The History of Ostomy Surgery

In the Beginning

The history of ostomy surgery is much like the history of WOC nursing; it is an inspiring story characterized by tremendous challenges, determined providers, and very courageous patients. This is their story and our heritage.

Development of Colostomy: Indications and Construction

Only sporadic accounts of ostomy surgery can be found before the 1700s. Throughout the 18th century, accepted management of intestinal perforation was to close any open abdominal wound and "hope for the best." This treatment plan was (not surprisingly) associated with extremely high mortality rates. The earliest stomas were actually fistulas that developed spontaneously following bowel perforation; one surgeon noted the correlation between spontaneous fistula development and patient survival and stated in his journal that perhaps surgeons should "take a lesson from Mother Nature" and construct planned stomas in such cases. Any surgical advance during this period was significantly complicated by the absence of anesthesia and asepsis, which of course resulted in extremely reluctant patients and dismal outcomes.

In the late 18th century (1793), an innovative surgeon performed a colostomy on a 3-day-old infant with an imperforate anus; to prepare for the procedure, he practiced on the bodies of dead babies he obtained from the city's poorhouse. The surgery was successful, and the patient lived to the age of 45, though we lack any data as to how he actually managed the stoma.

Following the development of anesthesia during the mid-1800s, surgery became a realistic treatment option; surgeons in the mid-1800s to late-1800s used diverting colostomy to manage bowel obstruction and also tried to cure patients with rectal cancer by surgical excision of the rectum (narrow abdominal perineal resection of rectum [APR]).

(Continued on Page 7)
Hello fellow ostomates and friends,

I would like to pass on a message from Kaiser Permanente with you. I hope that this information can help anyone in need.

Get the facts about ostomy surgery and what you can expect.

We know you have questions and we are here to help answer them.

Free confidential mentoring for you before and after surgery

Call 619-662-1222
Mon-Fri 8:30 AM - 5:00 PM

Appointments at your convenience 7 days/week at our clinic or hospital

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Thank you for your support......

President Al Nua

A.K.A The Samoan King of Escondido

It’s time to celebrate!
Ostomates celebrating their stomaversary this month are:
TennieBee Hall - 46 Years!!!
Roger Lebsock - 10 Years
Joyce Simpon - 3 Years
Lou Drexel - 3 Years
Richard Rettig - 19 Years!!!

Birthdays in August:
Marcy Lawson, Laraine Melzer,
James Baker, Mary Bowden,
Sandy Nichols, Carmen Danker,
Vicki Ingalls, Ann Parker,
Larry Lynch, Trino Cabezas,
& Clarice Bednarz

Thinking of you and get well:
Bob Ballentine
Val Alley
Marvin Goldman

Gone, but not forgotten:
Sharon Stange

Sympathy:
Lorna Goodman
Meeting News
By Paulette Frazelle
& Tammy Davis

Welcome visitors:
Ken Mihoky, Mari Anne Kacy,
Kathleen Moser, Mark Davis,
Jeff Clarke, Anita Bohensky,
Bob Sandoval, Darlene Johnson,
Murel Ray, Mike Erbst,
Lorena Eckert, & Charlene Goldman

Welcome new members:
Thomas Gaughan
Kenneth Mihoky
Sandra Nichols

Number of visitors in July:
42

Goodies Providers for August’s
general meeting:
Cecilia Cowles, Mona Villa, & Ruth Jurancich

Goodies Provider for August’s
board meeting:
Dodie Wilson

Thank you to:
Larry Reed, & the OSG
for providing July’s goodies

General meetings are held at Tri-City
Medical Center, 4002 Vista Way, Oceanside
Lower Level, Room AR 1 @ 1:00 P.M.

2014 General meeting dates:
— Friday, January 31st
— Friday, February 28th
— Thursday, March 20th
— Friday, April 25th
— Friday, May 30th
— Friday, June 20th
— Friday, July 25th
— Friday, August 29th
— Friday, September 26th
— Friday, October 31st
— Friday, November 28th
No meeting in December

Next board meeting date:
— Monday, January 13th
— Monday, February 10th
— Monday, March 10th
— Monday, April 14th
— Monday, May 12th
— Monday, June 9th
— Monday, July 14th
— Monday, August 11th
— Monday, September 8th
— Monday, October 13th
— Monday, November 10th
— Monday, December 8th
We Want Your Input
If you have any ideas or comments to give the OSGNSDC, please let me know. We want to know what kind of speakers you look forward to hearing, ideas for the newsletter, whether you like the date/time the meetings are held, and anything else you feel would benefit the group.

Email to: sierracabezas@gmail.com,
Mail to: P.O. Box 3019, Vista, CA 92085.
Or: Bring in your written ideas to the meeting and give them to the Newsletter Editor, Sierra Cabezas.

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Surplus Ostomy Supplies
Ostomy supplies have been donated by chapter members or their families when an ostomate has had a revision surgery or passed away. These supplies are available to our chapter members or individuals in need of supplies. Please contact Al Nua at (760) 213-2501 if you need supplies or have supplies that you no longer need.

Want to become a Certified Ostomy Visitor?
Al Nua, is looking for ostomates that would like to attend a class to become a Certified Ostomy Visitor. Visiting new and recent ostomates is the most important service our group provides. Visitors go through formal training and can make calls in the hospital and home. If you are interested, please call Al Nua at 760-213-2501.

Health Awareness Days this Month
Cataract Awareness Month
Children's Eye Health and Safety Month
National Immunization Awareness Month
Psoriasis Awareness Month
Spinal Muscular Atrophy Awareness Month
Medic Alert Awareness Month
1: National Minority Donor Awareness Day
1-7: World Breastfeeding Week
8-14: National Health Center Week
4: (second week) National Night Out
9: (always same date) International Day of the World's Indigenous People

If You Have Internet Access...
Are you still receiving this newsletter in hard copy? If you have internet access, you can save us money by joining our electronic mailing list. To try the electronic version, send an e-mail request to: sierracabezas@gmail.com. We won’t remove you from our hard-copy list until we know you can receive the electronic version successfully. We appreciate your efforts to keep costs down while also being more eco-friendly.
In this month's general meeting we celebrated with the caregivers in our lives. Cake was supplied by the OSG to show appreciation for the care givers that sacrifice so much for their loved ones.

President Al Nua read the sunshine report to the group. We sang happy birthday to Anita Bohensky, Dick Clarke, Ron Johnson, Robert Sandoval, & Lola Jiang. Larry Reed and the OSG were thanked for bringing in goodies for the care givers meeting. Dick Clarke was given a stoma pen for his stomaversary.

The raffle raised a total of $65.00. The winner was Joyce Simpson for the amount of $32.50. She donated $16.00 of winnings back for the Koins for Kids charity. Koins for Kids raised $47.35.

President Al Nua then went around the room asking members to share their favorite caregiver memories and stories with the group.

Before the meeting ended, Al announced that the OSG would like a picture of every member to go with their membership papers, updated everyone on the Annual Holiday Party, talked about membership reminders that will be going out soon, San Bernardino’s support group meetings, & Kaiser's support meetings.
Dr. Dhruvil P. Gandhi
At Colorectal Center of San Diego, Inc., we are committed to providing quality care to our patients. Dr. Dhruvil P. Gandhi is the only board-certified colon & rectal surgeon in the north San Diego county area, serving Oceanside, Vista, Carlsbad, Encinitas, and San Marcos.

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Unfortunately, these early attempts to cure rectal cancer with APR were associated with a 100% recurrence rate, because only the rectum and anal canal were removed. Surgeons learned quickly from these failures, and in the early 1900s surgeons Mayo and Miles modified the APR procedure to include radical resection of the perirectal tissue and lymphatics as well as the rectum and anal canal. During the early 1900s, surgeons also found that proximal colostomy could be used to protect a distal anastomosis and to reduce postoperative complications.

Early decompressive and protective colostomies were typically constructed as skin-level "loop" ostomies. They provided effective decompression of an obstructed bowel but only partial diversion of the stool, and they proved quite difficult to manage. In 1888, the support rod was introduced to prevent retraction of the loop stoma until it had granulated to the abdominal wall. The use of rods was a major advance, in that it produced a protruding stoma that provided almost complete diversion of the fecal stream. At this time, the standard of care was to leave the loop stoma closed until several days following surgery, at which point the anterior wall of the loop was opened with cautery at the patient’s bedside. The procedure was not painful but it frequently was traumatic since the patient could smell the burning tissue, and it meant that the stoma had to "self-mature" via gradual self-eversion to expose the mucosal layer of the bowel. This changed in the 1950s, when Dr Bryan Brooke made surgical maturation the standard of care for ileostomy; subsequently surgical maturation became the standard of care for colostomy construction as well.

Henry Hartmann popularized the concept of delayed anastomosis (and the Hartmann's Pouch) when he lectured in America during the early 1900s on his technique for managing obstructing sigmoid tumors: removal of the involved segment of bowel, closure of the distal stump, and formation of an end colostomy. Mikulicz-Radecki proposed another option for temporary diversion following bowel resection; he recommended bringing the proximal and distal segments of the bowel out as two side-by-side skin-level stomas, and he further recommended using a crushing clamp to create a fistula between the 2 loops of bowel (and thus restore intestinal continuity) once it was deemed safe for stool to pass through the distal bowel. He called this procedure a double-barrel colostomy. This procedure never gained popularity, and over time the term double-barrel colostomy came to indicate a proximal colostomy with a distal mucous fistula.

Development of Colostomy:
Location and Management
In the early 1800s the standard of care was to site a colostomy in the lumbar area. This site was selected through cadaveric work and showed that the posterior wall of the colon could be accessed and brought to the surface without involving the peritoneum, a critical consideration in the days preceding asepsis! Once aseptic technique became the standard of care, the lumbar location was replaced by an anterior approach. Nevertheless, the specific site was determined by the area of pathology, which meant that many stomas were located in the inguinal area. Both the lumbar and inguinal location rendered colostomy management challenging, and construction of most stomas at skin level added to the difficulty. It was not until the 1950s, when Dr Rupert Turnbull began to focus on ostomy patient rehabilitation and established the Enterostomal Therapist (ET) role, that pre-op stoma site marking became the standard of care. ▶
Colostomy formation became more and more common throughout the 20th century; however, there were no ostomy supply companies and few options when selecting a pouching system prior to the 1970s and 1980s. Fortunately, in 1924 an innovative surgeon originated the concept of colostomy irrigation. He worked with a supply company manager to develop the equipment. Irrigation remained the standard of care for colostomy patients until the late 1980s, at which time odor-proof pouching systems were available and patients could be given the choice between routine irrigation and management with pouching.

**Continent Colostomy**

There have been multiple unsuccessful attempts to develop a continent colostomy. One involved creation of an aperistaltic abdominal reservoir attached to an abdominal stoma; intussusception of the bowel between the reservoir and the stoma provided continence (a colonic version of the Kock Pouch). Not surprisingly, this attempt failed because the formed stool normally found in the colon could not be effectively drained through a catheter. Another approach involved a strip of muscle wrapped around the bowel just proximal to the stoma to create a neosphincter; the developers hoped that over time patients would be able to recognize colonic distention so that they could apply a pouch when needed. This procedure was associated with poor results and high complication rates. The third approach involved implantation of a metallic ring into the peristomal tissue; a magnetic cap with an obstructing plug was then inserted into the stoma to obstruct the bowel and prevent stool elimination. The patient was taught to irrigate to stimulate evacuation on a routine basis and to use the obstructing cap at all other times to prevent stool leakage. This procedure was associated with multiple complications related to foreign body reactions and soft tissue infections, and the continence rates were no better than those obtained with routine colostomy irrigation. Currently, routine colostomy irrigation is considered the best option for providing modified continence for patients with descending or sigmoid colostomies.

**To Be Continued**

Source: nursingcenter.com
American Cancer Society
Clinical Trials Continued:

What if I’m not eligible for a clinical trial?
Although some people may be too ill or have other problems that do not allow them to take part in clinical trials, most people will probably be eligible for some type of study. This is true even if they’ve had many different treatments already. Of course, not all studies you are eligible for are a good fit for you. It’s always important to understand the purpose of the study and to have a good idea of the possible risks and benefits for you.

Clinical trials offer the best access to experimental treatments. Study protocols, which are written based on the results of studies done before, are strictly followed and patients are watched carefully. Some people may be interested in a certain treatment that’s only available in clinical trials, but may not meet the eligibility criteria outlined for the studies. In some of these cases, a person’s doctor may ask the study sponsor if they can get an eligibility waiver or special exception to allow the person into the study, even though they do not strictly meet all of the criteria. This decision is usually made by the study’s clinical investigator, who sometimes consults with others involved in the study about the request. If entered in the study, the person is treated according to the study protocol (the same tests, doctor’s visits, follow-up, etc.), but the results from that person are not included in the final study results.

In other cases, the studies may have already enrolled enough people and aren’t taking more participants.

At times, there may be ways to get access to treatments that are in late phase clinical trials but not yet approved by the FDA. These are usually referred to as expanded access or compassionate use programs. In recent years the FDA has broadened these programs to allow some patients who urgently need these treatments to be able to get them. For more information, see our document, Compassionate Drug Use.

But it’s not always easy to get access to these treatments. The company making the treatment is not required to offer it for expanded access or compassionate use. Some companies may decide not to for various reasons (manufacturing issues, excess demand, etc.). Because of the amount of effort and paperwork involved, the process of trying to get an unapproved drug for compassionate use can be slow (weeks to months). And, not all doctors are willing to manage the use of an investigational drug for patients in their care.

Some of these programs are described below. All require your informed consent, much the same as for any clinical trial.

Treatment use of an investigational new drug (treatment IND)
In some cases, if a treatment is showing promise in late phase clinical trials, the maker may apply to the FDA for a treatment IND (investigational new drug) status. This is much like setting up a new study, but it’s meant mainly as a way for patients with no other options to be able to get the treatment before it’s approved.
This is sometimes done when a person would not have met the eligibility criteria for the clinical trials or when the studies are already closed to further enrollment. The patient must have a life-threatening or severely debilitating condition for which there are no other treatment options.

Your doctor would need to get in touch with the treatment manufacturer to see if such a program exists and what would be needed for you to enter it. As with clinical trials, these programs have to have a protocol (written guideline or plan) that meets FDA approval, as well as approval by an institutional review board (IRB) in many cases.

The supplier may or may not charge for the treatment in question. It’s important to find out beforehand whether you or your insurance company would pay for the treatment.

Single patient and emergency use of an investigational new drug
A single patient IND is used to get access to an unapproved treatment for one person with a serious condition who is not eligible for a clinical trial. It’s much like a treatment IND in some ways. It does not require that the clinical trial protocol be followed, but it requires that your doctor spell out in detail your case, previous treatments, the proposed treatment plan, and more.

To get a single patient IND, your doctor would need to contact the manufacturer of the treatment to see if they would supply it. He or she would then need to have the proposed treatment protocol approved by the IRB and the FDA before treatment would be allowed to begin.

An emergency IND can be used when there isn’t time to get approval from the IRB. Your doctor would need to contact the manufacturer to see if you can get the treatment, and then file the needed paperwork with the FDA. While IRB approval is not needed before starting treatment, the IRB would have to be told of the situation and would have to approve future uses.

Summing it all up
Clinical trials can offer benefits for many people during their cancer experience. These may include access to newer or more treatment options, getting more involved medical care, and having a greater sense of control over one’s situation. But by their nature, clinical trials involve some possible risks and downsides, too, and they may not be right for everyone. Your decision on whether to look into or enter a clinical trial should be based on a realistic understanding of the possible risks and benefits.

If you are thinking about entering a clinical trial, there are many groups, including the American Cancer Society, who can help guide you through the information needed to make your decision.

To learn more
More information from your American Cancer Society
Here is some information you might find helpful. You can order free copies of our documents from
our toll-free number, 1-800-227-2345, or read them on our Web site, www.cancer.org.

• Clinical trials and cancer treatments
• Clinical Trials: State Laws Regarding Insurance Coverage
• National Cancer Institute Cancer Center Programs
• Learning About New Cancer Treatments
• Learning About New Ways to Prevent Cancer
• Placebo Effect
• Informed Consent (also in Spanish)
• Compassionate Drug Use
• Coping with cancer
• Coping With Cancer in Everyday Life (also in Spanish)
• Helping Children When A Family Member Has Cancer: Dealing With Treatment (also in Spanish)

National organizations and Web sites
Along with the American Cancer Society, other sources of information and support include:

National Cancer Institute
Toll-free number: 1-800-422-6237 (1-800-4-CANCER)
Web site: www.cancer.gov
Offers general cancer information as well as information on clinical trials, deciding whether to take part, finding certain clinical trials, research news, and other resources. Special information on clinical trials at www.cancer.gov/clinicaltrials

Cancer Hope Network
Toll-free number: 1-877-467-3638
Web site: www.cancerhopenetwork.org
Matches adult cancer patients with trained volunteers who have recovered from a similar cancer experience for telephone support. One program matches volunteers who have been on clinical trials with others who are considering taking part in a clinical trial.

Centers for Medicare & Medicaid Services (CMS)
Toll-free number: 1-800-633-4227 (1-800-MEDICARE)
TTY: 1-877-486-2048
Web site: www.cms.hhs.gov
A federal agency with the US Department of Health and Human Services that helps Americans and small companies by ensuring effective, up-to-date health care coverage and promoting quality care for beneficiaries. They help answer questions, give information, and refer callers to state Medicare offices and local HMOs with Medicare contracts. (The Medicare phone number can be used to reach CMS as well.)

*Inclusion on this list does not imply endorsement by the American Cancer Society.

No matter who you are, we can help. Contact us anytime, day or night, for information and support. Call us at 1-800-227-2345 or visit www.cancer.org.

Source: cancer.org
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The Phoenix is the leading national magazine for ostomates, their families and caregivers. Each issue contains 72 pages of inspiration, education and information including new products, medical advice, management techniques, personal stories and more.

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OSGNSDC’s Annual Christmas Party

El Camino Country Club
3202 Vista Way, Oceanside, CA 92056

December 5th, 2014 11:00-3:00

$28.00 per plate will need to be collected by Tammy Davis.
Please bring payment with you by October 31st’s general meeting or mail your payment and food choices into: P.O. Box 3019 Vista, CA 92085

A three course lunch will be served.

First Course
A Garden Salad.

Second Course
Your choice of:

**Pasta Primavera** - Chef’s selection of Pasta served with Vegetables, Sweet Basil, and Parmesan Cheese.

**Monterey Chicken** - Breast of Chicken with Jack Cheese, Avocado and Tomato in Light Cream Sauce, served with Rice Pilaf and Vegetables.

**Tri Tip Beef** - Sliced and Fanned Tri Tip over Mashed Potatoes, served with Vegetables.

Third Course
New York Cheesecake with Strawberries.

There will be a silent auction and raffle prizes to raise money for the Support Group. There will also be an optimal $10.00 gift exchange. Please RSVP as soon as possible.
When To Call A Doctor Or A WOCN

- If cramps last more than two or three hours
- If you get a deep cut in the stoma
- Excessive bleeding from the stoma opening or a moderate amount in the pouch after several emptyings
- Bleeding at the juncture of the skin and stoma
- Severe skin irritation or deep ulcers
- Unusual change in the size or appearance of the stoma
- Change to a purple-blue color may be an indication
- Severe watery discharge lasting more than five or six hours
- Strong odor lasting more than a week
- Any other unusual occurrence with the stoma.

(Courtesy San Diego & Metro Maryland Newsletters)

Enterostomal Therapy And Wound Clinic Information

Cherie Sheehan, WOCN
760-216--8649

Karen Krause, CWOCN
760-434-8280

Suzasnn Crockett, CWOCN
Tri-City Medical Center
Mon-Fri 8 am—4:30 pm
Appointments: 760-802-9447

Donna Johnston, RN, ET
Palomar-Pomerado Wound Care
Mon-Fri 8:30 am—4:30 pm
760-510-7300

Mandy McDonough, WOCN
Scripps Ostomy Clinic
10666 North Torrey Pines Road
La Jolla, CA 92307
858-554-8984

Donna Rositani, CWOCN
Margaret Talley, CWCN
Palomar Hospital
Mon-Fri 8am—6pm
760-739-2891/2393

Phyllis Parker RN, CWOCN
Kaiser Garfield Clinic
5893 Copley Drive
San Diego, CA 92111
858-616-5006

Certified Ostomy Visitors
Visitor Coordinator
Al Nua
760-213-2501

Visiting new and recent ostomates is the most important service our group provides. Visitors go through formal training and can make calls in the hospital and home. They are proof that life after ostomy surgery can be normal. They can answer questions about living with an ostomy.

You can expect a visitor of the same gender and with the same surgery. I encourage you to take advantage of this valuable service.

The Ostomy Support Group Of North San Diego County trains and certifies ostomate members who can offer psychological support to individuals and their families both before and following surgery. Ostomy visitors may come to a home or to the hospital, but may only visit when invited by the patient, his or her doctor, or a family member.

The chief goal of a visitor is to reassure individuals that they can look forward to an essentially normal and satisfying life following ostomy surgery. To insure integrity, all medical questions which may arise during a visit are referred to medical practitioners. To request a certified ostomy visitor or to obtain additional information on this program, please contact Al Nua.
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We are pleased to have such a fine array of advertisers in our newsletter. We remind you that these advertisers are very important to us, not only as suppliers of Ostomy healthcare products, but also as supporters of our newsletter and group activities. We urge you to give them the opportunity to fulfill your ostomy healthcare needs. We request also that when you do call or e-mail them, to please mention that you saw their ad in our newsletter.

HAVE YOU ALL REMEMBERED TO PLACE YOUR ORDER FOR THE PHOENIX MAGAZINE?

REMINDER!
DID YOU REMEMBER YOUR OSTOMY SUPPORT GROUP IN YOUR WILL?

MEMBERSHIP APPLICATION

OSTOMY SUPPORT GROUP OF NORTH SAN DIEGO COUNTY

MEMBERSHIP is open to all ostomates and individuals with continent diversions, persons contemplating or scheduled for ostomy surgery, family members, medical professionals, and other interested persons.

MEMBERSHIP INCLUDES:

- **OSTOMY NEWS**, our Group’s monthly newsletter containing useful information on how to live a satisfying life as an ostomate, helpful hints for caregivers, and other relevant information.
- **Monthly meetings** to hear interesting speakers, exchange ideas, answer questions, receive emotional support, share the camaraderie of fellow ostomates, and enjoy refreshments.
- **One-on-one visits** by Certified Visitors to prospective or new ostomates, and to others as needed.
- **Access to the many services** and information made available by our national association, United Ostomy Associations of America, Inc. (UOAA).

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□Continent Urostomy □I do not have an ostomy □I am the parent of an ostomy child
How would you like to receive your newsletter? □By Mail □By E-mail

PLEASE ATTACH YOUR CHECK MADE PAYABLE TO: OSTOMY SUPPORT GROUP OF NORTH SAN DIEGO COUNTY OR OSGNSDC. SUBMIT YOUR PAYMENT AT A GROUP MEETING OR MAIL TO:
P.O. BOX 3019, VISTA, CA 92085
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NEXT MEETING:  
Friday, August 29th @ 1:00 P.M.

Director Leland Russell presents:  
An FBI Special Agent speaking about fraud and related issues.

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**Disclaimer**

It is not the intention of The Ostomy Support Group Of North San Diego County; advertisers; contributors; or writers of any articles to provide specific medical advice, but rather to provide users with information to better understand their health and their diagnosed disorders. Specific medical advice will not be provided, and this Group urges you to consult with a qualified medical professional for diagnosis and for answers to your personal questions.