Bernice Huck, RN, ET
- Implications of Obtaining Urine Specimens from Urostomies
  Patricia Freeman, RN, ET

12:00 - 1:30 p.m. Lunch

1:30 p.m. Gastro-Intestinal Stoma Management
- Common Ostomies
  Moderator -- *Monica DeYoung*, RN, MA, ET
- Long Term Management of the Colostomy
  Monica DeYoung, RN, MA, ET
  Vicki Rakowski, RN, ET
- Long Term Management of the Ileostomy
  JoAnn Mok, LPN, ET

3:00 p.m. Psycho-Social Adjustment to Ostomy Surgery
Moderator - *Ethel Pryor*, RN, MSN, ET
- Evaluation of Sexual Dysfunction in the Female Following Rectal Resection & Intestinal Stoma
  Ethel Pryor, RN, MSN, ET
- Evaluation of Sexual Function in the Male Following Penile Implant
  Betty Lowe, RN, BS, ET
  Ethel Pryor, RN, MSN, ET
- Role of Self Help Groups for the Stoma Patient
  JoAnn Makelbust, RN, BSN

4:30 p.m. Concluding Remarks & Evaluation

OBJECTIVES

At the end of the conference the participant will be able to:

- Describe the "expected" function of the common gastro-intestinal and urinary tract stomas.
- Describe the usual management routines for gastro-intestinal and urinary tract stomas.
- Identify preventive health practices recommended to maintain lifelong function of ostomies.
- Recognize ostomy disorders and skin problems that require medical or enterostomal therapy intervention.
- Identify community resources available to ostomy patients.

GENERAL INFORMATION

The conference is for registered nurses and licensed practical nurses from hospitals, nursing homes, extended care facilities, public health agencies, community health nurses and school nurses.

REGISTRATION DUE: OCTOBER 23, 1981

FEES: The $40.00 fee for RN's & LPN's and the $25.00 fee for ET's includes all seminar materials, lunch and coffee breaks. The fee will be refunded only if notice of cancellation is received NO LATER than October 23, 1981. All registration fees are subject to a $10 nonreturnable administrative charge.

CREDIT: This program has been submitted to M.N.A. for 8 contact hours.

ACCOMMODATIONS. Hotel reservations are your responsibility. A block of rooms has been reserved at the St. Regis Hotel for the night of Thursday, Nov. 5, 1981. Check in time is 1 p.m. Please call the St. Regis at (313) 873-3000 and identify yourself with this program.

NOTE: To all Mid-East Region Enterostomal Therapists Friday's program will be our annual educational day followed on Saturday, November 7, by our business meeting and an educational session. This meeting will be from 8 a.m. to 12 noon at Henry Ford Hospital, 2799 W. Grand Blvd., Detroit, Michigan 48202.

Return to: Nursing Educational Services
Henry Ford Hospital
2799 W. Grand Blvd.
Detroit, MI 48202
Attn.: Kathy Ledwick

Make checks payable to Henry Ford Hospital

WORLD COUNCIL OF ENTEROSTOMAL THERAPISTS

NORMA N GILL FOUNDATION

Ms Jane Beerck RN ET
Mid East Region IAET
691 Miami Boulevard West
St. Elizabeth Medical Center
DAYTON, OH 45408

P.O. Box 2000
JOHANNESBURG 2000
Republic of South Africa

9 June 1981

Dear Ms Beerck

DONATION : NORMA N GILL FOUNDATION : $250,00 (£116,00)

Thank you for the generous donation of $250,00 (£116,00) to the Norma N. Gill Foundation. (Proceeds taken during the WCET Congress, Cleveland, Ohio during August 1980). It is exciting to see the fund beginning to grow!

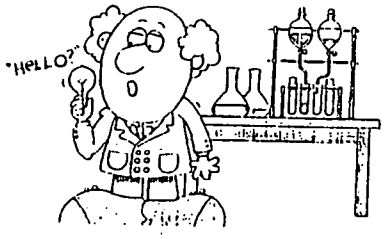
Receipt No. 005 dated 7.6.1981 is enclosed for your records.

Yours sincerely

MARYLYN MCMANUS
TREASURER : WCET

Murphy's Law №11:

The success of a good idea depends on knowing what to do with it!



International Association for Enterostomal Therapy, Inc.
505 North Tustin, Suite 219, Santa Ana, California 92705 (714) 972-1720

August 20,1981

Dear Friends,

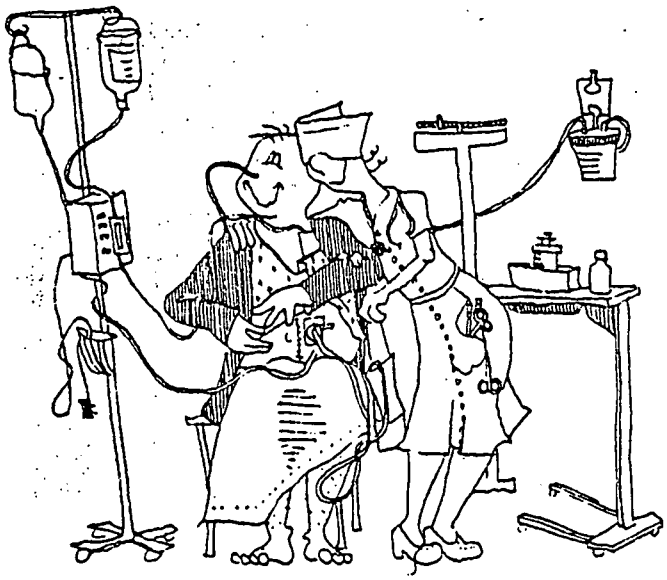
I would like to thank all of you for your support during my term as Regional Trustee and a special thanks to those who supported me so visibly and verbally for Vice-President of I.A.E.T. I could not have won the election without you. I certainly will try my best to make you proud that you supported me.

Sincerely,

Sue

Sue Hughes, R.N., E.T.
Vice President IAET

To Care



Tribute to Margaret Milen, R.N.E.T.

For those of you who were unable to attend the Mideast Region Meeting in Chicago, the announcement was made that Margaret Milen had resigned from her position at Riverside Hospital in Columbus due to ill health.

Margaret will be remembered for her countless hours of dedication and compassionate guidance not only to the ostomates but to the terminally ill patients.

Just to mention a few of her contributions Margaret was on numerous committees in the IAET association, a member of the Professional Advisory Board U.O.A. Central – Ohio Chapter and help founded the Columbus Chapter of Make Today Count.

She is a real friend to everyone. We shall miss her very much, especially her willingness to share her expertise in helping others. We do hope that she keeps in touch.

* * * * * * * * * * * *

PUBLICATIONS OF INTEREST

From Mid-Atlantic Region Newsletter Vol. 1 No. 22, Summer 1981.

(Contributed by Sue Currence, St. Joseph's Hospital, Towson, MD)

"Unusual Infammatory Processes involving the Colon", Toombs, et al., Southern Medical Journal, April, 1981, pp. 400

"The New York Court of Appeals Rules on the Rights of Incompetent Dying Patients", New England Journal of Medicine, No. 23, June 4, 1981, pp. 1424

"Classics in Oncology: Psychological Impact of Cancer & Its Therapy", CA-A Cancer Journal for Clinicians, Sutherland, May/June, 1981, pp. 159.

"Living With Cancer", Northouse, AJN, May, 1981, pp. 960.

"Topical Application of Insulin to Pressure Sores", Jerber, Rowe, AJN, June, 1981, pp. 1159.

"Nursing Research: Out of the Past & Into the Future", Gortner, Nursing Research, July, 1980, pp. 204.

"Endorphins", Wilson, Elmassian, AJN, April, 1981, pp. 722.

"Nurse Practitioner Regulations Signed", The Maryland Nurse, April & June, 1981, pp. 9.

* * * * * * * * * * * *

Welcomes New E.T.'s to the Mid-East Region

Mary E. Hennessy, R.N.E.T.
1139 East 634d Street
Cleveland, Ohio 44103
(Cleveland Clinic)

Pat Grizzle, R.N.E.T.
2716 Cranston Drive
Jeffersontown, Kentucky 40299
(Audubon Hospital)

Nancy Robb-Ellis, R.N.E.T.
425 Kenbrook Drive
Worthington, Ohio 43085
(Columbus Public Health)

Helen McMurtry, R.N., M.S. E.T.
4021 Richland
Louisville, Kentucky 40207
(Baptist Hospital East)

Jo Marion, R.N.E.T.
St. Johns Hospital Home Care
St. Clair Building
Detroit, Michigan 48236
(Sloan Kettering Hospital)

Joyce Billingsley, R.N.E.T.
South Macomb Hospital
11800 East 12 Mile Road
Warren, Michigan 48093
(Sloan Kettering Hospital)

Phyllis E. Helmerick, R.N.E.T.
4610 Miller Drive
Lafayette, Indiana 47905
(Abbott-Northwestern)

FRIENDSHIP

"Oh, the comfort, the inexpressible comfort of feeling safe with a person, having neither to weigh thoughts nor measure words, but to pour them all out just as they are, chaff and grain together, knowing that a faithful hand will take and sift them, keep what is worth keeping, and then, with the breath of kindness, blow the rest away."

By George Eliot

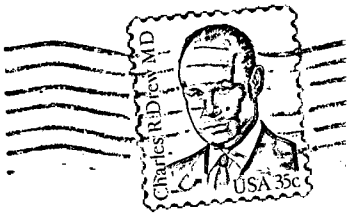
Cartoon from My Life and Hard Times by James Thurber 1933

Peace and joy
and love begin
When you let
the sun shine in!

THE END!

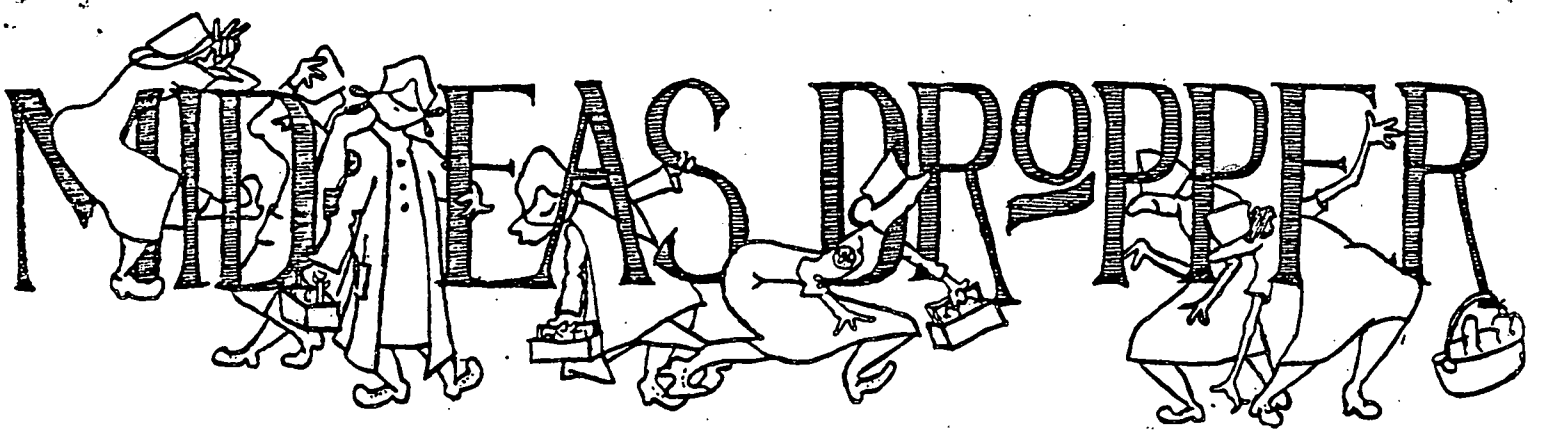
Betsy Hewitt, RN, ET
Barbara Montgomery, RN, ET
Room 221
Ohio State University Hospital
410 West 10th Avenue
Columbus, Ohio 43210

COLUMBUS, OH
OCT 3
PM
1981



Maude B. Timmons, R.N.E.T.
5319 Velle Vista Drive
Louisville, KY 40272

FIRST CLASS

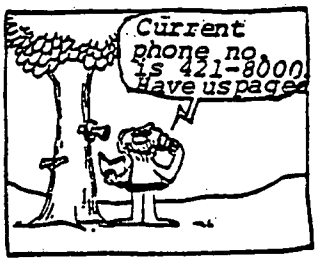


VOL. XII December 1981 NO. 4

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:	*Helen Arend*
TRUSTEES:	*Ethel Pryor* *Ruth Bailey* *Patricia Freeman*
COMMITTEES:	
Membership —	*Nancy Rioux*
Budget & Finance —	*Jane Beerck*
Education —	*Susan Cecil*
By-Laws —	*Ethel Pryor*
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*

IF ONLY
ALL THE
HANDS
THAT REACH
COULD TOUCH !!!

LOBSEG

love

MAY IT TOUCH,
YOUR HOLIDAYS,
MAY IT LIVE
IN YOUR HEART.

Barbara Ann

&

Betsy

from the "PRES"

Our November Regional Meeting in Detroit was very successful. The educational portion was very informative. Ethel Pryor and committee are to be commended.

The Business Meeting was especially rewarding for me. We had an excellent attendance and the support from the group was outstanding. The slate of nominees for office, compiled by Betty Gerth and committee, was probably the largest we have had. It's great to know so many of you are willing to work for the professional growth of our region.

I want to welcome our new officers; Trustees Ruth Bailey and Pat Freeman, and those other members who volunteered for committee work-thanks a million. You all will be hearing from me.

I am still sorting out events of the Business Meeting. It is difficult to keep up with correspondence, and Helen sends me so many new assignments.

Our 1983 Regional Meeting will be in Louisville, Ky., November 4-6. There will be a Board Meeting, November 4, from 6:00-8:00 p.m. November 5, Educational Day for R.N.'s, 8:00-4:00 p.m., and November is Mideast Regional Meeting.

Had a letter from Nancy Martin, West Virginia, they are staying with us and we're glad! Our 1983 Regional Meeting will be in Charleston, West Va. Have several other offers for Regional Meeting so we can plan ahead. South Bend, Indiana; Akron, Ohio; and Grand Rapids, Michigan want to host us.

I understand that National thinks Mideast is pushy about Tax Exempt status. Wouldn't say I've actually harrassed them but---they say it should be complete in January 1982.

Helen posed the question to me if Mideast Region should bid for National Conference. Anyone from a BIG city interested?

We have Regional By-Law changes coming up in June at National. You will receive changes in Mid-eas Dropper published just prior to June. This adds time to our Business Meeting, but I will try to keep it to two hours.

The following is information from Sue Hughes on several IAET key projects:

I. IAET STRATEGIC PLANNING PROJECT

This project has been made possible due to a grant from Bard Home Health. The project has been awarded to Infomedics Research Corporation. In this assignment, INFOMEDICS will gather information and provide analysis in order to resolve the following key issues:

A. What should the mission of E.T. Specialists be that will optimize career growth and employment opportunities while utilizing skills already learned.

B. What needs do ostomates have that are not being met by the health-care system, and how can E.T.'s take action to see that these are resolved.

C. To what extent are third party reimbursement practices helping or hindering the E.T. Specialist and what needs to be done to improve such practices.

D. Given the nature of training received by E.T.'s and the services they are capable of providing, what should their role within the healthcare delivery system be, and how should their employment setting be structured to fulfill this role.

E. What is the impact now and for the future of government legislation on the E.T. Specialist? Can it be influenced to be more supportive?

In resolving these issues, specific recommendations will be forthcoming for the IAET's use in developing scenarios for the future. These recommendations will be based on input from many sources, including you, our membership. Therefore, when you receive a survey from INFOMEDICS RESEARCH CORPORATION please do not discard it. It may be time consuming to respond, but please take the time. Your opinion is important.

One last comment concerning this project, John Jeter is the President of INFOMEDICS RESEARCH CORPORATION. He is NOT related to Katherine.

II. The Telecommunication Proposal is a key project of the IAET at this time. The purpose of Telecommunications is to reach nurses, other health care professionals, and consumers to provide education and assistance for those persons requiring Enterostomal Therapy services. Telecommunications is a general term which reflects a wide variety of new communication technologies. Cable television, direct broadcast satellite, and teleconferencing are the technologies the IAET is investigating.

The IAET for several years has provided an IAET Outreach education program for nurses interested in ostomy care. The purpose of the Outreach is to reach out into the community and provide quality education for nurses. The evaluations of the programs show a definite need for the continued Outreach program and the development of educational programs in the rural communities. Based on the results of the Outreach program and the IAET's committment to reach more people, we are examining the Telecommunication technologies.

III. We are applying for accreditation as a provider and approver of continuing education for nurses. This will enable us to provide CEU's for our nursing educational programs through Telecommunications when they are developed, and also for all IAET educational programs.

Our application for accreditation as a provider and approver of continuing education will be submitted in December 1981. (That's next month!) So you can see that your officers and Board of Directors have been very busy. This is a massive endeavor. Harriet Pilert, Karen Alterescue, and Debbie Broadwell have burned a lot of midnight oil to get us to this point and I would like to commend them for their endeavors.

Marjorie Rose (Lexington) retired April 81'. We'll miss you Marjorie, but wish you a happy, healthy retirement.

Should have Mideast pins for you all ($1.00 ea.) in New York.

For those of you attending meeting in November, please excuse repetition of information-for those of you unable to attend, hope this enlightens you to the exciting happening of our professional group.

I wish all of you the best of Holidays and look forward to seeing a great number of Mideast members in New York.

Again let me thank you for your support. You're great people!

Fondly,

Joyce

MIDEAST REGION

INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY, INC.

Indiana Kentucky Ohio Michigan West Virginia

SEMI-ANNUAL MEMBERSHIP MEETING

Detroit, Michigan
November 7, 1981

TIME: 8:00 a.m.

PLACE: Henry Ford Hospital

PRESIDING: Joyce Hawley, President

MEMBERS PRESENT:

Brenda Kindea
Ruth Bailey
Rosemarie Vantingen
Sr. Consolata Wolking
Kathleen Wood
Lois Jean Holloway
Maude Timmons
Pat Grizzle
Linda McGee
Lynne Bieberitz
Bernice Huck
Monica DeYoung
Vicki Rakowski
Patricia Freeman
Karen Granby
Susan L. Brady
Janice S. Pitre
S.E. Buffin
Sally Thompson
Norma Gill
Becky Beckwith
Esther Aszodi
Ethel Pryor
Joe Hancock
Julianne Stroud
Phyllis Milmcrick
Heather Wigmore *
Joyce Billingsly
Joanne Martin
Olga Cameron
Joann Mok
Eleanor Higginson
Marlene P. Boone
Beverly Wallace
Margie Dreffer
Darcey Savo
Trudy Blied
Barb Montgomery
Nancy Rioux
Pat Hurd
Betsy Hewitt
Helen Arend
Joyce Hawley
Jane Beerck
Polly Bevier
Betty Gerth

Total: 46 members present

* Guest from Canada

COMMITTEES OF MID-EAST REGION OF I.A.E.T.
November 1, 1980

		Term of Office
Membership:	Chairperson: Nancy Rioux RN ET	11-79 to 11-81
	1. Sherry Birdsall RN.ET	
	2. Susan Brown	
Program: (Education)	Chairperson: Susan Cecil RN ET	11-80 to 11-82
	1. Joan Baptie RN ET	
	2. Mary Bowling RN ET	
Publications:	Chairperson: Barb Montgomery RN ET	11-79 to
	1. Betsy Hewitt RN ET	11-79 to
	2.	
Parliamentarian:	Trudy Blied RN ET	
By-Laws:	Ethel Pryor RN MN ET	11-80 to 11-82
Historian:	Maude Timmons RN ET	
Nominating:	Chairperson:	
	1.	
	2.	
Budget & Finance:	Chairperson: Jane Beerck RN ET	
	1. Joyce Hawley RN ET	
	2. Luann Hartly RN ET	

ORDER OF BUSINESS

Nov. 7, 1981.

Joyce Hawley, President, welcomed all members to the meeting. Officers were introduced to the membership. All new E.T.'s and the E.T.'s who were attending their first meeting were asked to stand and indentify themselves and their place of employement.

A quorum was established. Trudy Bliea, Parliamentarian passed out copies of the "Roberts Rules of Order," which were read and applied to the meeting.

SECRETARY'S REPORT

The minutes of the last semi-annual meeting held in Chicago, Illinois, were published in the September, 1981, Mid-East Dropper. The minutes were accepted as published.

TREASURER'S REPORT

A copy of the financial report from 5/31/81 to 10/31/81 was passed out to all members to review. The treasurer's report was accepted as read.

REGIONAL TRUSTEE REPORT

Helen Arend reports that she has been assigned to be the UOA liesion, historicly this has been a committee to work with the UOA at the National level to foster communication and cooperation between the IAET and UOA. In the past the person on this committee has worked alone. Helen has asked the National officer if she could work with a committee, which was agreed to. The committee consists of Helen, Becky Beckwith and Suzanne Buffin from Grand Rapids. Becky and Helen have met once and expressed hopes to help communication between the IAET and UOA.

Involvement was encouraged in the committees at the national level.

Confusion about the Bard Project was cleared up. Bard is providing the funding for the project, but is not involved in the project at all. It is an IAET project called the IAET Strategic Planning Project, done by the Infomedics Co., main investigator is John Getter. Project is to be completed in 6 months. It is focusing on, the future of the ET specialist; needs ostomates have that are not being met by the ET specialist; what to do to improve the situation of third party reimbursement; what is the role of the ET specialist in the health care delivery system; and impact of government legislation on the ET specialist. To conduct the project a questionnaire will be sent to a random selection of IAET members and UOA members. Project is important to our future, it will help give us direction in planning, please return questionnaire and encourage UOA members to do the same.

Starting at the National level a National conference planning committee was formed to address some of the problems at the conferences.

The publishing contract with Mosby Co. and the ET Journal is almost finalized.

IAET membership now stands at 1515.

As of January 1982, Canada will separate from the IAET.

The organization is looking into a house of delegates structure.

The 1982 conference will be in New York City at the Grand Hyatt, June 23 - 25. The 1983 conference will be held in Kansas City.

A tele-communication project is being initiated, more will be learned about this at a later date, but it is to do with the production of some type of education aides.

IAET has applied for accreditation as a provider from the ANA. That should be set up soon.

Helen will check into the possibility of tours being set up for the IAET members during the conference in New York in 1982.

PRESIDENT'S REPORT

A thank you was extended to Ethel Pryor and her committee members for hosting the semi-annual regional meeting.

The succeeding of West Virginia was discussed by Joyce who spoke with Debra Broadwell, President of IAET about this. Debra stated that the succeeding of West Virginia would have to be done at the national level and felt they should stay with the mideast region.

The ETs of West Virginia have met and at this time are not talking about succeeding. They were asked to host the 1983 mideast regional. No response has been heard at this time. South Bend, Indiana has offered to host the 1983 regional and if W.V. declines South Bend will host it.

1982 regional will be held in Louisville, Kentucky. Nov. 4-6, at the Executive Inn. Nov. 4 is the Board of directors meeting 6-8 p.m. Educational day Nov. 5 for RNs from 8-4 p.m., wine and cheese reception from 6-8 p.m. Nov. 6 the mideast regional business membership meeting.

Hollister will continue with its outreach program. It is to be referred to as the National Outreach Program and not to be used to promote Hollister.

Margaret Rose of Lexington, Kentucy has retired as of April 3rd. Her successor is Darlene Murphy.

Our policy is to pay the dues of our retired ETs of the Mideast region. Due to the increasing numbers of retiring members this could become a financial burden. This policy will be voted on at the next regional meeting.

Samples of types of regional pins were presented. Helen Arend agreed to take our regional banner to be reproduced into a badge by children at the retarded school in Kalamazoo. 250 badges will be ordered. A motion was made by Betty Gerth of Cincinnati to have members purchase their own badges for $1.00. Motion passed.

A special committee was formed to study the purchasing and management of a Mideast exhibit booth to represent ETs at important meetings throughout the region. Committee members are Sue Brady, Sue Buffin and Joe Hancock.

A task force was formed to investigate ways and meand of financing the Mideast Dropper. Task force members are Sally Thompson and Norma Gill. A report of their findings will be presented at the next meeting.

MEMBERSHIP

IAET members are reminded in order to keep the printed read outs of ETs current, send your updated information to the IAET central office.

A regional membership listing sheet is being considered which would include work and home telephone numbers to be possibly published in the MIDEAST DROPPER.

Any IAET member that has not paid their dues 60 days after Jan. should no longer be receiving IAET literature. Any member not receiving the IAET literature who have paid their dues notify Nancy Rioux.

EDUCATION

No report given. A motion was made by Jane Beerck, Dayton, Ohio to donate $500. to fund a mideast region person to attend ET school. Motion passed.

PUBLICATIONS

Barb Montgomery asked the members to help out the newsletter by writing articles to be printed and for ideas of what type of articles they would like to have printed.

BYLAWS

Ethel Pryor read a letter received by her from Ann Lee Chairman of the National By-laws Committee. Due to the poor attendance at the business meeting the committee was back to to propose an amendment for a house of delegates. Five delegates from each region, an additional delegate for the first 100 members and each 50 members or a fraction there of above 100. Delegates would be elected by their region and would go to the conference with instruction on how their members felt about the issues. Officers would continue to be elected by popular vote. The proposed amendment will be presented to the board of directors in November at the semi-annual board meeting. If approved it will be presented at the annual business meeting in New York next June for membership approval. Any questions or comments can be sent to Ann Lee. Please consider the impact of this change on our region before the next business meeting in New York.

HISTORIAN

Maude Timmons reports she has received more photographs from past conferences, some from Vancourver Conference, WCET conference and from Outreach. She was pleased to announce this and asked to keep them coming.

OLD BUSINESS

Joyce Hawley reported we are not yet tax exempt.

Youth conference for 1982 will begin July 4th for five days. Children 12-18 will be able to to. Fee will be $150. for five days. It will be in Boulder, Colorado. 120 youths can attend. It will be co-sponsored by UOA and IAET. A motion was made by Kathleen Wood of Fort Wayne to sponsor a youth from the mideast region to attend the 1982 Youth conference, paying their transportation and registration. Motion passed. Ets having names of youths who they would like to see attend can forward them to Olga Ramis of the Cleveland Clinic. Olga will be selecting a committee of 4 with each state represented for screening of youth applicants.

ELECTION OF OFFICERS

Conducted by Betty Gerth, chairman of the nominating committee.

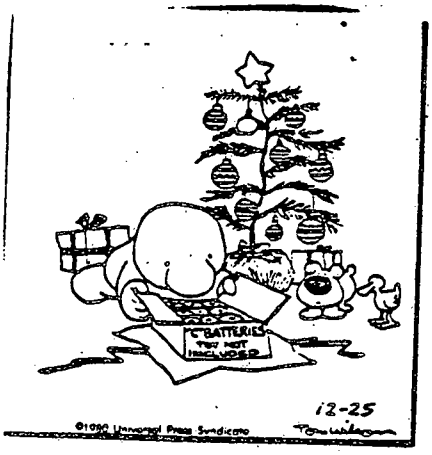
-- Elected Officers:
-- Regional representative for the Mideast Region of IAET: Helen Arend, Kalamazoo, Michigan
-- Treasurer: Jane Beerck, Dayton, Ohio
-- Trustees: Ruth Bailey, Cincinnati, Ohio

ADJOURNMENT Patricia Freeman, Lansing, Michigan

The motion to adjourn was made and seconded.

Respectfully submitted,

Rosemarie VanIngen, Secretary



Regional Trustee's Report

The I.A.E.T. Board of Trustees met at the Grand Hyatt Hotel in New York on Nov. 14 and 15 for the semi-annual board meeting. The Mideast Region was well represented with Sue Hughes (Vice-pres.), Bonnie Bolinger (past-pres.), and myself attending.

The Grand Hyatt Hotel is the site of the 1982 annual conference in June. The hotel itself is beautiful. The lobby is very pleasant--many large fresh flower arrangements everywhere. The rooms are very nice--roomy and pleasant, and the service is prompt and courteous. The charges are not inexpensive, but not too far differe nt than some other years, when inflation is taken into account. The hotel dining rooms are good but again somewhat costly. I purposely scouted the area around the hotel and found many reasonably priced eating places within a two block radius. The conference committee has worked hard and has made some great plans. They have listened to some of our concerns and suggestions and have made some changes that will be appreciated by many members.

At the meeting, I was proud to be a member of a region which has so many members working on national committees. Almost every committee has a Mideast Region member, and that's GREAT!

Highlights from national:

1. Conference Planning Committee--This new committee will facilitate planning for national confere nces and assure help for the host region.
2. Outreach-(Hollister)- There are plans for two in 1982. Attempts are being made to select an area where there is a need for education.
3. Canada--will formally separate from I.A.E.T. and have their own association as of Dec. 31, 1981.
4. W.C.E.T.--conference will be May 9-14, 1982 in Bristol, England.
5. Increase in Dues--Is probably inevitable, most likely in 1983. Watch the JET Newsline for more information.
6. Youth Rally--is scheduled July 4-9 in Boulder, Colorado. Youths aged 12-17 years will be eligible to go. There is room for 125 youths and 25 adults. We need 1 member each from U.O.A. and I.A.E.T. for each 10 youths and 1 extra E.T. for every 3 handicapped kids. It is not too early to start working at the local level with your U.O.A. chapters to find young people who would benefit and to help raise funding if that is necessary.
7. I.A.E.T. Membership--is now at 1600 members. The membership list is being re-designed and improved.
8. I.A.E.T. Strategic Planning--This project, which is being done by Infomedics Corp. will be d one in Feb. Please complete and mail the questionnaires as soon as possible. Also encourage U.O.A. members to complete the questionnaires (randomly selected) they receive. This project is most important to our professional future. (Refer to JET newsline article)
9. Certification Exam--will be offered at national conference on Sat., June 26. In answer to requests to have it at a d ifferent time, it cannot be done. The testing company will only give the tests on Sat. Write to the central office for information. At this time, 425 members have passed the exam.
10. Continuing Education Committee--needs applications 60 days before the educational offering. As soon as provider status is obtained, this is the only place that application will have to be made to.
11. House of Delegates--This concept will be presented to the members for consideration at the annual conference. If adopted, the Delegates from the regions would conduct all business with the exception of officers. election of

2--Regional Trustees Report.

Watch the JET Newsline for details.
12. Address Changes-- should be sent to I.A.E.T. central office, Not to the JET in Illinois.

I have tried to be brief with this information. If you would like clarification, or have questions, please call or write.

Happy Holidays,

Helen

November 1981

OFFICERS OF MID-EAST REGION OF I.A.E.T.

November 1, 1981

		Term of Office
President:	Joyce Hawley RN ET Grandview Hospital 405 Grand Avenue Dayton, Ohio 45405 Work# (513) 226-3200 & page	11-80 to 11-82
President Elect:	Sally Thompson ET Worldwide Ostomy Center 926 E. Tallmadge Akron, Ohio 44310 Work# (216) 633-0366	11-80 to 11-82
Secretary:	Rosemarie VanIngen BS ET Providence Hospital 16001 W. Nine Mile Rd. Southfield, Mi. 48075 Work# (313) 424-3435	11-80 to 11-82
Treasurer:	June Beerck RN BSN ET St Elizabeth Medical Center 601 Miami Blvd. W Dayton, Ohio 45408 Work# (513) 223-3141	11-81 to 11-83
Regional Trustee:	Helen Arend RN ET Bronson Methodist Hospital 252 E. Lovell St Kalamazoo, Mich. 49008 Work# (616) 349-8522	11-81 to 11-83
Trustees:	Ruth Baily RN ET Providence Hospital 2446 Kipling Cincinnati, Ohio 45239 Work# (513) 522-3831	11-81 to 11-83
	Patricia Freeman RN ET Edw Sparrow Hospital 1215 E. Michigan Box 30480 Lansing, Mich. 48912 Work# (517) 487-2797	11-81 to 11-83
	Ethel Pryor RN MN ET Henry Ford Hospital 2799 W. Grand Blvd. Detroit, Mi. 48202 Work# (313) 876-2492	11-80 to 11-82

REPORT FROM
IAET LIAISON TO INDIANA STATE NURSES' ASSCCIATION

Following receipt of a recent letter from Bonnie L. Bolinger, RN, ET, Chairman, IAET Legislative Committee, asking that I continue to serve as IAET state liaison to the Indiana State Nurses' Association (ISNA), I contacted Linda J. Shinn, RN, Executive Director, ISNA, by letter. Specifically, I requested current information on the following issues:

1) Current status of mandatory licensure for registered nurses in Indiana. (Legislation introduced in the last session of the Indiana Legislature.)
2) Relevant state legislative issues which Indiana IAET members should ask their senators and representatives to support or defeat in the next session of the Indiana General Assembly.
3) Other concerns of the ISNA Legislative Committee on issues relating to introduction of (or pending) legislative bills that will lead to:
   a) recognition of nursing specialties, including enterostomal therapy.
   b) third party payments, including information relative to insurance company, Medicare, or Medicaid payments to institutions or to nurse specialists.
4) Status of plans of the ISNA Legislative Committee to introduce legislation regarding enterostomal therapy and/or other nursing specialties.

This inquiry led to the following responses from Ms. Shinn:

"1) The manatory licensure legislation was enacted by the 1981 Indiana General Assembly. It becomes effective July 1, 1982.

"2) We are not yet sure of what we will be introducing, supporting or opposing in the 1982 General Assembly. We will know more after the first of the year.

"3) We are not at this time, planning to introduce any legislation in 1982 related to nursing specialties or third party payments.

"4) ISNA has not officially discussed the issue of legislation regarding specialty areas of practice other than the legislation that was introduced into and enacted by the 1981 legislature regarding nurse practitioners."

Indiana has defined a "nurse practitioner" in State Enrolled Act 305, which amends IC 25-23-1 concerning the regulation of nursing and nursing education, under Section I (c), as follows:

> "(c) the term "nurse practitioner" means a registered nurse qualified to practice nursing in a specialty role based upon the additional knowledge and skill gained by the registered nurse through a formal organized program of study and clinical experience or equivalent as determined by the Board which does not limit but extends or expands the function of the nurse in the area of primary health care, which care may be initiated by the client or provider in settings which shall include but not be limited to hospital outpatient clinics and health maintenance organizations;"

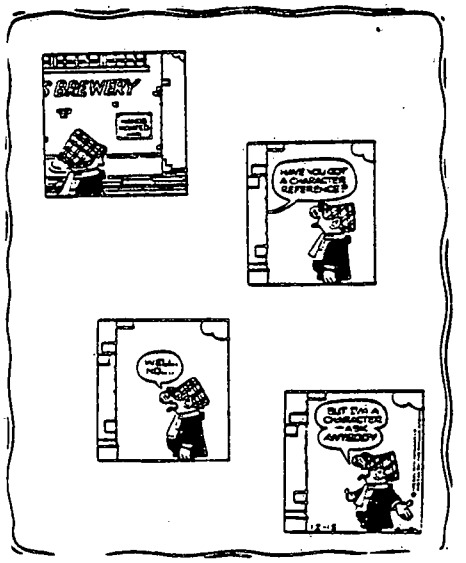
It is hoped that this Indiana legislative update will be of special interest to Indiana ETs who may be affected by it, as well as to other IAET Mideast Region members. In addition to myself in Indiana, the Mideast Region presently has the following IAET state liaisons:

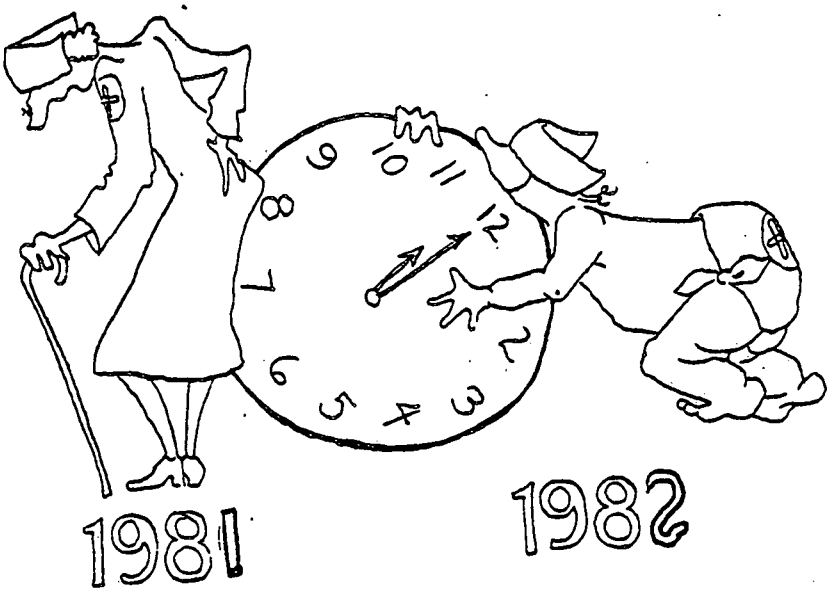
Bonnie Bolinger - OHIO
Rose Marie Van Ingen - MICHIGAN

Current legislative information that will or potentially could affect enterostomal therapy is of vital interest to the IAET Legislative Committee. Hence, anyone wishing to serve as an IAET state liaison where the need is unmet should contact Bonnie Bolinger for further information.

Respectfully submitted,

Harriett May, E...
Lafayette, IN





EDITOR'S NOTE

Cost Containment is an area we feel has been neglected in the past. How many times have you wondered whether a particular piece of equipment is economically feasible for the patient? We hope that the following information will clarify the various costs in ostomy pouches.

Remember, as you view the graph that individual patient characteristics such as age, vision, home environment, activity, mental status, etc. must also be considered.

Our special thanks to Sally Thompson for an outstanding and professional article.

Good Job!

Cost Comparison of Ostomy Pouches

To evaluate whether certain equipment is less expensive for a patient, the E.T./Nurse must also consider other variables. Certainly cost is a factor, but in rehabilitation the cheapest is not always the best selections. The following points should be considered along with the price factor:

1. *Skin barrier attached or needed to be purchased separately?*
2. *Is the material odorproof or odor resistant?*
3. *Shape and/or contour of the pouch, length, open or closed?*
4. *Adhesion to the body - wearing time?*
5. *Reaction to adhesive or material?*
6. *Patient's preference.*
7. *Disposable versus reusable.*

With the above factors to consider, the following chart is to be used only as a guideline.

NOTE: Prices may vary depending on the dealer.
Prices include all increases through 11-30-81.

Sally Thompson, E.T.

Drainable Pouches - 1.

Category	Brand	Each Pouch Price
Adhesive-Backed Odorproof / Odor Resistant Clear Drainable Pouches	United #1115 Bongart Odorproof Drainable Pouch	81¢
	United #1103 Bongart Odorproof Drainable Pouch w/ Collar	93¢
	Nu-Hope #8387 Dualstick Drain	42¢
	Greer #9060 E-Z Access Pouch	70¢
	Bard #1660 Open End Drain with Micropore Adhesive	1.05
	Hollister #9760 Post-Op Pouch with Micropore Adhesive	82¢
Adhesive-Backed Odorproof/ Odor Resistant Opaque Drainable Pouches	Marlen #OB-700 Odour Ban Post Op Ileo Pouch	1.10*
	Bard #960401-05 Ileo B Pouch	1.19
	Hollister #304 Series Secure Adh. Ostomy System Pouch	93¢

*Can be reused

Drainable Pouches - 2

Category	Brand	Each Pouch Price
Adh. Backed, Opaque Odorproof Drainable Pouch Cont'd	Hollister #743 Series Adhesive Drainable Pouch	63¢
Odorproof / Odor Resistant Pouches with Adhesive and/or Skin Barriers	Hollister #311 or #322 Series Karaya Seal w/ Micropore Adh.	1.10
	Hollister #360 Series Premium Pouch w/ Karaya S. Micro Adh.	1.45
	Bard #437 Series Micro. Adh. w/ Crinkline Ring	1.09
	ConvaTec #2564 Series Sur-Fit Drainable Pouch w/ Sur Fit Flange	1.32* + 2.40 flange

*Can be reused

RADIATION INJURY OF THE INTESTINE

Victor W. Fazio, M.D.

Chairman

Department of Colon and Rectal Surgery

The Cleveland Clinic Foundation

Cleveland, Ohio

Ionizing irradiation is used therapeutically for many conditions occuring in the abdomen or pelvis. Some of these include carcinoma of the rectum, prostate, bladder, ovary, cervix and uterus. Radiation treatment is frequently used as an adjunct in the treatment of renal and testicular carcinoma as well. Radiotherapy exerts its effect by transforming cell water molecules into ionized radicals. These in turn injure intracellular components important for cell replication; D.N.A. and R.N.A., and as such impede or cause cessation of growth in malignant cells that are irradiated, especially those with a rapid cellular turn over time. However other normal tissues that receive a direct or scatter effect of the radiation treatment, will also exhibit degrees of cell damage. The cells that are quite vulnerable in this respect are those of the intestinal tract, where metabolic activity is considerable; hence, the terms radiation enteritis (small bowel), radiation enterocolitis (small and large bowel) and radiation procitis (rectum) are seen in reference to injuries to those organs usually arising from the treatment of a non-bowel cancer. The injury affects especially the lining membrane of the intestine, producing an inflamed, swollen appearance; bleeding is a frequent accompaniment of the inflammation. Also affected is the lining of small blood vessels -- the arterioles. There is produced a narrowing of the arteriolar lining -- an endarteritis -- which in turns produces an ischemic effect to the organ it nourishes. In a severe form, this ischemia can produce necrosis, gangrene, fistula or bowel perforation. In less severe form, a fibrosis of the wall of the bowel occurs with stricture formation and possibly obstruction. This endarteritis is one which can continue to exert an effect months or even many years after the radiation treatment has been given and to a certain extent is progressive.

Clearly not all patients receiving radiation treatment will develop symptoms of radiation bowel disease, if the bowel was "caught" in the treated zone. There are certain factors which increase the likelihood of radiation injury.

1. Dose:

The dose chosen must be one that offers a reasonable prospect of cure for a given cancer yet has an acceptable low complication rate as the result of affecting other organs. On one large series: (1) surgical complications involving intestine appeared at doses over 4500 rads, and increased as the dose increased beyond this; in another study of 500 patients, (2) serious rectal injury increased from 4.2% to 15.3% once the dose exceeded 6000 rads.

2. Size of individual dose:

Injury is more likely when the individual doses for a planned program are given at higher levels, e.g., 5000 rads given in ten doses of 500 rads is far more injurious than 25 doses of 200 rads.

3. Other factors having a negative effect include hypertension and diabetes. Previous surgery that allows for trapping of the small bowel in the pelvis by adhesions, will favor the fixed intestine developing enteritis. The technique of radiation treatment is of particular importance in terms of minimizing the risk of injury.

FEATURES OF RADIATION INJURY TO THE INTESTINE

There is a spectrum of illness, and therefore of symptoms, signs and manner of presentation depending upon the extent of the injury. It is not uncommon, for example, for a patient having radiotherapy for cancer of the cervix, to have some rectal urgency or diarrhea, possibly mild rectal bleeding following treatment, but then it promptly disappears. For the severe injury affecting the rectum, gross ulceration, bleeding to the point of anemia and constant, severe rectal pain may occur. As a late feature, rectal stricture of rectovaginal fistula may develop. In the small intestine, the patient exhibiting enteritis may have evidence of malabsorption, steatorrhea, weight loss, hypoalbuminemia anemia; obstructive symptoms due to stricture may occur. In certain severe cases, fistula into an adjacent organ (bladder, skin, vagina) or bowel perforation may occur.

Immediate effect of direct radiation injury to the intestine include degrees of nausea, vomiting, diarrhea and abdominal pain. Rectal bleeding and diarrhea occur after a latent period of weeks to years.

TREATMENT OF RADIATION DISEASE OF BOWEL

A. Rectum:

For mild or moderate radiation injury to the rectum, symptomatic treatment is given. Antidiarrhea medications and topical steroids such as cortisone enemas or suppositories, in concert with a low roughage diet, are frequently of value in these types of cases. Rectal pain that is not relieved by steroid enemas may frequently be alleviated by topical antispasmodics such as belladonna and opium suppositories.

Surgical treatment:

When the rectum is severely affected, surgery is often indicated. Disabling symptoms refractory to medical treatment; obstruction/stricture; perforation and abscess; fistulae; will frequently dictate a need for surgery. In most cases, this will mean a permanent colostomy. Techniques are described for bowel anastomosis to the lower rectum or anal canal, when those segments are relatively spared of radiation effect. These techniques include the pull-through operation; abdominotrans-sacral anastomosis (Localio) and coloplasty (Bricker) for certain types of rectovaginal fistulae. For lesions located in the upper rectum or sigmoid colon, resection of the involved segment with bowel anastomosis is usually possible using conventional technique. Most patients that require colostomy for diffuse rectal disease end up with a permanent stoma. In a few select instances, the inflammatory change may revert sufficiently for colostomy closure to be effective.

B. Small intestine:

Medical treatment is directed towards restoration of nutrition, treatment of malabsorption and diarrhea, and symptomatic relief of pain occasioned by degrees of partial bowel obstruction. In certain cases, the patient will exhibit the features of short bowel syndrome and require home total parenteral nutrition, after an adequate trial of hyperalimentation by elemental diet.

Surgery is reserved for other complications of radiation enteritis such as fistulae (to skin, bladder, vagina, colon); perforation/abdominal abscess; bowel obstruction. Depending upon the extent of the problem, home T.P.N. may still be required to supplement surgery that, while resolving the immediate problem, still leaves the patient unable to be hydrated adequately or repleted nutritionally. Resection of diseased small bowel segments in the anastomosis is the ideal method of surgical treatment when operation is indicated. However, the scatter effect of radiation may well involve the apparently "normal" bowel. In these bowel segments affected in an occult way by radiation injury, there is a potential hazard for fistula formation due to poor healing of the anastomosis. Consequently, an ileostomy is frequently necessary, when the surgeon is unwilling to risk joining the bowel ends in a particular case.

Editor's Note

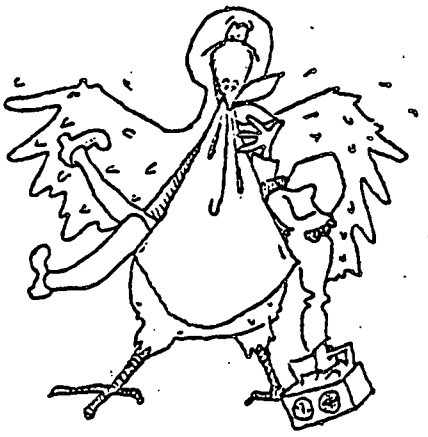
NOTICE: *The following People are not Paid through National as of September 1. This will be your last Newsletter until payment is received.*

Esther Aszodi
Bonnie K. Blackburn
Laura M. Carlton
Mary L. K. Castillo
Teresa K. Chaffins
Carole A. Davis
Natalie M. Dutch
Pamela J. Feaster
Susan Ferguson
Sandra Gustwiller
Patty H. Halstead
Luann Hartley
Kathleen Hoeksema
Barbara E. Howe
Patricia A. Jager
L. Juanita Jenkins
Janice L. Joseph
Denise D. Keating
Mildred G. Kemp
Marky Kriete
J. Michelle Logan
Joan Long
Rita Morman
Mary Ann Pallante
Marilyn Pekol
Priscilla L. Pike
Anna L. Phoads
Jacqueline Rockey
Mary Ann Sammon
Wyonna Stiffler
Karen P. Welsh
Agnes J. Yost
K. Jane Younger

if you have any questions about this don't call me call iaet!

NOTICE: *Newsletters have been returned on these people. Anyone knowing the correct address of these people please let us know.*

BRENDA F. KINDER
SUSAN MUENCH



WELCOME TO THE MIDEAST REGION OF INTERNATIONAL ASSOCIATION FOR ENTEROSTOMAL THERAPY, INC.

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513-861-3100

welcome

ATTENTION:

"CLEVELAND OSTOMY DAY"

Date - *January 30th, 1982*

Content - *Pain management, Colon & Rectal CA*
Radical Cystectomy for Bladder CA.
Pediatric Problems, G.I. Problems

Sponsors - *Cleveland Ostomy Assoc.*
Colon & Rectal Dept.
at Cleveland Clinic

Cost - *Free*

Invited Guests - *ET.'s, Nurses, Physicians, Ostomates*

Lectures presented by the Staff of the Colon and Rectal Department Urology and Pediatrics

**Exhibits following program*
Wine and Cheese Reception at Clinic Inn

1982 YOUTH RALLY

I.A.E.T. and U.O.A. are co-sponsoring the next youth rally in Boulder, Colorado, July 4-9, 1982. Young people, aged 12-17 will be eligible to attend. There is room for 125 youth and 25 adults and the cost will be $150.00. This will include all expenses: food, lodging and all activities at the rally. It is not too early to work with your local U.O.A. chapters to identify young people with ostomies who would benefit from attending the rally, and to look for funding sources, if necessary. Jan Jester is the I.A.E.T. chairperson for the rally. Application blanks will be mailed to local U.O.A. chapters after the first of the year.

"Imagination is more important than knowledge."—ALBERT EINSTEIN

God Gives Us Two Ends: One End To Think and One To Sit On. Our Success Depends on Which End We Use Most... It Is Heads We Win and Tails We Lose.

- Author unknown.

POTPOURRI from "other" regions

FROM

NORTHWEST NEWSLETTER

RESOURCES: SEXUAL REHABILITATION

Mary Beth Pieprzyca has a patient who, out of an identified need, started a business for both men and women in shich she makes pouch covers, crotchless pants, and a few other things as sexual aids which are all very professionally done. Mary Beth reports that this has been a particularly positive thing for her patients as the garments are much better suited for many ostomates. All of the prices are cheaper or competively proced with what is now available on the market. The name of the company is:

"Very Important Personals"
2192 South 60th Street
Milwaukee, WI 53219
(414) 327-5451

There is a pamphlet available entitled "Sexual Intimacy and the Ostomate" which is now being used by many ETs in the Pacific Northwest region. It was written by an ileostomate who has also written several articles for the Ostomy Quarterly and who has published an article of similiar content in AJN. he and her husband have held workshops for UOA organizations nationally and internationally not only in the area of sexuality, but also in other areas of psychological importance to ostomates and their families.

Pamphlets may be purchased by sending a check or money order to:

Kathy Simmons
9901 Cameo Drive
Sun City, Arizona 85351
Telephone: 602-974-8685

The cost of the pamphlets is as follows:

$6.75 for 25
$12.50 for 50
$20.00 for 100
$32.50 for 200.

HOW TO REDUCE STRESS

Dr. Robert S. Eliot, director of the University of Nebraska Medical Center's Cardiovascular Center and chairman of the Preventive and Stress Medicine Department, offers this advice: "Stress may be the spice of life or the kiss of death," depending on how you handle it.

His recommendations:

"Change the way you react to troublesome things, but not too much. Pick out a few -- the straws that break the camel's back -- and deal with those.

"Reduce the number of events in your life and you'll reduce the circuit overload.

"Change the way you see things. Learn to recognize stress for what it is. Increase your body's feedback and make stress self-regulating.

"The bottom line of stress management is, 'I upset myself.' Develop a thick skin.

"Why hate when a little dislike will do? Why foment anxiety when you can be nervous? Why rage when anger will do the job? Why be depressed when you can just be sad?

"Set realistic goals for yourself. Learn how to do nothing. "Don't sweat the small stuff. Remember it's all small stuff. "And if you can't fight what's bothering you and you can't flee from it, then just flow with it."

- Parade - June 14, 1981

"Nutritional Hints for the Person With an Ileostomy" and "Traveling With Ease for the Person With a Stoma" are two brochures written by Lynda Brubacher, R.N., E.T. Nutritional Hints" discusses precautions the ileostomate can take to prevent problems such as dehydration or intestinal blockage. "Traveling With Ease" is a collection of hints on supplies to carry when traveling and how to obtain medical care in unfamiliar situations.

Single copies, $2.00 each
Over 5 copies, $1.50 each

Order from:
Enterostomal Therapist
Virginia Mason Hospital
925 Seneca Street
P.O. Box 1930
Seattle, Wa. 98111

The Kodak Instatech-X Close-up camera is an easy to use camera for stoma and draining wound slides. The basic set-up cost is $120.95 plus taxes and postage.

For further information contact:
Lester A. Dine, Inc.
2080 Jericho Turnpike
Box 190
New Hyde Park, New York 11041
Phone: (516) 437-3220

FROM SOUTHWEST REGION

Every Which Way But Up..

Leah Curtin, Editor of Supervisor Nurse, lashed out against apathy, infighting, and backbiting in the nursing profession in her May, 1981, editorial. "Nursing," she says, "is about to complete a perfect revolution: three hundred and sixty degrees." Ms. Curtin warns that "we will be right back where we started--the ignorant will nurse the sick, the art will be reduced to a task, and the task (for the patient) will be to survive."

Ms. Curtin says that the signs of danger are clear:

1) Depowering of State Boards of Nursing - In some states, the state boards have lost the statutory authority to prevent non-nurses from practicing nursing.
2) Institutional Licensure - One result of the state board's loss of statutory authority is an informal adoption of institutional licensure. That is, any institution can hire any person with any (or no) credentials and authorize her (or him) to practice nursing within its walls.
3) Pressure to Drop J.C.A.H. Nursing Standards - The Joint Commission is under pressure from hospitals all over the country to drop the nursing component of the JCAH Standards. The reasons can be boiled down to cost containment and the nursing shortage.
4) Downgrading of Nursing Education Governor Brown of California has proposed one-year nursing schools that are supposed to produce "professional" nurses. Please note that a school of nursing need not be accredited by N.L.N. for its graduates to sit for state board examinations - the school only needs to be state approved.

"If educational requirements are lowered, standards are dropped, state boards are depowered, and institutional licensure accepted," Ms. Curtin says, "nurses and nursing will be back where they were 100 years ago." We can stop the process, she says, but it is critical that we act now. On the individual level, nurses can refuse to accept employment in hospitals, nursing homes, or agencies that practice institutional licensure and they can work together to prevent other institutions from adopting this practice. They can obtain information from their state nursing organization (they might even join it!) about the condition of their own state board and write letters to state representatives and senators. They can support, guide, and nurture one another on a personal level. They can and must identify nursing competencies and outcomes and validate them through research. "To survive," Ms. Curtin warns, "nurses and nursing organizations must work together. If we don't, nurses and nursing care will go every which way but up."

(Editor's Note: Many thanks to Ellen Shipes for sending a copy of this article to be passed on to our readers.)

HELPFUL HINTS

Iodine is neutralized by Sodium Thiosulfate. In order to remove Iodine or Betadine stains easily from uniforms and lab coats, have your pharmacist mix a 10% Sodium Thiosulfate Solution (1 Gm. Sodium Thiosulfate Powder:10 cc tap water). A more concentrated solution may be mixed for real stubborn stains. Pour a little solution on a wash cloth and proceed to remove the stain easily. Sodium Thiosulfate is known commercially as Hypo and may be obtained from any camera supply store.

Robert L. Swann, RPh.
Shirley P. LeHue, RN,ET
Stanly Memorial Hospital
Albemarle, North Carolina

Product Report

CONVEEN, Male External Catheter with Uriliner, Coloplast International
"The secret of the CONVEEN system is the unique adhesive uriliner, soft, wafer-thin, but most important, flexible." Available in 4 sheath sizes.

URIHESIVE SYSTEM, Male External Catheter with Urihesive Strip, Squibb
"Urihesive strips are made from the same basic nonsensitizing ingredients as the STOMAHESIVE wafer. It adheres easily to delicate skin without surface adhesives that can cause irritation. It holds the external catheter in place without constriction, when applied as directed." Available in 4 condom sizes.

RO-SAN PLUS, Male External Catheter, Mentor
"It has a unique bulb-stem catheter; its kink-proof design allows free urine flow in any position; it prevents urine pooling to avoid skin irritation." Available in 1 size.

HOLLISTER MALE URINARY COLLECTION SYSTEM
This system consists of an adhesive skin protector, an external catheter, extension tubing, leg bag, and leg straps. Items are available separately.
Adhesive Skin Protector - "It features a unique design. It won't impair circulation or create channels for leakage. It absorbs excess moisture or urine. It conforms to any size. It has memory after being stretched, has superior tack on both sides."
External Catheter - It has "two convolutions at the end of the catheter, eliminating any chance for the flow of urine to be cut off. The catheter won't kink or twist closed."
Extension Tubing - It is made of "latex, instead of vinyl to resist kinking and twisting."
Leg Bag - Made of "soft vinyl, one size. It pleats in the sides to increase capacity. The top and bottom valves are free-floating, not to press against the legs. It features a no-flowback valve, and a sterilized fluid pathway to allow the leg bag to be adapted to an indwelling catheter. It features a drain tube clamp so that even quadriplegics with severely limited hand movements can empty the bag easily."
Leg Straps - They are "wide, made of nonrolling, woven material which is breathable and washable."

NEXT ISSUE: SKIN BARRIERS, PROTECTORS, AND RELATED PRODUCTS

FROM MID ATLANTIC REGION

CURRENT PUBLICATIONS (Contributed by Susan Currence, RNET - Towson, Md.

PUBLIC AND PATIENT INFORMATION

-The Ileal Pouch Procedure: A New Outlook for the Person with an Ileostomy-48 page brochure
COST: $1.50 plus postage, etc.
SOURCE: Schmidt Printing, Inc., 1416 Valley Drive, N.W., Rochester, Mn. 55901

-Living with Your Colostomy-39 page brochure
COST: Free
SOURCE: University of Utah College of Nursing, 25 South Medical Dr., Salt Lake City, Utah 84132

-MY OSTOMY & YOURS-6 page brochure
COST: Free
SOURCE: Hollister, Inc., Customer Service, 211 E. Chicago Ave., Chicago, Ill. 60611

-So You Have or Will Have an Ostomy-6 page brochure
COST: 100 for $7.50
SOURCE: U.O.A., Inc., 2001 W. Beverly Blvd., Los Angeles, Calif. 90057

-Urinary Ostomies: A Guidebook for Patients- 31 page brochure
COST: $3.00
SOURCE: U.O.A., Inc., 2001 W. Beverly Blvd., Los Angeles, Calif. 90057

AUDIO VISUALS

-Concerns & Anxieties of Osotmates (Videotape-28 minutes-Sound and Color)
½,1" or 2" tape - 3/4" casette
COST: Free to non-profit institutions
Order # VT 696
Send blank tape with request
SOURCE: U.S. Army Academy of Health Science, ATTN: HSA-SMD, Ft. Sam Houston, Texas, 78234

-Managing Your Colostomy (Videocassette: 16 min., Sound & Color, 3/4")
COST: $60.00
SOURCE: University of Kansas Medical Center, Educational Resource Center, M-10 Orr Major Bldg., Rainbow Blvd., Kansas City, Kansas 66103

PROFESSIONAL INFORMATION

-Colostomy, Ileostomy, Ureterostomy Care: A Guide of Practical Information for Nurses, 58 page brochure
COST: Free
SOURCE: American Cancer Society, Ohio Div., Inc., 453 Lincoln Bldg., 1367 E. 6th St., Cleveland, Ohio 44114

-Nursing Care of Patient with an Ostomy from National Conference on Cancer Nursing - Sept., 1973
COST: Free
SOURCE: Local ACS Units

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st Update

Certification Committee Information

Nancy Wright

ET's across the country have expressed a desire to help write test questions for the certification examination. The certification committee welcomes this valuable input. To make the process of writing questions easier, our professional testing organization, The Psychological Corporation, offers some helpful guidelines.

"Multiple - choice tests are the most widely used type of objective examination. It offers so many advantages over other kinds of tests that it is relied upon almost exclusively for testing sizeable groups under standardized conditions."

A multiple - choice test consists of a series of items. Each item comprises a stem and three or more answer choices or options. One of the options is correct while the others (distracters) are incorrect. The examinee's task is to select the correct option for each item. The score is based on the number of items the person answers correctly.

The following principles and illustrations are intended to help interested test-question writers avoid some of the pitfalls that frequently lead to defective items.

1. The stem may be in the form of a question or an incomplete statement. Both ways of writing this item are acceptable.

Question Type

What is the usual frequency of intubation six months following continent ileostomy surgery?

1. once daily
2. every two hours
3. 3 - 4 times in 24 hours
4. 8 - 10 times in 24 hours

Completion Type

The usual frequency of intubation six months following continent ileostomy surgery is

1. once daily
2. every two hours
3. 3 - 4 times in 24 hours
4. 8 - 10 times in 24 hours

2. The problem or question should be presented clearly in the stem. A well-informed examinee should be able to anticipate the appropriate answer before looking at the options.

Example

In what age group is bladder cancer most prevalent?

1. under 20
2. 20 - 30
3. 40 - 50
4. 60 and over

3. Both the stem and the options should be as brief and straightforward as possible. Avoid complex sentence structure that make comprehension difficult.

Example

The pH of freshly-voided urine specimen from a patient on a normal diet will be about

1. 3.0
2. 6.0
3. 7.0
4. 9.0

The above three principles cannot be applied rigidly because some of them might have to be sacrificed in favor of others. Nevertheless, they do cover many of the problems commonly encountered in test item construction.

Many tests and pamphlets contain more detailed discussions of the theory and practice of test construction. The following are good sources of information.

Ebel, Robert L. Essentials of Education Measurement. Englewood Cliffs, NJ: Prentice-Hall, 1972.

Gronlund, Norman E. Constructing Achievement Tests. Englewood Cliffs, NJ: Prentice-Hall, 1968.

The Psychological Corporation. "Some Principles for Preparing Multiple - Choice Items." New York, NY.

Your participation in writing and submitting test items is critical to the strengthening and refining of the certification examination.

If you would like a prepared list of suggested test item topics and a copy of the Psychological Corporation's "Principles for Preparing Multiple-Choice Items," please write or call me. I will be glad to assist you in any way possible.

Thank you for your input into the IAET.

Nancy E. Wright, RN, M.Ed., ET
Chairperson, IAET Certification Committee
7801 Delmar Boulevard
St. Louis, MO 63130
Phones: (314) 652-4100
(314) 726-1777

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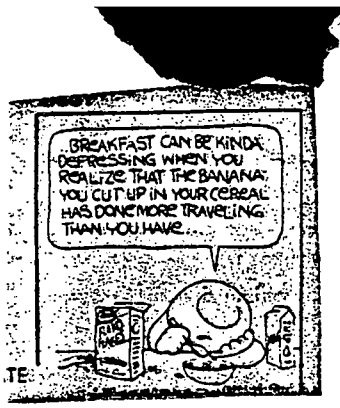
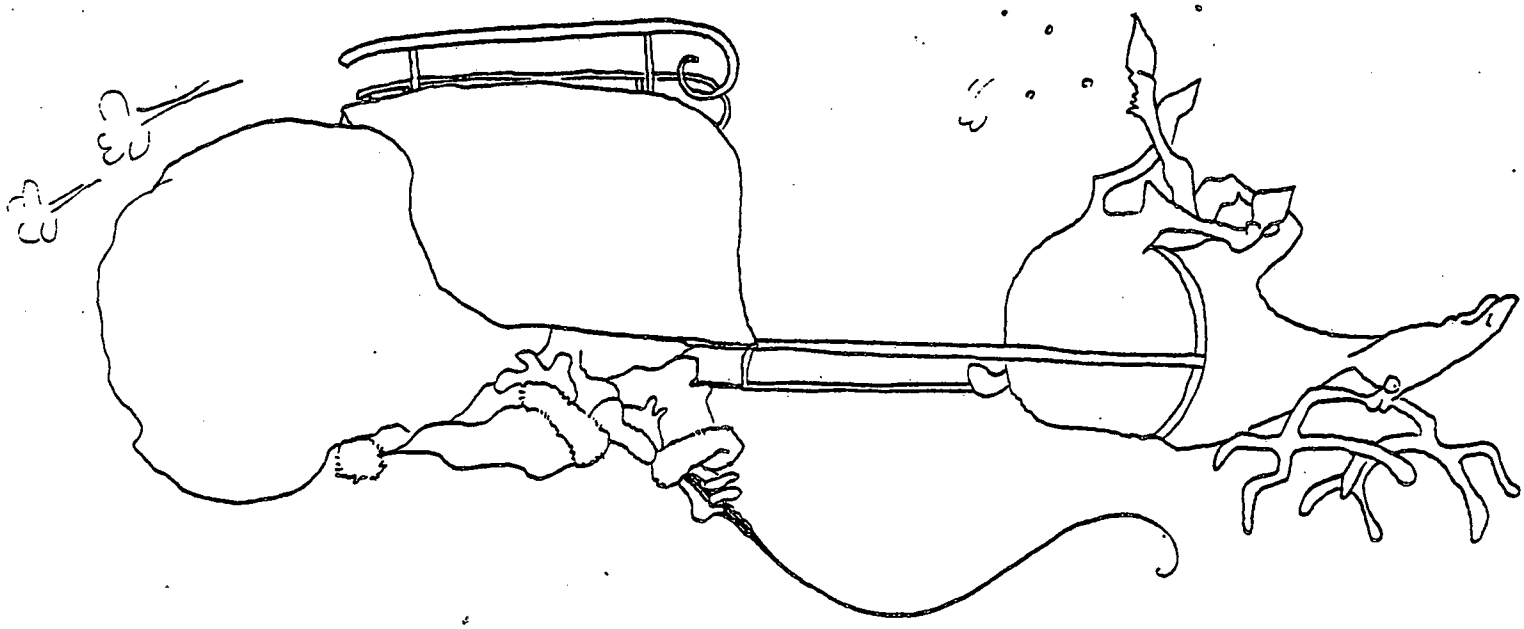


"Gee, I wish I'd known that."



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