



Evidence of
innovation



“
**SKIN HAS NOT BEEN
SORE SINCE USING
THE AURA® POUCH.”**

Mrs R, UK
Uses Aura® urostomy pouches

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2020

A VERY SPECIAL YEAR FOR NURSES.

Moira Evans, Clinical Marketing Manager, Welland Medical

As we celebrate Florence Nightingale's bicentennial year, designated by the World Health Organisation as the first ever global **Year of the Nurse and Midwife**.

2020 is our time to reflect on these skills, the commitment and expert clinical care they bring, and the impact they make on the lives of so many¹.

Florence Nightingale² said "the more experience we gain, the more progress we can make". The common clinical theme throughout this edition is the improvement made to peristomal skin complications following the introduction of medical grade Manuka honey in the stoma flange adhesive.

Together we can review examples of nursing care which have made a positive impact upon patients' quality of life, as we take a trip around the globe to read patient case studies and published articles from Australia, Holland, Italy, New Zealand and the UK.

Through patient scenarios, we are able to follow specialist nurses as they support their patients' journey through peristomal skin complications. Katy Martin-Skurr reviews the impact of pyoderma gangrenosum, Moira Evans, Pamela White and Lynn Ridley

share the impact of dementia upon stoma care, whilst Dannielle Barr introduces complex social situations and mental health issues, for Nelleke Van de Vliert and Leila Fatemifar the focus is upon problematic abdominal contours.

The dynamic of change is discussed in Rebecca Howson's review of patient education models and the review of patients' clinical needs by Pamela White and Moira Evans.

Peate (2019) stated that: 'The proverb prevention is better than cure means that it is easier to stop something happening in the first place than to have to repair the damage after it has happened'.³

This edition recognises stoma therapy nurses in their never-ending quest to enhance the lives of patients with stomas. Florence Nightingale said that we should "live life when you have it. Life is a splendid gift-there is nothing small about it".⁴

“
THE MORE EXPERIENCE WE GAIN, THE MORE PROGRESS WE CAN MAKE.”

Florence Nightingale

Florence Nightingale (1820-1910), photograph ca. 1880



OSTOMY CHALLENGES

PERISTOMAL SKIN COMPLICATIONS

Peristomal skin complications are the most common issue following creation of a stoma, Martins et al (2013), and range from mild dermatitis to severe complications such as ulceration or necrosis.

PERISTOMAL PYODERMA GANGRENOSUM (PPG)

Pyoderma gangrenosum (PG) is a debilitating skin disease most often associated with inflammatory bowel disease and is a reportedly rare cause of peristomal ulceration. The lesions of PG rapidly evolve from small, erythematous pustules to deep, painful, pyogenic ulcers within hours to days of onset. Although the behaviour and the appearance of the lesions of peristomal PG are diagnostic, a lack of familiarity with PG often leads to misdiagnosis and inappropriate therapy.¹

As an uncommon subtype, peristomal pyoderma gangrenosum (PPG), which occurs close to abdominal stomas, comprises about 15% of all cases of PG. The lesions are painful and often interfere with the stoma bag adhering to the abdominal wall, which can cause the contents of the bag to irritate the skin more than usual.²

Wallace (2017) suggests that the rarity of pyoderma gangrenosum means that **there is a need for clinicians to share their treatment experiences to act as a guide for future best practice.**³

There is no universally accepted guideline for treatment of pyoderma gangrenosum, and no disease-specific therapies have been subjected to controlled clinical trial.⁴ Instead, a multidisciplinary approach to treatment is required, and is based on case reports, randomised controlled trials into various drug therapies, and previous clinical experience.



Peristomal pyoderma gangrenosum (PPG) comprises about

15% of all cases of Pyoderma gangrenosum (PG).²

“**THERE IS A NEED FOR CLINICIANS TO SHARE THEIR TREATMENT EXPERIENCES TO ACT AS A GUIDE FOR FUTURE BEST PRACTICE.**”

Wallace A (2017)

STUDY

BALANCING STOMA COMPLEXITIES WITH POUCH CONVEXITY

Moira Evans, Clinical Marketing Manager, Welland Medical Ltd.
Pamela White, Clinical Governance Manager, CliniMed Ltd and SecuriCare (Medical) Ltd.
Lynn Ridley, SecuriCare Nurse Manager (North), SecuriCare (Medical) Ltd.

A review of one patient's journey through peristomal skin complication management.

AIM

To present a patient scenario to demonstrate the positive impacts upon peristomal skin integrity, following the introduction of medical grade Manuka honey within the convex flange adhesive.



OUR PATIENT

An 82-year-old lady with dementia, who was cared for in her own home by her family, this included her daily ileostomy care.

The patient was using a one piece convex pouch.

The family noticed a deterioration in the peristomal skin condition. They had been advised to get in touch with their Stoma Care Nurse (SCN) if they had any concerns relating to the stoma.

The family contacted their SCN following the deterioration of the peristomal skin condition.

WHICH PROBLEM STARTED FIRST?

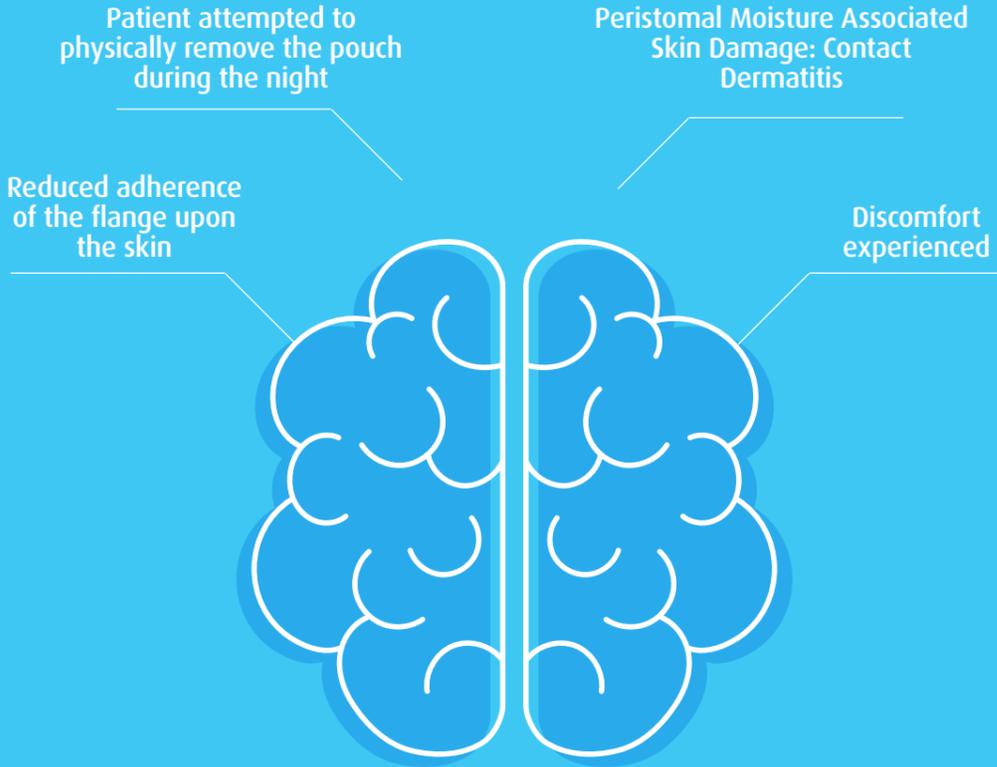
- Patient attempted to physically remove the pouch during the night
- The impact of dementia upon her stoma awareness
- Reduced adherence of the flange upon the skin
- Discomfort experienced
- Peristomal Moisture Associated Skin Damage: Contact Dermatitis

THE IMPACT OF DEMENTIA UPON HER STOMA AWARENESS



METHOD

The SCNs utilised SecuriCare Medical Ltd.'s Clinical Stoma Scoring Thermometer tool to acknowledge and manage cumulative risk factors to enable prioritising and proactivity of care input, as the patient's score was ranked as 8, a same day visit was arranged.



NURSE ASSESSMENT 02-NOVEMBER

The SCN's holistic assessment, prompted a change of pouch adhesive to a Manuka honey convex flange to:

1. Improve pouch to skin adhesion
2. Support the improvement of skin integrity
3. Provide comfort to the patient during wear-time

NURSE REVIEW 09-NOVEMBER (7 DAYS)

The review of the change of pouch 7 days later, showed peristomal skin improvement and the same pouch was used until the next planned review date.

TREATMENT CONTINUATION 12-NOVEMBER (10 DAYS)

The holistic nursing care and the change to a Manuka honey adhesive convex pouch had resolved the patient's peristomal skin problems and the use of a convex Manuka honey pouch continued.



THE PATIENT'S JOURNEY LED TO:

1. The vigilance of the patient's family carers
2. The SCN prompt intervention
3. The change to a convex Manuka honey adhesive flange

All of these have contributed to the resolution of the peristomal moisture associated skin damage experienced by the patient.

*Consent on file to share photos

Poster presented to the ASCN 2019 Conference, ICC Wales.

CASE STUDY: A CHALLENGING PATIENT

Homelessness and emergency stomal surgery

Dannielle Barr, Registered Nurse, Stomal Therapy Nurse
The Royal Melbourne Hospital, Parkville, VIC 3050

Taken from the Journal of Stomal Therapy Australia – Volume 39 Number 3
September 2019. Printed with the kind permission of the AASTN.

THE PERSON / THE STORY

Mr C presented as an emergency patient via ambulance with severe abdominal pain and haematemesis. Shortly after admission he was taken to theatre and underwent an emergency laparotomy/total colectomy and washout. His large bowel was necrotic from the distal ileum to the proximal rectum with no obvious cause. At this stage the wound was left open (laparostomy) and a topical negative pressure dressing was put in place. The patient was admitted to ICU. The following day he returned to theatre again for a re-look laparotomy/proctectomy and small bowel resection. An end ileostomy was formed at this stage. The patient was critically unwell and it was unknown whether he would survive these procedures. Stomal therapy was contacted on day 2 postoperatively. Surprising everyone, Mr C did recover from his surgery but his stoma proved to be challenging.

SOCIAL, MEDICAL AND SURGICAL HISTORY / DIAGNOSIS

Mr C is an ex-IV drug user and has Hep C. At the time of admission he was officially homeless; although he had been sleeping in emergency housing he had lost his bed when he did not present. He has no next of kin and suffers from PTSD¹ due to childhood abuse from when he spent his youth in a boys' orphanage. He was currently on a high dose anti-depressant and on a methadone programme. He had no relevant surgical history.

The surgical diagnosis was ischaemic bowel of unknown cause. Mr C had no recollection of what event may have triggered the ischaemic bowel. Although he was an ex-IV drug user, he could not recall using in the period prior to admission.

POSTOPERATIVE ASSESSMENT AND DISCHARGE

Mr C's ileostomy was found to be flat, non-spouted, initially sloughy, with healthy tissue becoming visible after using stoma powder for several days. His stoma required a convex appliance and a seal was also used. However, no real issues with this presented during his hospital stay.

Stomal therapy worked closely with social work to emphasise the importance of Mr C returning to emergency housing as we were gravely concerned about him returning to the streets with his new stoma and complicated social history. Thankfully, the social worker was able to secure accommodation back at the place he was previously so he was discharged there.

However, the meals provided had little variation and were not ideal for someone with an ileostomy. In addition, his stoma caused embarrassment to Mr C when it produced noisy flatus. The facility not only had a shared kitchen and living areas but shared bathroom cubicles which left little privacy for changing a stoma appliance.

Mr C became depressed and admitted to being "really, really low". He was struggling with body image associated with the stoma, compounded by ongoing leaks which he attributed to the excess flatus. He also struggled, and continues to struggle, with not knowing why he'd become so unwell in the first place since he has no memory of that time. Cognitively, we thought Mr C may have some short-term memory loss associated with being so critically unwell. In addition, his peristomal skin was erythematous with abrasions and was painful, although the stoma size had decreased.



Figure 1. The Welland Aurum Convex plus belt.



Figure 2. Mr C's stoma.

THE PLAN FOR MR C

It was absolutely critical for us to use a product that would have healing properties. In addition, the appliance would need convexity. It was clear a belt would be beneficial also to 'pop' the stoma out as much as possible due to its flat profile. The product used prior to discharge had a belt, but Mr C found it difficult to manage. The stomal therapy team therefore chose to use the Welland Aurum Convex (Figure 1) with a belt². We needed to be confident that the product would not leak and would heal the sore skin. Another reason we chose this product is that the belt is easy to manage with the velcro that easily slides through the belt hole. As Mr C is often forgetful, it needed to be simple to ensure self-efficacy³. We also facilitated a referral to the psychiatric team for ongoing management of his depression.

OUTCOME

Mr C came back to an outpatient appointment a couple of weeks later for review. He loved the Welland Aurum Convex drainable and had experienced no leaks since we had seen him last. He found the pouch easy to empty with the built-in tab. He also loved the ease of the adjustable velcro belt. His skin was healed and was no longer sore as indicated in Figure 2.

Mr C was also now seeing the psychiatrist regularly. Although he still has a long way to go psychologically, having had no leaks for a period of time has made a huge improvement in his confidence, and he is obviously coping much better. For some weeks Mr C chose to have weekly STN OPD appointments which he titrated down as his mental health improved. It was therefore great news to hear this week that Mr C had moved from emergency housing into his own public housing flat where he is living independently.

CASE STUDY: STOMA EDUCATION

For the older person is about keeping it as simple as 1, 2, 3

Rebecca Howson, Stomal Therapy Nurse, Caulfield Hospital, Caulfield VIC 3162

ABSTRACT

Australia's aging population presents unique hurdles when planning, providing care and educating new ostomates, and these variations to care differ greatly depending on the individual.

Whilst there are many predictors to flag potential issues, and well-planned-out pathways for the stoma's physical journey, this article is aimed at highlighting the often overlooked and under-documented complexities encountered as we navigate patients in the transition to home. This is an example of how not all complications and barriers to discharge are due to the stoma, the output, or any medical issue, but rather about the patient's ability to self-manage. The ability to self-manage a stoma is often the defining factor to an aged person's ability to either return to their lives at home or be placed into formal care. This article follows the journey of a non-English speaking background patient transferred from the acute setting to rehabilitation. She was struggling to manage her colostomy appliance which could put her, and her husband with dementia, into residential care – her motivation to prevent this was demonstrated by her readiness to learn. As stomal therapy nurses, it is our responsibility to identify the barriers to self-care, adapt product selection, and implement the most achievable goals. The patient's specific goals and the interventions produced to achieve these were individualised so that she was able to return home to continue to live her life, and not be dictated by her new stoma. This meant that the concept of self-care had to be as simple as 1, 2, 3.

“**AN EDUCATION PLAN WAS SET UP IN ORDER TO REITERATE THAT SELF-CARE IS A 1, 2, 3 PROCESS.**”

Taken from the Journal of Stomal Therapy Australia – Volume 39 Number 3 September 2019. Printed with the kind permission of the AASTN.

BACKGROUND

The aging population presents an array of issues when trying to educate an individual on how to self-manage their new stoma and, with the world's population aging rapidly, this is an area of particular importance.

Between 2015 and 2050, the proportion of the world's older adults is estimated to almost double from about 12% to 22%¹. In absolute terms, this is an expected increase from 900 million to 2 billion people over the age of 60¹. In Australia, the proportion of the population aged 65 years and over increased from 12.2% to 15.7% between 1998 and 2018². This group is projected to increase more rapidly over the next decade as further cohorts of baby boomers reach 65 years². Also, over the past 2 decades the number of people aged 85 years and over increased by 125.1% compared with a total population growth of 34.3%² over the same period. Typical issues related to aging include loss in dexterity, decreased sensation in extremities, changes to eyesight, decreased problem solving abilities and slower recall. However, the aging brain is still able to learn new skills³.

In addition, the cultural and linguistic diversity of Australia's resident population has been reshaped over many years by migration. Historically, more people immigrate to than emigrate from, Australia. At 30 June 2017, 29% of the estimated resident population was born overseas (7.1 million persons)⁴. This was an increase from 2016 of 28.6%³. In 2007, 10 years earlier, 25.1% of the population was born overseas⁴. These statistics highlight that Australia has not only an aging but also a multicultural population, and while interpreters are invaluable assets they are not always available.

So how do we provide effective education to this cohort of patients? By keeping it simple, as this allows the patients to learn without the need to always have an additional person during all education sessions. Also, by removing unnecessary products and steps in order to simplify the process, the task becomes achievable and increases patients' likely success.

CASE STUDY

Mrs R is an 87-year-old non-English speaking background Greek lady. She lived at home with her husband, who has dementia, and was his primary carer. Since her admission, her husband had been placed into respite care and, if she were unable to achieve independence with her colostomy care, her family had discussed permanent placement for both her and her husband. Whilst Mrs R was able to speak

English, an interpreter was utilised during the initial education session to ensure that she was able to fully express the issues with changing her appliance and to have any questions answered. Prior to the stomal therapy nurse review, it was documented that Mrs R was requiring assistance with all aspects related to her colostomy care.

SURGICAL HISTORY

On 20 June 2018 Mrs R underwent an emergency Hartmann's procedure for colonic perforation. This was followed by an extended stay in the acute setting. On 5 July 2018 she was transferred to subacute/rehabilitation for stomal therapy education, assessment

and complex discharge planning. At the time the colostomy measured 32 mm, the mucocutaneous junction had healed, but peristomal skin complications were present related to contact with output.



Figure 1: Mrs R's stoma prior to education. The peristomal skin is unprotected due to a mis-fitting stoma appliance.



Figure 2: Photo care plan for the patient showing the 1, 2, 3 supplies required for bag change.

ISSUES IDENTIFIED

Mrs R explained that she had difficulty cutting the flange to the correct size and also trying to attach the bag to the flange. She was unable to visualise her colostomy without the use of a mirror and said she didn't have 'enough hands' to apply the flange correctly. These issues had caused her to cut the

opening for the stoma too large which had led to the circumferential damage (Figure 1). Therefore the main issues were language limitations, a two-piece mechanical coupling, incorrect sizing of product, and difficulties with fine motor skills due to dexterity and sensation.

REHABILITATION PLAN

A number of suggestions were made. Firstly, that Mrs R changes to a one-piece product to simplify the process. Secondly, that she begins to use a pre-cut product and as she was not able to read English well. The Aurum with Manuka Honey was chosen as this came in the appropriate pre-cut size, would aid in healing the

damaged peristomal skin, and is easy to apply. Thirdly, that she creates a photo care plan (Figure 2) to refer to when changing her colostomy bag. In addition to this, an education plan was set up in order to reiterate that self-care is a 1, 2, 3 process. This is defined as there being only three things to collect prior to changing.



Figure 3: Photo care plan for the patient showing Step 1: how to remove the bag.



Figure 4: Photo care plan for the patient showing Step 2: cleaning the skin and the stoma.

This is defined as there being only three things to collect prior to changing.



and then that there are three steps to take (Figures 3-6):

Each step was demonstrated by saying 1 as the bag is removed, 2 while cleaning the skin and stoma, and 3 while applying the new bag.

REVIEW

Mrs R reported at the next review that it was much easier to change her appliance and liked having the photo care plan to refer to during appliance changes. Her peristomal skin had improved in the 3 days of using the Aurum with Manuka Honey (Figure 7) and Mrs R also commented that she didn't feel "itchy" around her stoma. She was no longer requiring any assistance from nursing staff and was confident to be discharged home to resume caring for her husband. Mrs R was discharged home with district nurse support.



Figure 5: Photo care plan for the patient showing Step 3: applying the bag.

CONCLUSION

The use of unnecessary products and numerous steps in the process of changing bags creates complicated and confusing tasks for the aged or for those patients with limited English. Simplifying the process allows for all patients to be presented with the same education process and facilitates continuity of care as handover of the process for education is then also simplified. The 1, 2, 3 step education process requires only repetition and practice. STNs provide hands-on bedside education to all patients and, by using this process, can minimise the potential for variation and miscommunication between STNs and bedside nurses.

Note: Consent was obtained to use these images and case study from the patient within the guidelines of the organisation.



Figure 6: Photo care plan for the patient showing Step 3: checking the position of the bag.



Figure 7: Review of the stoma – the peristomal skin showed much improvement.

CASE STUDY

Aurum® 2 urostomy flange in combination with Aurum® 2 colostomy pouch

A clinical account by Nelleke van de Vliert, Nursing Consultant

Patient

Male, 75, colostomy

Source

Nelleke van de Vliert, Nursing Consultant, Welland Service Team, Welland Nederlands

Problem

Peristomal skin complication

Solution

Aurum®2 urostomy flange in combination with Aurum®2 colostomy pouch and UltraFrame® flange extender

Data held on file.

The views and opinions expressed in this article are those of the source and do not necessarily reflect the views and opinions of Welland Medical.

DIAGNOSIS AND TREATMENT

The Welland Service Team (WST) was approached by a hospital stoma nurse for help. They had a patient with a colostomy who had a severe moist, red and irritated peristomal complication.

The hospital nurses were unable to determine the cause of his skin problem and had already recommended a two piece pouching system, this did not relieve the skin complication and an Aurum 1 piece was given to the patient. Prior to this, the patient used multiple 1 piece flat flange colostomy pouches from several manufacturers.

To clearly identify the problem I visited the patient at his home address.

When I met the patient, he was only able to leave the 1 piece pouch in place for four hours as the flange started to lift away from his skin.

During the home visit I observed that the patient had moist and red skin around his stoma (Figure 1). In addition, the patient had some problems with leakage, probably caused by his very moist skin.



Figure 1. Patient before 22-05-2019.

The next step was to speak to the patient about what one of the causes of the problem could be, namely the moist skin which caused most of the leakage. I decided to use a 2 piece system with an Aurum 2 urostomy flange due to its absorption capacity (Figure 2). I selected a two piece urostomy flange as it has a thicker flange, a deeper hydrocolloid base.

extended the pouch wear time to 48 hours during the second week and progressed to a 72 hour wear time from the three week period onwards. In the first week UltraFrame flange extender was used to ensure that the flange remained in place. The outcome was that the urostomy flange appeared to have absorbed most of the moisture from the skin surface.

As the skin produced so much moisture, it was decided to initially change the 2 piece system daily, we then



Figure 2. Aurum 2 urostomy flange in combination with Aurum 2 colostomy pouch.



HOME VISIT 27-05-2019

Situation after 5 days using an Aurum 2 urostomy flange. Skin is not as moist and the leakage is resolved. Welland Aurum was specifically chosen to enable the skin to heal and recover (Figure 3).



Figure 3. Situation after 5 days using an Aurum 2 urostomy flange.

HOME VISIT 06-06-2019

Skin is still red but dry. The moisture has disappeared. No leakage has occurred since the use of an Aurum 2 urostomy flange (Figure 4). The patient briefly tried an Aurum 1 piece colostomy pouch, but this resulted in moist and red skin again. The decision was made to permanently use an Aurum 2 urostomy flange in combination with an Aurum 2 colostomy pouch and the patient is very happy with this solution.



Figure 4. Home visit 06-06-2019.

OUTCOME AND FOLLOW UP

The patient is comfortable with the use of the Aurum 2 pouch system. Aurum has had a positive healing influence on the moist and red skin (Figure 5). He is able to start his hobbies again, such as gardening.



Figure 5. Home visit 23-08-2019.



CASE STUDY

Providing convexity for a patient with peristomal skin complications using **Aurum® 2** piece convex

A clinical account by Leila Fatemifar, Stoma Therapist Nurse

Patient

A 75-year-old gentleman, who is diabetic and has a terminal end colostomy

Source

Leila Fatemifar, Stoma Therapist Nurse, San Pietro Hospital, Rome, Italy

Problem

Itching and burning across the peristomal area along with continuous detachment of the previous convex pouch

Solution

Aurum® 2 Convex with Manuka honey colostomy pouch



Figure 1.



Figure 2. After two weeks of using Aurum® 2 piece convex.

DIAGNOSIS AND TREATMENT

The gentleman, presented to the San Pietro Hospital in Rome, Italy as an emergency patient. Following diagnosis of a pelvic abscess, the patient underwent emergency surgery resulting in the formation of a terminal colostomy following a Hartmann's procedure. The patient complained of itching and burning across the peristomal area along with continuous detachment of the previous convex pouch.

Upon initial assessment by the Stoma therapist nurse, the stoma was assessed as flush to the abdominal contour with three areas of peristomal ulceration. These can be seen in Figure 1. It is assumed that these have been caused by the previous stoma flange.

The decision to change the stoma flange type from

flat to a convex flange was taken and the peristomal area was cleaned and a protective powder and paste applied prior to the flange application.

The Aurum 2 piece was selected as it provided a soft and flexible convexity, whilst the Manuka honey may improve the peristomal lesions.

The peristomal skin integrity improvement can be seen following two applications of the Aurum 2 piece convex pouch (Figure 2). The same skin preparation was undertaken as discussed above.

The three ulcerated areas have significantly improved along with the general peristomal skin area following the introduction of Manuka honey in the flange and the soft convexity.

CONCLUSION

The desired outcome was to enable the stoma effluent to drain into the pouch following the insertion of soft pressure around the stoma via the convex flange, enabling the stoma to be raised rather than continuing to rest so close to the skin.

Data held on file.

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CASE STUDY

The use of Manuka honey in the treatment of Pyoderma Gangrenosum revisited

A clinical account by Katy Martin-Skurr, Stomal Therapy Nurse Specialist

Patient

Mrs. D, Female, 38, ulcerated colitis. Underwent an elective total colectomy with end ileostomy

Source

Katy-Martin Skurr, Stomal Therapy Nurse Specialist, Omnigon, New Zealand

Problem

Ulcerated lesions caused by pyoderma gangrenosum (Pg)

Solution

Aurum® Convex with Manuka honey Ileostomy pouch and HyperSeal® Washers with Manuka honey

This case study identifies how, as nurses, we are challenged by our patients in our everyday practice which test our ingenuity and resourcefulness and how we need to constantly refresh our clinical knowledge bank. I hope that through this clinical reflection we can continue to share clinical practice and patient outcomes as Walls (2016) stated this improves our practice and helps to add to our armoury.

Moira Evans, Clinical Marketing Manager, Welland Medical.

Data held on file.

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PRESENTATION AND HISTORY

Mrs. D has had severe ulcerative colitis which was diagnosed in 2012. Her bowels move up to 10 times a day passing blood and mucous with associated urgency, incontinence and cramping abdominal pain.

Because her condition has been resistant and non-responsive to medical treatment Mrs. D underwent an elective total colectomy with end ileostomy. She recovered well from surgery, discharging home after 4 days in hospital.

Mrs. D managed her stoma well after surgery with no concerns. Her stoma was healthy, 32mm in diameter and well spouted.

She was followed up in the community by both the local district nurses and the stomal therapy nurse.

PARASTOMAL ABSCESS OR PYODERMA GANGRENOSUM?

One month following surgery Mrs. D was seen in the District Nursing clinic. She was troubled by a remaining suture and hypergranulation tissue at the 6 o'clock position (Fig 1). The suture was removed, and the granuloma was treated with silver nitrate.

Over the following month the area became inflamed with what looked like a suture abscess appearing. Mrs. D reported slight discomfort from this area. The area appeared to resolve using stoma powder.

A month later Mrs. D attended surgical clinic with what appeared to be a reformation of the abscess. The Stomal Therapy Nurse (STN) suggested the use of topical betadine. A week later, with little improvement Mrs. D was prescribed antibiotics by her GP. This resulted in some slight improvement.

A week later a new area of concern at 11 o'clock was also noted by the STN and a photograph was taken and sent to her surgeon.



Figure 1. First appearance of painful area at 6 o'clock position inferior to stoma.





Figure 2. Following incision of what was presumed to be an abscess.

3 months post her initial surgery Mrs. D attended clinic. Her surgeon arranged her admission to hospital for incision and drainage of the apparent parastomal abscess (2.5mm x 0.8mm). The area was excised and opened leaving a larger area of tissue which was painful during pouch changes (Fig 2). At this point I became involved in Mrs. D's care. I was suspicious that as Mrs. D had ulcerative colitis an autoimmune disease we were likely to be dealing with Pyoderma gangrenosum (PG).

PYODERMA GANGRENOSUM (PG)

PG is a rare auto-inflammatory disorder also known as neutrophilic dermatosis. It is associated with other autoimmune disorders including that of inflammatory bowel diseases such as ulcerative colitis and Crohn's disease, rheumatoid arthritis and some haematological conditions. PG may start as a small pustule, red bump or blood blister often starting suddenly after a minor injury. The skin breaks down resulting in extremely painful ulcers with ragged edges and undermining. There may be a bluish coloration to the wound's edges. Surgery is contraindicated as it tends to extend the area and not contribute to healing.

Due to my previous success using the Welland Manuka honey product range for the treatment of PG I commenced using the Aurum® Convex pouch with Welland HyperSeal washer with Manuka honey.

I accompanied Mrs. D a week later to her next clinic appointment. The surgeon agreed with the PG diagnosis and asked for an urgent Dermatology review. The Dermatologist attended clinic and confirmed our suspicions (Figure 3). Application of Locoid® cream, a steroid, was recommended.

We continued to use the Welland Manuka honey products as the PG had shown some improvement from the previous weeks.



Figure 3. Confirmed diagnosis of Pyoderma gangrenosum.



Figure 4. 8 weeks from commencement of treatment.



Figure 5. 10 weeks from commencement of treatment.

The pouch was maintaining a good seal however Mrs. D preferred her previous product. To allow Mrs. D's choice of product we negotiated to continue the use of Manuka honey and the healing of her PG by using a large Welland HyperSeal® washer with Manuka honey underneath the product of her choice. This allowed full coverage of the PG and surrounding peristomal skin.

With the above treatments Mrs. D continued to have a marked improvement in the pain, inflammation and

healing so the treatment plan was continued. The healing process took approximately 3 months from PG diagnosis to complete resolution.

The current treatment in use to maintain healthy peristomal skin and prevent the reoccurrence of PG is the smaller Welland HyperSeal washer with Manuka honey (40mm) and intermittent use of Locoid® cream when Mrs. D suspects a flare up (tingling/discomfort and slight erythema).

CONCLUSION

An earlier diagnosis of PG may have prevented the surgery and Mrs. D's prolonged recovery. With the repeated successful use of Welland Manuka honey products for the treatment and prevention of PG reoccurrence, I would now consider and recommend using this product range as a first line choice in patients with autoimmune diseases.

FROM NATURE TO NURTURE

How and why does medical-grade Manuka honey promote skin health? What's the story and the science behind this natural remedy, used for centuries in wound care.



LIFECYCLE AND PROPERTIES OF MANUKA HONEY

FROM NATURE TO NURTURE

THE PLANT



Leptospermum scoparium

is a shrub or small tree native to New Zealand, that blooms just 2-6 weeks per year. Commonly known as the Manuka or tea tree bush. Tea tree arose because Captain Cook used the leaves to make a 'tea' drink.¹

THE NECTAR



Manuka Power of Three

There are three key natural markers in Manuka Honey (Methylglyoxal, Leptosperin, and Dihydroxyacetone), which are tested in registered laboratories and the results measure the "Manuka-ness" of the honey.³

THE GRADE



UNIQUE MANUKA FACTOR[®]
HONEY ASSOCIATION

Unique Manuka Factor (UMF)

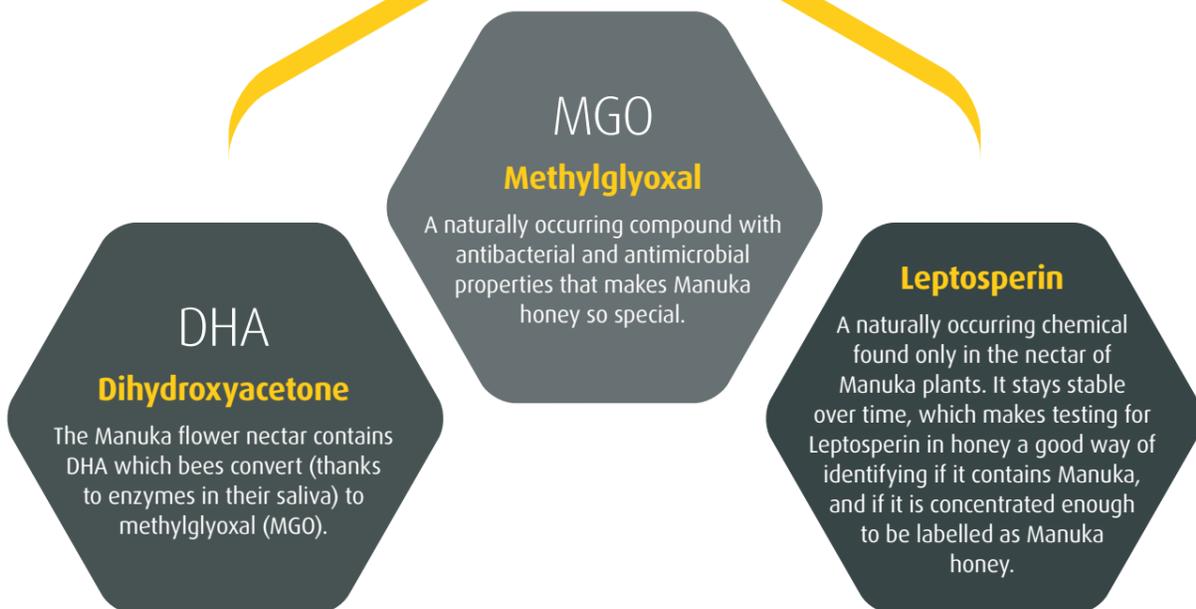
This is the official stamp on honey that has been scientifically tested and graded appropriately. The honey companies that use this gold standards grading system are official licensees of the UMF Honey Association (UMFHA), which has strict criteria and audits its members' packaging and marketing material. Testing for MGO levels is important as they can vary greatly – not all Manuka honey is equal!³

THE PRODUCT



From Hive to Harvest

Beekeepers gather the honey at the end of the summer season. This harvested honey is tested by The New Zealand Ministry for Primary Industries (MPI) standards and certified using the UMF-approved grading system.



16+ UMF
MEDICAL GRADE MANUKA HONEY

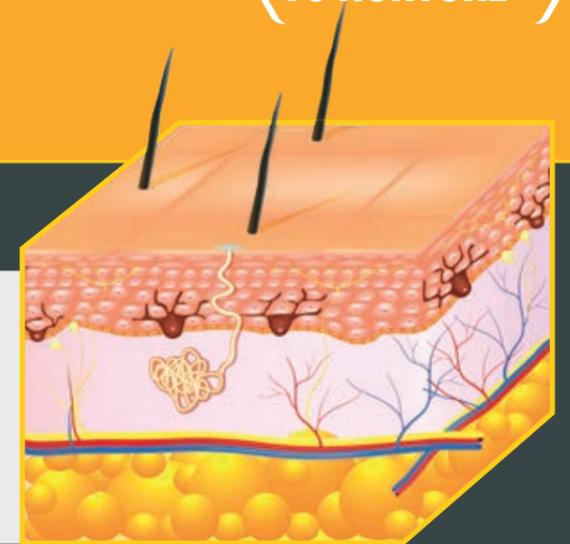
is used in Aurum[®] ostomy pouches and accessories.

SKIN FRIENDLY PROPERTIES

SKIN HEALTH IN STOMA CARE

FROM NATURE TO NURTURE

MANUKA HONEY



Anti-inflammatory

- Reduces oedema, which reduces pain from pressure on tissues

Provides a moist wound healing environment

- Hygroscopic therefore draws moisture from environment to wound
- Clinical evidence has been published to support the antibacterial properties of Manuka honey to speed up growth of new tissue to heal wounds

Antimicrobial activity

- Low pH: Inhibits bacterial growth
- High sugar content: Reduces water available for bacterial growth
- Methylglyoxal (MGO): non-enzymatic antibacterial compound unique to Manuka honey and is reflected through the MGO content. One way to look at this is that 'traditional' honey and Manuka honey can both exhibit antibacterial properties, but Manuka honey has a unique additional component (MGO) which relies on non-hydrogen peroxide activity
- High viscosity: Forms protective barrier against bacteria

The importance of skin health in stoma care

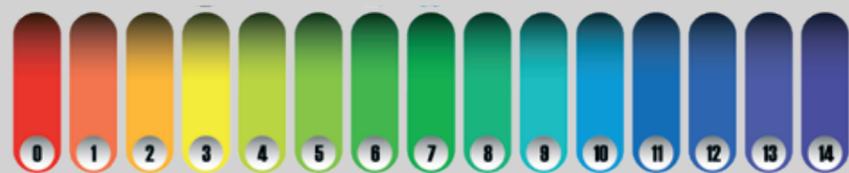
- The waste output from the stoma can disrupt the normal skin barrier function
- The skin pH is usually between 4.1 - 5.8, but the waste matter from the stoma is alkaline which disrupts this balance and can cause irritation, breakdown and infection of the skin
- Some studies report up to 75 percent of people with an ostomy experience a peristomal skin condition*

Aurum with Manuka Honey



THE pH SCALE

Skin pH



Acidic

Neutral

Alkaline

MAORI MANUKA STORY



'Manuka' Meaning

Maori are the indigenous people of Aotearoa New Zealand and have a cultural connection to its taonga (treasure) Manuka. Maori are tangata whenua (people of the land) who are responsible for protecting our taonga for current and future generations.

"Manuka has a whakapapa (genealogy) from a Maori world view. Tane Mahuta - the god of the forests - was responsible for separating his parents Rangiui (sky father) and Papatuanuku (earth mother). After the separation, Papatuanuku was naked and vulnerable so Tane Mahuta covered her in trees. Tane Mahuta married Tawake-toro and they had Manuka. Therefore, from a Maori perspective, Manuka is not just a name on a label but has a whakapapa. This is our Maori story and only we can tell this."

Tane Mahuta
=
Tawake-toro
▼
Manuka

The story of Manuka

"Rangiui (sky father) and Papatuanuku (earth mother) were locked in an eternal embrace. Their children became frustrated with the cramped conditions and decided to separate their parents - Tane Mahuta (god of the forests) lay on his back and forced his parents apart. He adorned Rangiui with the sun, moon and the stars. He also cloaked his mother with trees. Tane Mahuta had a union with Tawake-toro which gave rise to Manuka. Tane Mahuta also introduced all our native tree species, our native birds and insects. Tane Mahuta also breathed life into the first female giving rise to humankind."

**Victor Goldsmith, Ngati Porou Miere
Limited Partnership Managing Director**



COLOSTOMY UK RUGBY MATCH ULTRAFRAME® INTERVIEW

Many thanks to Oliver, Chris and Kav for sharing their thoughts on UltraFrame®.



So, you are now wearing UltraFrame, how do you feel?

- Oliver:** Yeah, I can feel it extends the natural part of the pouch
- Kav:** I always feel like the natural part of the bag you have isn't quite big enough. So, anything to support round the edges helps.
- Chris:** And they feel invisible and you can't feel it.
- Oliver:** And the best thing is, you just forget about it. Which is what you want.

Have you worn them before, during physical activity?

- All three:** I have, yeah.
- Chris:** To the gym. They bend and move with all your movements and really well shaped.
- Kav:** You don't really feel like you've got anything on.

How easy were they to apply?

- Oliver:** Pretty simple. Follow the numbers. As long as you can count to 4, you'll be alright!

What does it mean to you to represent Team Colostomy UK?

- Kav:** It means an awful lot. It's good to show what is possible. Especially this time round, with the publicity, this one has been immense.
- Chris:** The reason I wanted to play is just to show everybody who has a stoma you can do all the things you did before.
- Oliver:** I didn't even play Rugby before I had a stoma. So, I've only just started playing since I've had it. For me its been great to start a new sport and meet lots of people who are in a similar situation.

How did you find the game today?

- All three:** Great, really good.

Did your stoma bag remain secure throughout the match?

- Chris:** Absolutely no worries. No problems at all.

How does UltraFrame compare to other flange extenders?

- Kav:** It's a lot thinner than all the others. Even in everyday activities, you don't feel it. It moulds to your body. It's great.
- Oliver:** You don't notice it. You want it to be as strong as possible, but not actually notice it's there.

Does it give you the confidence to play without holding back?

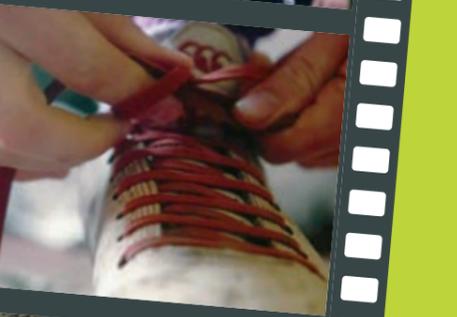
- Chris:** You've seen the film. I don't think anyone was holding back at all!

What was the best part about playing for team Colostomy UK today?

- Oliver:** I think probably awareness. You can see how many people are here today and the difference that can make. People just knowing about what it is like to have a stoma and it's not a barrier to doing what you want to do.
- Chris:** If you asked one of the Chorley players who in our team had a stoma, they probably wouldn't be able to tell you. (All three show their stoma bags).
- Chris:** and I've got two!

The views and opinions expressed by the featured users on UltraFrame are their own and do not necessarily reflect those of Welland Medical PID7379

UltraFrame®





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**CREATIVITY IS
INTELLIGENCE
HAVING FUN.**”

Albert Einstein



Welland Medical Ltd., Hydehurst Lane, Crawley,
West Sussex RH10 9AS United Kingdom

Tel: +44 (0) 1293 615455
Fax: +44 (0) 1293 615411
Email: info@wellandmedical.com

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www.wellandmedical.com



AU **1800 819 274**
info@omnigon.com.au
NZ **0800 440 027**
www.omnigon.com.au

