IL-MUSBIEH

MALTA NURSING AND MIDWIFERY JOURNAL
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It's never too early to protect children's teeth from acid erosion

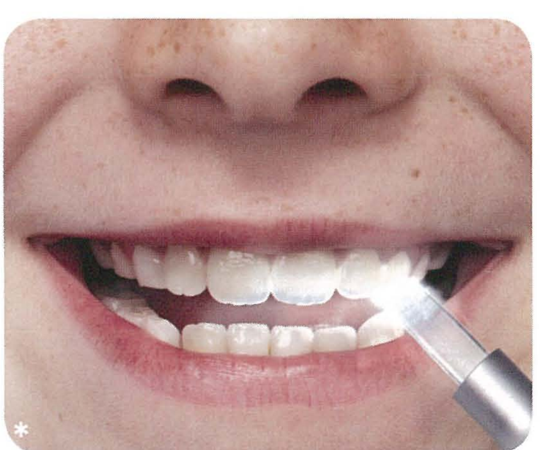

*Image adjusted to illustrate clinical situation

Acid erosion in children's teeth is a growing concern.[1-4] When enamel is gone, it's gone for good. But with early diagnosis and timely advice to parents, you can help prevent enamel loss. For instance, tell them about Sensodyne Pronamel for Children, specially designed to protect children's teeth against the effects of acid erosion as well as caries. What could be simpler for their future dental health?

Daily protection against acid erosion for children

References:
1. Nunn JH *et al*. Int J Paediatr Dent 2003; 13: 98-105. 2. Dugmore CR and Rock WP. Int J Paediatr Dent 2003; 13: 295-303. 3. Lussi A. Monogr Oral Sci 2006; 20: 1-8. 4. Chadwick BL *et al*. Br Dent J 2006; 200: 379-384.

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editorial

What would you say if you had to explain Christmas to someone who knew nothing about it? You might begin with the shepherds in the fields by night or Santa at the North Pole. Redemption and rejoicing, feasting and singing, humility and awe — these would all be parts of your answer. The personal explanations would come easiest: the rituals of Christmas Eve, the smell of fresh balsam, the stillness of a world cloaked in snow although we don't have it in Malta we still asociate Christmas to it.. You would probably have something to say about the importance of family and the force of a holiday whose strongest emotions center upon children, and upon our memories of being children.

What would you say if you had to give a report about our nursing situation in Malta to someone who knew nothing about it? You might begin with the achievements we managed to get through the years or what nurses hoped to achieve. Workload and human resources, waiting lists and patients, rights and duties – these would be part of our answers.

And yet to really explain Christmas you would also have to try to answer the question that seems more pressing every year: how do those emotions and memories connect to the frenzied commercial machinery of the weeks that lead up to Christmas? And to really explain the nurses and midwives true situation we need to try and answer the questions that arise year after year: what is our goal... what do we want to achieve...how are we going to achieve these goals... who will benefit...why?

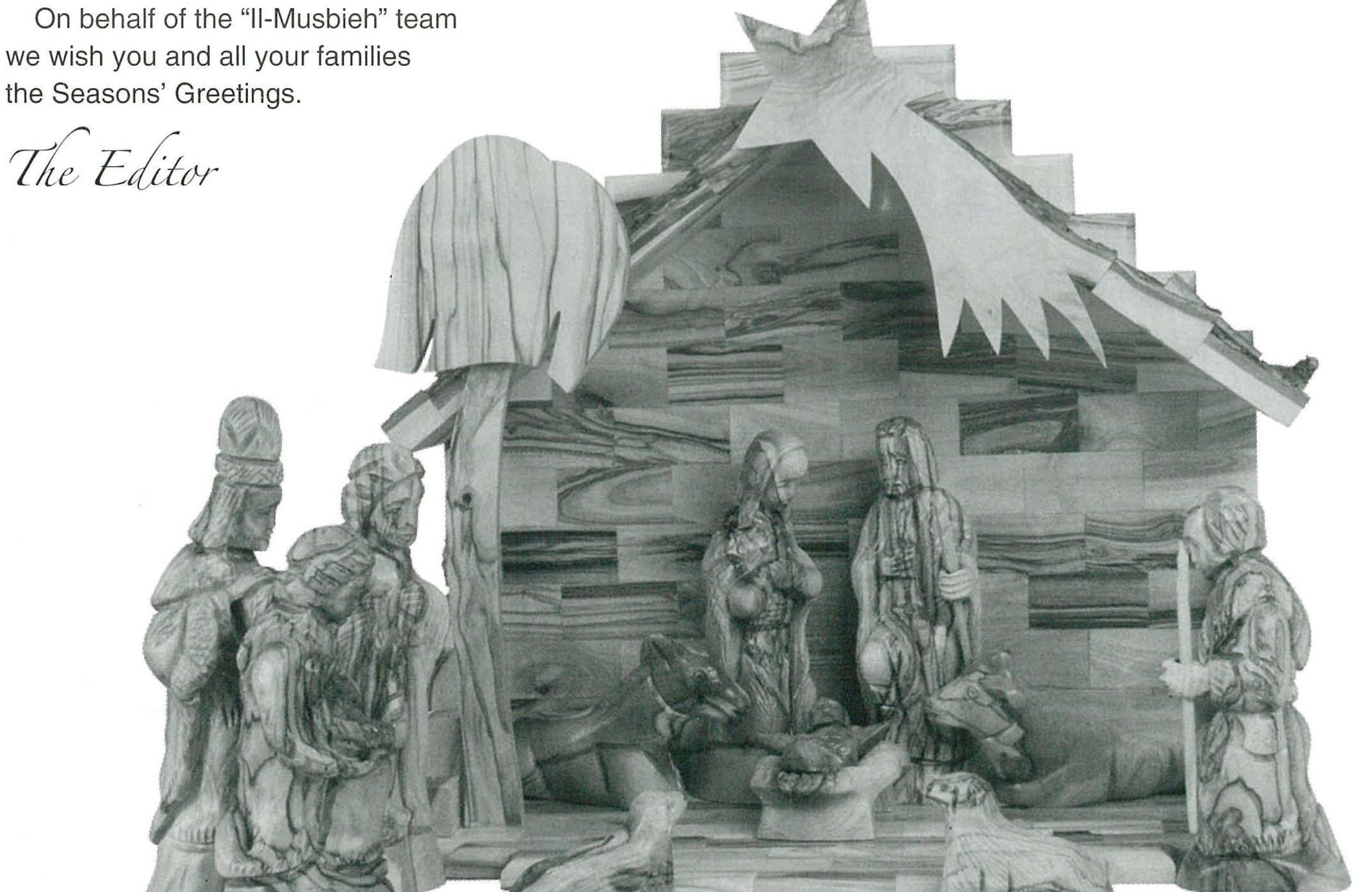
There is no glossing over the problem — not to a puzzled stranger and not to ourselves. What matters is not just the disjunction between what nurses and midwives need and what they have. It is that maybe these entire goal, did not really catch the feeling we were looking for, did not say what we hoped to say.

These questions point to something most of us already know, that for all the push and pull of nurses and midwives to achieve these goals, for all the sputtering of the volcano that erupts every year with new problems, this is truly a vicious circle that is leaving us nurses and midwives exhausted to enjoy the benefits from the achieved goals, and to look constantly at what we did not achieve.

Let us all make a New Year's resolution to look forward and set new achievable goals without loosing touch with the true reason for these goals.

On behalf of the "Il-Musbieh" team
we wish you and all your families
the Seasons' Greetings.

The Editor



messaġġ from the president

Paul Pace President

mumn@maltanet.net

Another year over and a new one will soon begin. What a year it was not just for MUMN but also for its numerous members. The numbers of claims, the varous issues tackled, the numerous emails, industrial actions which as MUMN had to resort to and the number of meetings is outstanding in number. Looking back, I would dare say that was not even one hospital or department which during the 2009 did not make use of services MUMN.

Christmas is always a time to reflect. It is times were members have to appreciate not to take anything for granted. The working conditions most nurses and midwives enjoy and the increase in salary are all part of intense negotiations this union had in the name of its members.

Nurses and midwives should also reflect on the service we provide to our patients. We should always try to provide the best service to our patients with all the restrains we have at our work places. We should never discriminate between our patients no matter their sexual habits, colour of the skin and cultures and beliefs. As nurses and midwives, we have to realise that we take care of the most precious possession in any family. We are given in our care children, mothers, fathers and grand parents and we have to do our utmost to see to their needs and not just the physical needs.

We need to reflect on our approach to the patients, on how we greet our patients and how to show them that we really care for the whole needs of their mind and body. We should consider taking more care of the psychology aspect of our patients making more emphasis on making our patients less anxious and less afraid.

I am pleased to announce that after numerous phone calls and meetings (some even nasty), the warrants will soon be provided in a historic ceremony which will be put down in the history of the nursing profession in Malta. Again one would never dream what we as MUMN, have been through to implement this part of the agreement of October 07 into practise. The hiccups and the snail pace which the process took is astonishing. But as we all say better late than never. MUMN managed to dress up the nursing profession in Malta on par with the other medical professions - process which was literally an uphill battle all the way. But by hook and by crook we got there.

What will be in store for us nurses and midwives next year? I can't predict everything but according to the Prim Minister budget, a reform in the primary care is being planned, the migration of Zammit Clapp to Karen Grech hospital, the effect of the waiting list on us nurses and many more. We still have parts of the agreement not implimented yet and that would be another issue. But I am sure there will much mor issues which as nurses and midwives might have to face. The good aspect is that what ever the issues are, MUMN will be the voice, shield and will see that nurses and midwives will not suffer unjustly or in that case our patients.

It was a pleasure serving you as President, with all the frustrations and workload such a post brings with it. Enjoy these festive season with your family and friends since our work makes you appreciate that life is precious and that life is too short. So make best use of this festive season and I in the name of all the MUMN council I wish you all a happy Christmas and a happy new year to you and your family.

Paul Pace
MUMN President

messaġġ

mis-segretarju ġenerali

Colin Galea Segretarju
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Iż- żmien ma jistenna lil ħadd. Għaddiet sena oħra, sena ta' ħidma mill-MUMN indirizzata sabiex ittejjeb is-sitwazzjoni tal-membri tagħha. Mill-aħħar ħarġa tal-'Musbieħ' seħħew bosta avenimenti li jkun xieraq li n-Nurses u l-Midwives ikunu konxji taghhom.

Il-Union kellha diversi laqgħat mad-Diviżjoni tas-Saħħa dwar is-sistema tas-CPD. Ressaqna l-ilmenti ġġustifikati u nstabu s-soluzzjonijiet għalihom. B'sodisfazzjon nixtieq ninfurmakom li s-sistema tas-CPD, b'effett minn Jannar li ġej ser tieħu dimensjoni oħra. L-akbar żewġ problemi li kien hemm dwar id-dewmien tal-ħlas kif ukoll is-sistema kif jiġu preżentati l-formoli issa ġew solvuti. Filwaqt li l-ħlas lura ser jibda jingħata f'perjodu ta' sitt xhur, il-preżentazzjoni tal-formoli ser jibdew isiru fl-isptarijiet stess f'ħinijiet itwal sabiex ikun jista jinqeda kulħadd. Barra minn hekk inbidlu ċerti dettalji li ma kienux qed jagħmlu aktar sens bħaż-żmien stipulat sabiex jiġu preżentati ċ-ċertifikati u oħrajn. Ma' din il-ħarġa qed nibgħatu l-ewwel informazzjoni fuq it-tibdil ta' din is-sistema. Aktar tard ser tiġi ppubblikata informazzjoni oħra. Minn hawn nixtieq nieħu l-opportunita sabiex nirringrazzja lil Ms. Shirley Sultana, il-persuna li issa ġiet responsabbli mis-sistema tas-CPD, tal-kollaborazzjoni sħiħa tagħha.

Kellna wkoll numru sostanzjali ta' laqgħat dwar il-Ftehim ta' sentejn ilu. Ġew solvuti *issues* importanti bħal l-ogħti ta' l-*appointment* lil *partime* u *casual* Enrolled Nurses, il-*Bridging* ta' l-Enrolled Nurses li saru Staff Nurses qabel l-iffirmar tal-Ftehim, ġie mogħti s-salarju sħiħ lil dawk in-Nurses u Midwives li għażlu li jkomplu jaħdmu wara s-sena ta' l-irtirar kif ukoll ir-rikonoxximent tal-ħidma fuq bażi każwali qabel ma ingħata it-tieni *appointment*. Issa baqgħa żewġ *issues* oħra li qed jiġu diskussi li jitrattaw is-sistema sabiex isir il-*banking* tal-*vacation leave* u numru ta' siegħat maħduma, kif ukoll is-sistema li Nurse/ Midwife, wara 30 sena servizz tibda taħdem ġimgħa mnaqqsa u tibqa tircievi s-salarju li jammonta għal *basic pay*. Dawn il-laqgħat mhux faċli però qed nasslu wkoll sabiex il-klawsoli tal-Ftehim jidħlu kollha fis-seħħ.

Ftit tal-ġimgħat ilu ġew imwaqqfa żewġ Group Committees ġodda. Wieħed huwa tal-Midwives u l-ieħor dak ta' l-Isptar Monte Carmeli. B'hekk il-membri konċernati jkollhom aktar aċċess għall-MUMN fuq il-postijiet tax-xogħol tagħhom stess. Awguri lil dawn il-membri li qed jiffurmaw dawn iż-żewġ kumitati tal-Union speċjalment lil Cathrine Bonnici li hija iċ-Chairperson tal-Midwives Group Committee u lil Christopher Siegersma li huwa iċ-Chairman tal-MCH Group Committee.

Ftit tal-ġimgħat ilhu smajna li ġie mniedi proċess ta' konsultazzjoni dwar ir-Riforma fil-Kura Primarja. L-MUMN ilha snin tħambaq għal bżonn ta' din ir-riforma u għalhekk din il-Union ser tkun qed tipparteċipa bis-sħiħ sabiex din ir-riforma tirnexxi fl-interess taċ-ċittadini u n-Nurses ikunu kuntenti jagħtu servizz b'aktar sodisfazzjon professjonali.

Irrid nieħu din l-opportunità sabiex nirringrazzja lill-Onor. Ministru John Dalli tal-ħidma tiegħu li wettaq f'dan is-settur u nawguralu aktar suċċess fil-karriera ġdida tiegħu. Huwa mportanti li l-Ministru l-ġdid jiltaqgħa ma l-MUMN b'mod frekwenti sabiex flimkien naħdmu kemm fl-interess tas-servizz tas-saħħa kif ukoll fl-interess tal-professjonisti li jagħtu s-servizz tagħhom 24 siegħa kuljum.

F'dan iż-żmien ta' festi nixtieq nawgura Milied Hieni u Sena Ġdida mimlija Risq u Barka lil Membri kollha tal-Union u l-familji tagħhom.

Colin Galea
Segretarju Ġenerali

The pastoral care of the dying

Fr Mario Attard OFM Cap

One of the most challenging experiences for every chaplain is when s/he confronts death with all its concomitant features. As a chaplain I deem it important to reflect on how my ministry evolves at the crucial hour of death. Since ministry is a process *per se*, I like to envisage the pastoral care of the dying in its tripartite division, namely: ***Prior to Death***, at the ***Time of Death***, and ***Immediately after Death***.

Prior to Death

When the chaplain arrives at the ward, s/he informs the nursing staff of her/his presence and asks them to inform her/him regarding the situation. The chaplain is to make sure that s/he assures the staff of her/his availability. Her/his availability and continual support should be communicated to the patient and/or family too. After introducing herself/himself to the patient and /or family it would be wise if the chaplain becomes familiar with the religious tradition/s and rituals of the patient and/or the family. Even if in Malta the hospital chaplains is still mainly catering for Roman Catholic believers, the incidences of people coming from different Christian and non Christian traditions in our Islands are on the increase. This helps the chaplain to identify others that may need to be contacted if the patient and/or family request so.

The chaplain is also to make sure that s/he is available for the family by her/his compassionate pastoral presence that is supportive and non-intrusive. In such time frame pastoral care facilitates the sharing of stories and memories as well as maintaining a comfortable physical environment (such as chairs, tissues, noise in the ward etc).

The chaplain encourages the family to comfort the patient through loving words and meaningful touches. When a family is stuck because it cannot find words to say to its loved one a chaplain may offer five things to be said at this stage: "I love you, I know you love me, I forgive you, I know you forgive me, I'll miss you". The chaplain is to be aware when family members may need self-care, especially if they feel exhausted in their rotations at the bedside of their loved one. S/he is to offer a tender caring listening ear to their concerns.

At Time of Death

When a patient passes away, the chaplain's role becomes more meaningful. The first thing that s/he can do is offering a setting where it is comfortable and beneficial for the grieving process to occur. The chaplain is to reassure the family of the dying person that it is okay to stay close to the bedside, talk to the patient, hold her/his hand, or touch the patient. As the chaplain encourages the family to communicate with the patient, s/he is to create an atmosphere wherein they can vent out their feelings to and regarding their loved one. The chaplain can facilitate this by saying words of reassurance, love, as well as encouragement.

It is crucial that the chaplain reveres the sacredness of this moment. Since every family has its own way of grieving, it is pastorally wise that the chaplain allows the necessary space for the family to grief their loved one in the manner it is familiar with. This pastoral attitude is highly recommendable since it is a powerful expression of a supportive and non-intrusive presence. In my pastoral experience I learnt over the years that giving the family time alone with their loved one so as to say their goodbyes or just to stay in silence has a powerful healing effect. Other families opt for a communitarian accompaniment during their grief. For such families the consoling presence of a chaplain proves vital for them. The physical presence of the chaplain is supportive because in accompanying the family the chaplain offers the assurance that the family is not journeying on its own in the rough waters of this peculiar time. The chaplain can provide a shoulder to cry on, helping a family member to sit on a chair, or by providing a hand to hold. Having said that, it is pastorally prudent to ask the permission of the individual before actually giving any physical help.

There are cases where a patient is dying by her/his own. In these sad situations the chaplain can become the most meaningful person. S/he can help the person be comfortable with her/his impending life passage

by holding hands or giving a comforting touch. Furthermore the chaplain has to be ready to face some challenging situations such as when the family members become very emotional with their grief, like fainting, screaming, throwing themselves on the deceased, pounding on the deceased, or also hitting objects or other people. Family conflicts, (surely not a rarity), may worsen the grieving process. At times similar situations call for separate times of visitation for different family members. In these peculiar situations it is important that the chaplain be familiar with useful resources like key family members or hospital security so as to control the chaos and bring order back.

Immediately After Death

Immediately after death the chaplaincy ministry is expected to do two things. To begin with, the chaplain is to provide a non-intrusive pastoral presence, mainly by ministering to those who are by the deceased bedside through providing a safe and welcoming space where they can experience the first stage of grief and loss. Pastoral experience and empathy can help the chaplain a great deal in order for her/him to know when to stand close in support, comforting the loved ones, listening to their stories and concerns, praying with them, and when to leave them in peace, leaving the room so that they may have sufficient time for private grief. Ministry after death incorporates both family members and staff. It occurs not merely in the deceased's room but also in the corridor or at the nursing station. What is crucial for the chaplain is that s/he is available, supportive and non-intrusive. The bottom line of this ministry is that it is primarily a skill learned not taught.

Secondly, the chaplain has to be prepared to answer to questions concerning administrative details. The often voiced questions are the following ones: "What do I do now? What happens to the body?". The first question is dealt with pastorally. The latter question, which refers to hospital procedure, entails a nursing staff referral from the chaplain. In cases where no family members are present, staff might need support in processing the loss. The chaplain is to invite the staff members to debrief their experience by encouraging them to talk and pray at this sacred moment.

Being a hospital chaplain is a privilege. In virtue of her/his vocation, the chaplain is 'anointed' to represent the Divine by her/his words, deeds and, most of all, 'consecrated presence'. Death remains a mystery for the dying patients as well as for those who accompany them. It can only be dealt with from a ministry that incorporates in itself the Mystery, the Divine. This reflection helps me to conclude that hospital chaplaincy is an essential element for a sound holistic care of the dying. ■

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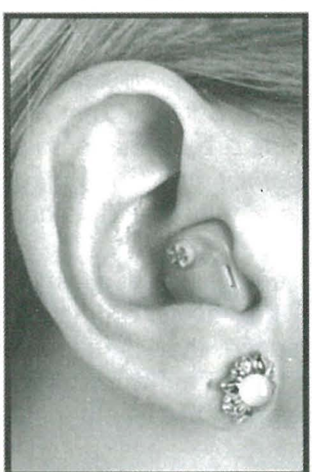
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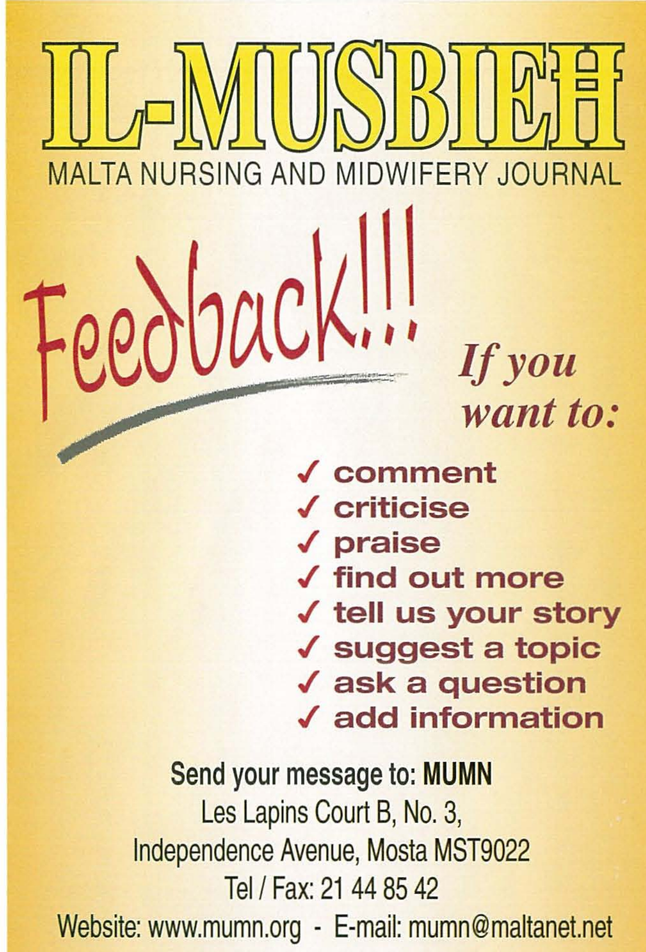

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Anxiety & Panic Attacks

One in 20 people suffers from severe anxiety or neurosis, feeling agitated and worried about what are often trivial day-to-day issues to a degree that interferes with their life.

They may constantly feel butterflies in their stomach, **palpitations**, sickness or **headaches**. Sleep problems are also common and there may be endless health worries.

The situation is often made worse by **stress** (such as work), noise (even at home) and **relationship problems**. Difficult life events, even pleasant ones such as a wedding, can make the anxiety unbearable.

Tranquillisers used to be handed out for anxiety with hardly a thought, but these days they're only used in short courses to help people through particularly difficult times.

Instead, therapies that help a person to understand their anxiety and learn how to deal with stress are used, such as counselling, psychotherapy, relaxation techniques and hypnotherapy.

For an **in-depth look at anxiety disorders**, go to the Mental health section.

Panic attacks

Many people who suffer from anxiety also have panic attacks, or panic disorder. Panic attacks can also happen out of the blue to someone who wasn't aware they were particularly anxious.

Panic attacks are a form of fear - in this case a fear of fear itself. Instead of an identifiable fear of an object that occurs every time they go near it, sufferers experience intense fear of the unknown. It's a sort of internal and self-generated fear.

Symptoms can include:

- Sudden feelings of fear or intense anxiety
- Feeling faint or nauseous
- Palpitations or a racing heartbeat
- Terrible pain in the chest
- Rapid shallow breathing
- Profuse sweating
- Tingling in fingers
- Blurry vision
- Ringing in ears

Symptoms are often so severe, sudden and unexpected that people think they're having a heart attack or are dying.
Panic attacks can be frightening and debilitating, especially if they happen frequently, and many people with panic disorder develop **depression**.

There are various treatments for panic disorder, from medication to working with a psychotherapist to gain more control over anxieties. Research shows both kinds of treatment can be effective - a combination of the two may even be better than either on its own.

The earlier you get treatment the more likely it is that you'll be able to put panic behind you and get back to normal.

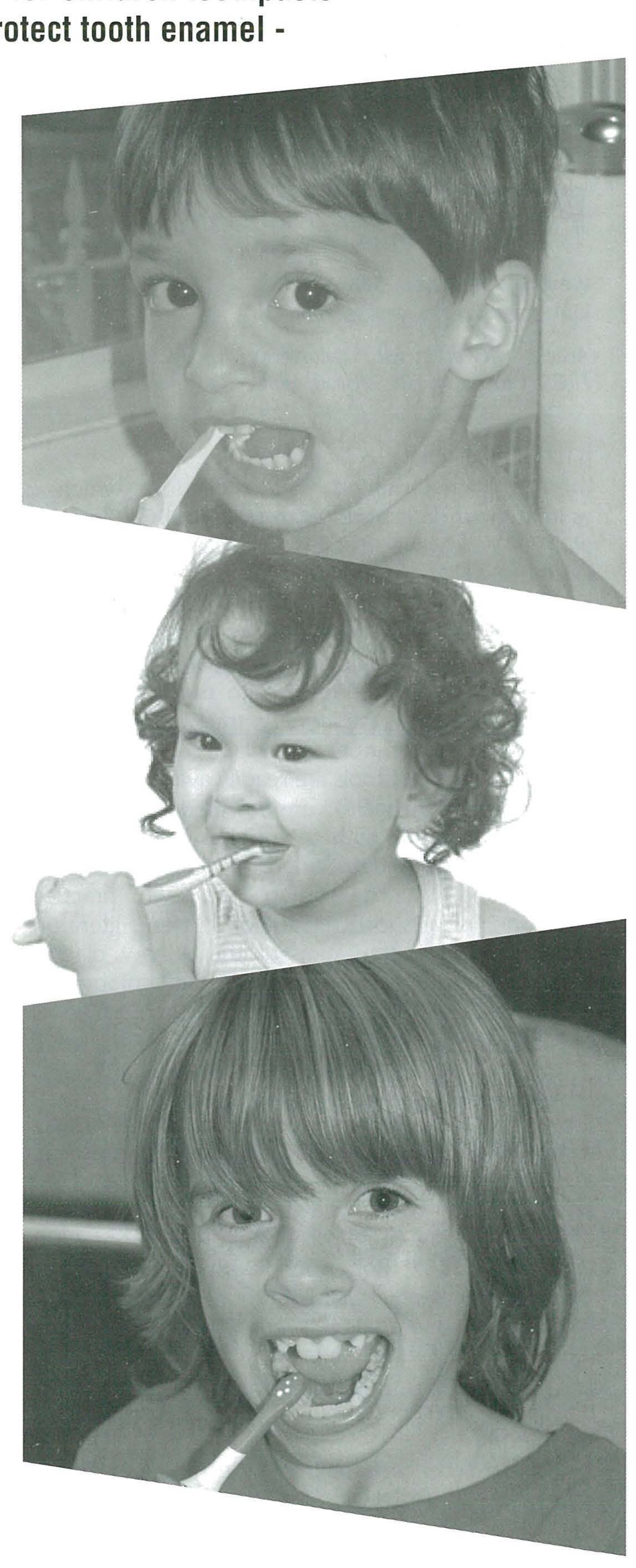
For a closer look at panic attacks, go to the Mental health section.

This article was last medically reviewed by Dr Trisha Macnair in August 2007.

Source: http://www.bbc.co.uk/health/womens_health/mind_anxiety.shtml

ACIDIC THREAT TO CHILDREN'S TEETH

- Sensodyne Pronamel for Children toothpaste launches to help protect tooth enamel -



Did you know that children's everyday food and drinks can be highly acidic which can lead to erosion of their teeth and – over time – could affect their appearance?

This condition is called acid erosion and dentists are increasingly worried about its effects on children's teeth. In response, Sensodyne Pronamel for Children - a new toothpaste specifically designed to help protect teeth against the effects of acidic food and drinks – has been launched.

Acid erosion is mainly caused by the acids found in children's daily diets, including items such as fruit, fruit juices, fizzy drinks and ketchups. When acidic foods and drinks are consumed, the acids temporarily soften the tooth's hard enamel surface and the tooth loses some of its mineral content.

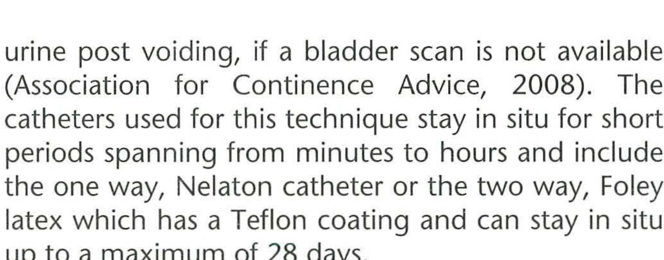
Over time, this acidic softening - particularly when combined with abrasion from toothpaste during toothbrushing - can lead to significant wear of the teeth, resulting in the enamel becoming thinner. Adult teeth generally start to appear when children are six years-old and onwards and will need to last a lifetime, so protection from an early age is key.

While parents are often concerned about protecting their children's teeth from sugar-related tooth decay, most are largely unaware of acid erosion. As such, Sensodyne is calling for parents to get their children into good eating, drinking and oral care habits which will help to protect their teeth for life. Simple steps include drinking fizzy drinks and fruit juices through a straw placed at the back of the mouth, away from the teeth and not brushing teeth immediately after eating a meal.

In addition, Sensodyne Pronamel for Children toothpaste can be used daily to help protect teeth from the effects of acid erosion, by hardening acid-softened tooth enamel and limiting toothwear during toothbrushing. Sensodyne Pronamel for Children also has all of the benefits of regular toothpaste.

Approaches to catheterisation of the urinary bladder:

Time to challenge practice?



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Article reviewed by Mr. S. Mattocks MD, FRCS (Edin.), FRCS (Glasgow), FRCS (Urol), FEBU.

Introduction

Urethral catheterisation is a procedure which is estimated to date back to around 300BC (Bloom *et al*, 1994). However it is possible that it has been in existence well before that (Robinson, 2009). Morbidity and mortality statistics of the times where palm leaves and bamboo canes were used to drain the urinary bladder are not available. In comparison, today we have a broad knowledge of both the anatomy and the physiology of the urinary tract, a plethora of research based literature is available on the subject, and a vast range of tools are readily available. Despite the progress that health care has made, we still face problems related to catheterisation on a regular basis which could easily be avoided through a knowledge update and by challenging our own practice. Following is a short review of current literature available on catheterisation of the urinary bladder with some tips from current practice in Urology with the aim of decreasing the incidence of such problems.

Indications and Assessment

It is estimated that a quarter of the patients admitted to hospital will have an indwelling catheter inserted (Gokula *et al*, 2004; Hazelett *et al*, 2006; Loeb *et al*, 2008). Whilst indwelling catheterisation is performed by a trained practitioner (Robinson, 2004; Pratt *et al*, 2007; Robinson, 2009) and only when clinically necessary, Gokula (2004) and Jain *et al* (1995) estimated that 30% to 50% of catheterised patients have a catheter inserted after inappropriate assessments. The disadvantages include discomfort, blockage, infection, trauma to the urethra and haematuria.

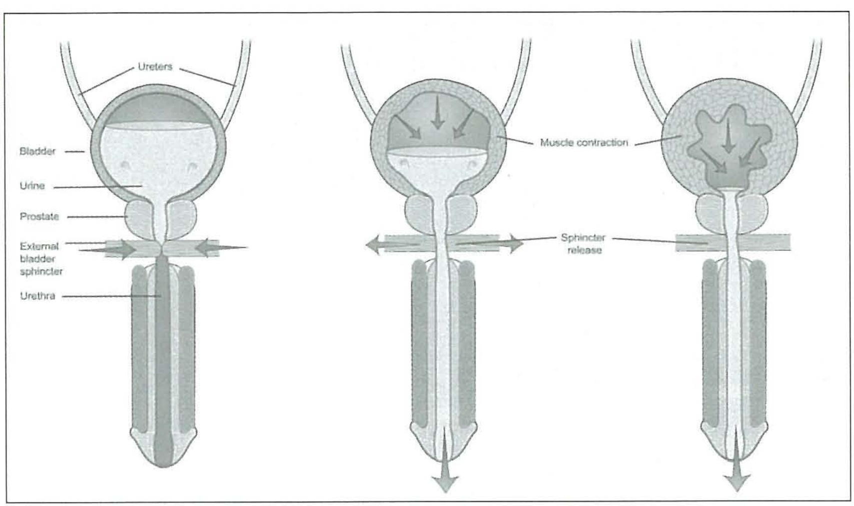
A ***short term catheterisation*** technique is advised during labour or delivery, for instillation of cytotoxic medications within the bladder or to measure residual urine post voiding, if a bladder scan is not available (Association for Continence Advice, 2008). The catheters used for this technique stay in situ for short periods spanning from minutes to hours and include the one way, Nelaton catheter or the two way, Foley latex which has a Teflon coating and can stay in situ up to a maximum of 28 days.

A ***short to medium term catheterisation*** is mostly indicated for those clients who undergo abdominal surgery, have undergone interventions on the prostate or bladder or have been admitted with gross haematuria necessitating continuous bladder irrigation. Patients who will have the catheter in situ for a few days until an acute phase is dealt with or until they start mobilising well can very well be catheterised using a Teflon coated latex catheter like the ones currently available. The duration of the need for the indwelling catheter can be determined by liaison with the medical team.

The patients who are admitted with haematuria warrant a good assessment upon admission to the Emergency and Admitting department. Our current practice suggests that not all those presenting with haematuria need catheterisation and continuous bladder irrigation. Unless the bleed is profuse or clots present, it might prove less problematic not to catheterise at all whilst pushing fluids and closely monitoring urine output and colour.

If the need for an indwelling catheter arises, the choice of catheter is paramount to avoid unnecessary discomfort to the patient and waste of resources. An 18Fr sized, 3 way, prostatic catheter (haematuria type) most usually suits its purpose. The two major disadvantages to it are its cost and the slightly different insertion technique needed. On the other hand, its positive attributes outweigh the disadvantages. It is equipped with a 'whistle tip' to facilitate evacuation of large clots; it is firmer and allows more effective

manual irrigation should the need arise; and its internal lumen is larger than that of 22Fr, 3 way, latex catheter. Thus, a smaller sized catheter is inserted causing less discomfort whilst proving to be more efficient in dealing with the clots. Knowing this, one challenges the practice of inserting a 3 way latex catheter which is very likely to get blocked within minutes of insertion! This practice results in a lose-lose situation. The patient will most probably experience pain due to the irrigation solution collecting within the bladder hosting a blocked catheter whilst on the way to the ward; the client will eventually have to undergo a change to a haematuria catheter with an unnecessary exposure to infection, urethral spasms, and possibly further insult to the site which is bleeding; all this not to mention the waste of resources.



A ***medium to long term catheterisation*** technique is mostly advised for clients who present with urethral strictures. This condition leads to voiding problems and retention of urine. This technique is used until the patient is given a trial without catheter or taught how to perform clean, intermittent, self catheterisation (CISC, CSIC, CIC, or SIC) which will keep the stricture dilated. The 100% Silicone catheters which are either attached to a leg bag or to a valve which allows the maintenance of normal function of the bladder are the catheters of choice until the self catheterisation is done by means of one way, Nelaton catheters made out of PVC.

A ***long term catheterisation*** approach is occasionally warranted for those who decline or who are found not to be fit for surgical treatment or as treatment for urinary incontinence when all other measures have failed. In these cases too, **the smallest catheter which will serve its purpose** is to be used. In an acute phase, a 12Fr or a 14Fr catheter might serve its purpose well but the health professional must consider that the client will have this catheter in situ' for approximately 6 weeks. Unfortunately, in our practice we find two major problems with these catheters. First, unless the client can or will maintain a fluid intake of over two litres daily, such a catheter is very likely to get blocked (Morris and Stickler, 2001). Even if they do maintain such a fluid intake, these catheters tend to be problematic by the fourth week due to encrustation. Currently, we discharge patients on long term catheterisation with 16Fr Silicone catheters unless their condition or its management dictates otherwise.

Securing the urethral catheter

A review of the literature by Gray (2008) did not provide enough evidence to define routine securement of an indwelling catheter as a research based initiative. On the other hand, clinical experience and expert opinions (Society of Urologic Nurses and Associates, 2006) suggest that this practice is more than mere tradition and should be adopted. A primary reason why a catheter should be secured is the prevention of urethral trauma or erosion (Gray, 2006) as well as inadvertent removal of the catheter.

Strapping can be done in three ways. The most commonly used locally are the improvised devices such as adhesive tape or ribbon and safety pins. Pomfret (1996) holds that the adhesive could damage the urethral catheter's core and so should never come into contact with the catheter material. The ribbon is often times passed in between the Y provided by the drainage and balloon inflation lumens and held in place by a safety pin taking care not to puncture the tube. There are also two types of manufactured devices. Some have an adhesive backing which sticks to the skin where the catheter is to be fixed and a non adhesive strap which holds the catheter in place. Another consists of non adhesive, velcro fastenings. There is a lack of consensus with regards to strapping of the catheter to the lower abdomen. This can be done in males but it can be problematic with a tendency of the strap to come off and cause more trauma. Strapping to the upper thigh in both sexes is more accepted.

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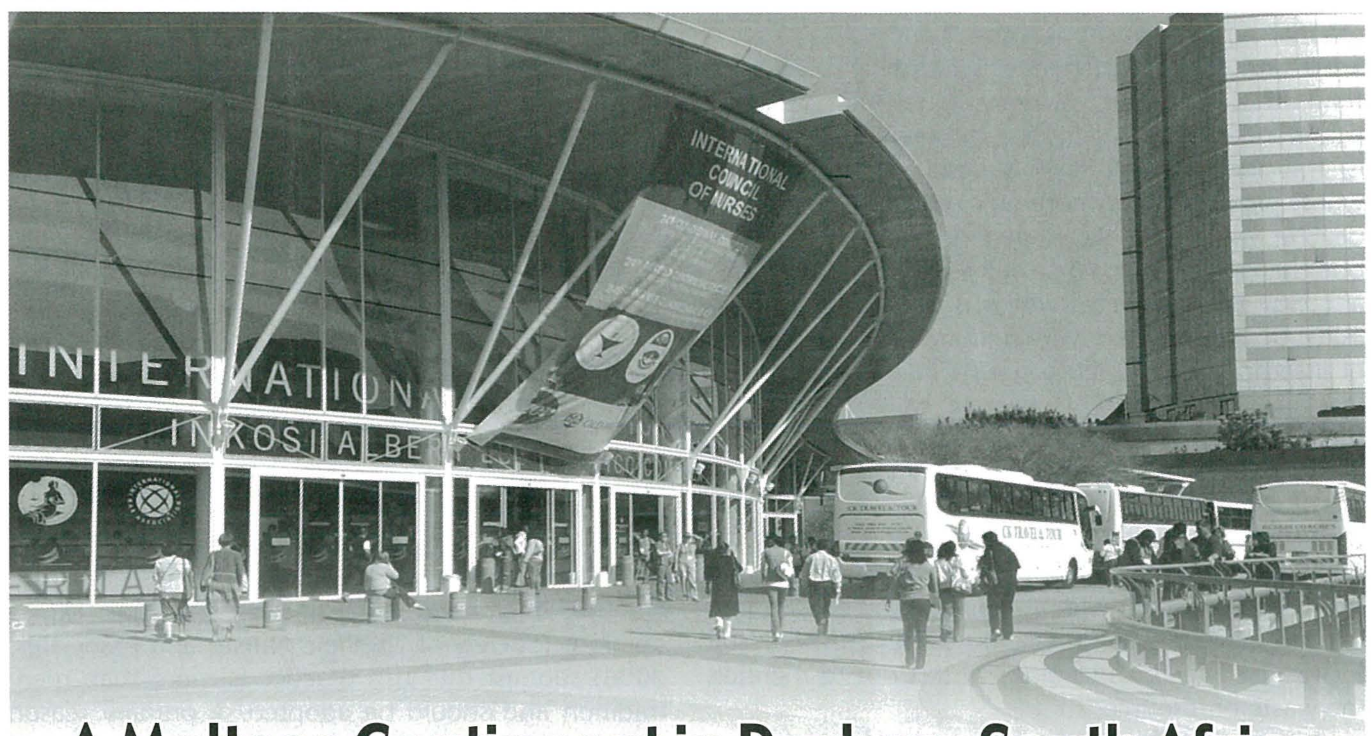

A Maltese Contingent in Durban, South Africa

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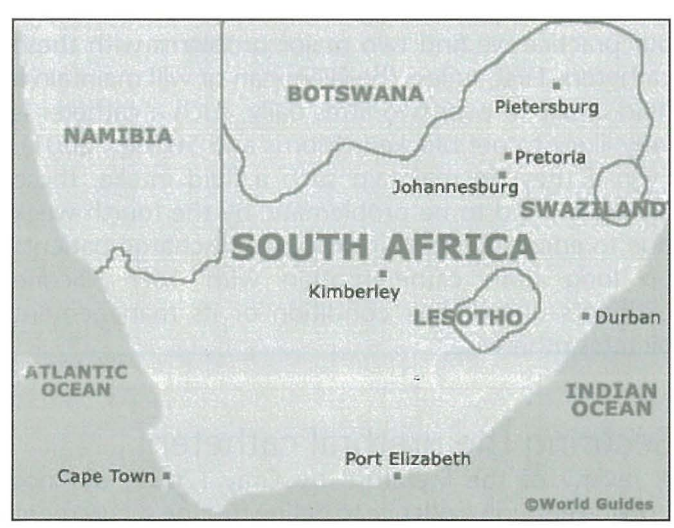
The International Council of Nurses' (ICN) 24TH Quadrennial Congress was held during the 27June – 4 July 2009 in Durban, South Africa. The title selected for this Congress was 'Leading Change - Building Healthier Nations'. More than 5,000 Nurses from 134 countries gathered at the Congress, ICN's first on the African continent. Of the 5,000 Nurses attending, 3,300 are from the African continent. The International Council of Nurses (ICN) is a federation of 133 national Nurses associations representing the millions of Nurses worldwide. Operated by Nurses and leading nursing internationally, ICN works to ensure quality Nursing care for all and sound health policies globally.

This was a special request for Malta to attend for the Congress in Durban, since we will be hosting the next ICN conference in 2011. I made part of the Maltese delegation that was made up of members from the MUMN, led by Mr. Paul Pace, Ms. Maria Cutajar and Mr. Colin Galea. We were given various tasks to follow in order to promote the Maltese islands. I need to mention here, that for this event to be productive several preparations were organised beforehand locally, which mainly consisted of intense meetings focused on logistics and folklore dancing rehearsals, which were bravely taught by Ms. Ingrid Spiteri. Other meetings were carried out in a form of a seminar which focused on the History of Malta and Gozo, by a professional tourist guide who also invited us to visit the Archeology Museum in Valletta for further visual information, where a range of archaeological remains from the numerous prehistoric temples in Malta and Gozo, together with remains of the Bronze Age and of the Roman period in these islands are found there. Mr. Frans Ripard held the responsibility to assemble the activities fulfilled at the International Convention Centre (ICC) which mainly consisted of the setting up of the hall for the Malta Night and the coordination of this event. It is crucial here to mention that the ICC is the biggest conference and exhibition centre in South Africa.



Apart from the visiting Nursing delegation, we had the support of Ms. Suzanne Cassar Dimech from the Malta Tourism Authority (MTA) where her expertise was clearly visible in the setting up of the exhibition stand and on how she led the delegates. Support was also expressed by the Management and Chefs from

the Island Caterers, where these prepared the Maltese food for the Malta Night, which undoubtedly went down deliciously by all foreign delegates present.

Flying out to South Africa, never hit my mind until I was given the opportunity. I was grateful. The flight was an epic which affected me dearly, since I was not lucky enough to doze off throughout almost 2 days of travelling to and fro. We travelled as a team which had a common task in mind, that of giving our best for the interest of our islands. For certain, the MUMN were well prepared for this event as for both the hotel we stayed in and the location of the ICC, were just a few feet away from one another. Hence this really facilitated our daily schedules as there was no need for further travelling.

The Malta Night offered a reception to which various foreign Nursing delegates were invited to. On looking back, that evening was a remarkable one as apart from the narration about the Maltese island's heritage from Mr. Joseph Aquilina a tenor himself, who also represented the Town Crier, gave an astounding rendition of a famous song written by Italian journalist Peppino Turco and set to music by Italian composer Luigi Denza in 1880 'Funiculi' 'Funicula' for which those present relished. The guests later tasted our local fresh cheeses, pastizzi, ħobż biż-żejt, and wine amongst other delicious food. The parading involved mainly all of us, in full costumes of the Lords and Noble Ladies, Knights Gran Croche, 8 Knights flags, Paġġi, the Għonnella (known as Faldetta), folklore dances led by characters known as Żepp u Grezz alongside with historical audio-visual accounts that went down well with all those present. Ms Eleanor Spiteri and Ms. Lara Azzopardi sang a handful of songs which were familiar to all those present and which contributed to the merriment of the show. The commemorative night was ended by the sky-high waving of the Maltese flag accompanied by Maltese traditional songs, where all those present enthusiastically joined in.

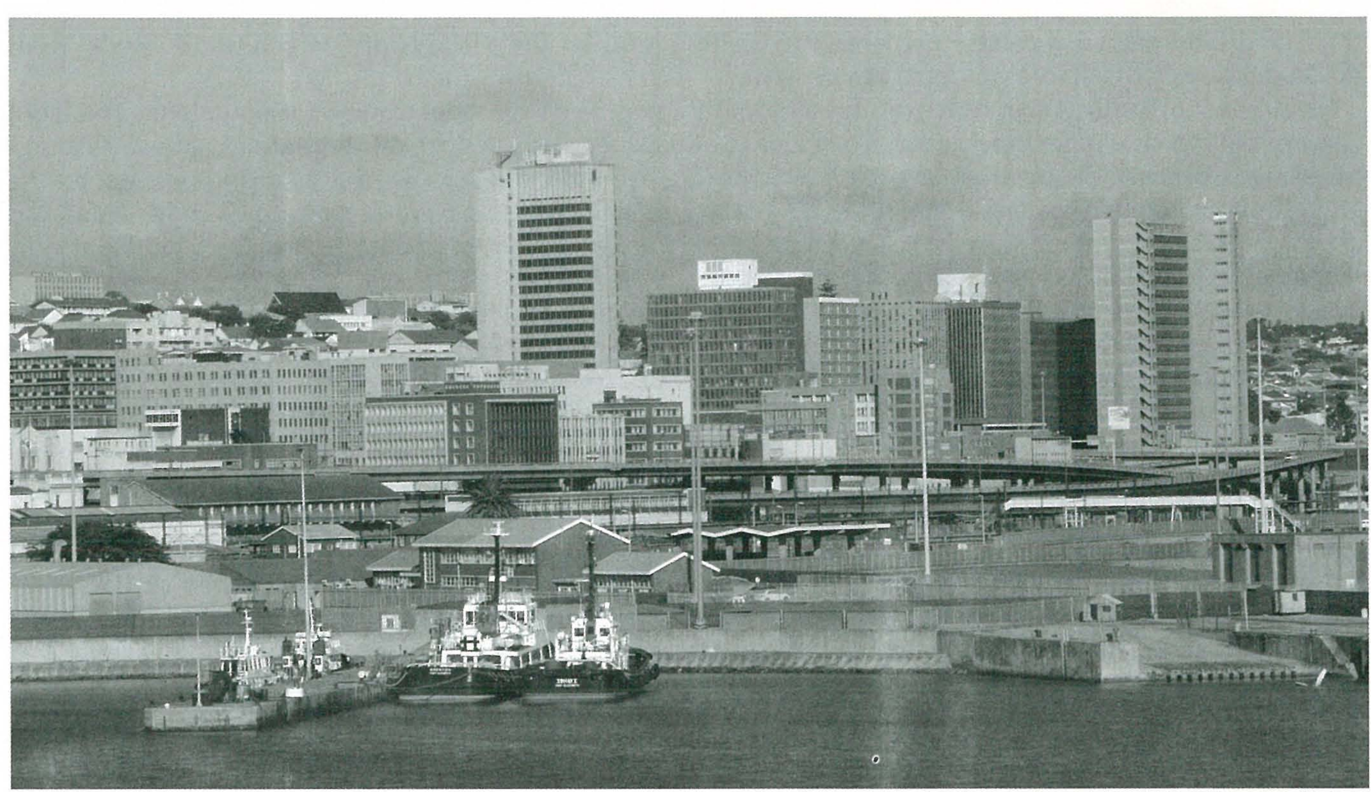
The Opening Ceremony of the ICN was also a huge experience. The Council of each nation was introduced including the Maltese, followed by a moving speech from the South African Deputy President Kaglema Motlanthe, which charmed the South African delegates present. The ceremony was concluded with a performance by a traditional African music group, who fascinated the audience with their dances and uplifting rhythms.

The following days were all based on us organising the Malta stand which we set up, and assisting delegates both in our costumes and casual wear. The casual wear entailed a red and white t-shirt with prints featuring the MUMN symbol, the Maltese cross, the ICN logo and the Uniform Resource Locator (URL) to a local website with information about Malta. The stand contained colourful books and posters about the Maltese islands, pens, t-shirts, stress balls, and other souvenirs all of which were distributed to all visitors. We followed a daily roster to alternate one another in following our respective duties, and responding to queries elicited mainly on the heritage of our islands and the Nursing/Midwifery practices in Malta and Gozo. One can also state that very few delegates from all those who visited our stands knew about the Maltese islands and their whereabouts. However we all strived to brief them with the necessary information. There were a few who also assured us that they'll be visiting for a holiday in the coming months. At times, especially when at the stand, I had an odd feeling where I often exclaimed to myself, 'Wow so many Nurses from around the world!!'

As part of our roster, we were also assigned the duty to attend plenary sessions and workshops which were of particular interest. The reason for this assignment was to observe the logistics behind the organisation of such a big conference so as to gain experience when this same event is to be organised in Malta. One poignant plenary session was chaired by Professor Miriam K Were from Kenya on Health and Human Rights. It was sad to learn that a number of qualified Nurses in Kenya are jobless because their government employs health care workers solely from private agencies, with the intention that these do the same tasks and skills of a registered Nurse with a lesser pay. One could easily sense that she was very emotional throughout her speech.

During the Closing Ceremony the new elected Board of Directors was announced. The newly elected ICN President, Ms. Rosemary Bryant, thanked the outgoing president Dr. Hiroko Minami for her marvellous, unyielding work over the past five years, and wished her every success for the future. Ms Bryant has had a wide experience in policy development both in nursing and the broader health sector. MUMN's representative, Mr. Rudolph Cini was elected again to serve another four-year term as First Vice-President of ICN.

A memorable moment for the Maltese delegation came at the time of the official



handing over of the Ceremony. This was the time where we were called out for our very last costume parade, all the way through an entire conference hall of 5,000 delegates acclaiming. During the parade, which was also viewed on in-built big screens we gave out souvenirs, such as t-shirts and stress balls (all featuring the word Malta and the logo of the Maltese cross), these mainly being two of the most requested souvenirs from those present. It was here that Mr. Paul Pace addressed his final speech of praise to what had been carried out throughout the South African Congress and where at the same time welcomed all those present to the 2011 ICN Congress in Malta. A promotional video with regards to the Maltese islands and their heritage was also shown to all those present which again resulted in grand applause. Furthermore, I felt that this was a moment of pride for the Maltese contingent as we all could tell that all those delegates in attendance liked the package 'Malta' and deep down I personally felt that yes, we do have a lot to offer to other nations ... no matter what dimension.

The Way Forward...

As it has already been announced in the press briefings locally, the next ICN Conference will be held in Malta on 5th 6th and 7th May 2011. Prior to the Conference, MUMN Officials will also attend a three day Commonwealth Nurses Federation meeting. Furthermore, MUMN Officials will also attend another 3 day meeting known as the Council of National Representatives, where officials from organisations affiliated within ICN will discuss issues related to Nurses and nursing standards. The ICN Conference will then follow and ends with a number of professional visits.

Although 2011 seems rather distant, with the extensive work needed to be completed, it is only 20 months near!! MUMN Officials have already started their preparations. All Nurses and Midwives should embrace this historical moment as this will constitute to a lifetime memorable experience.

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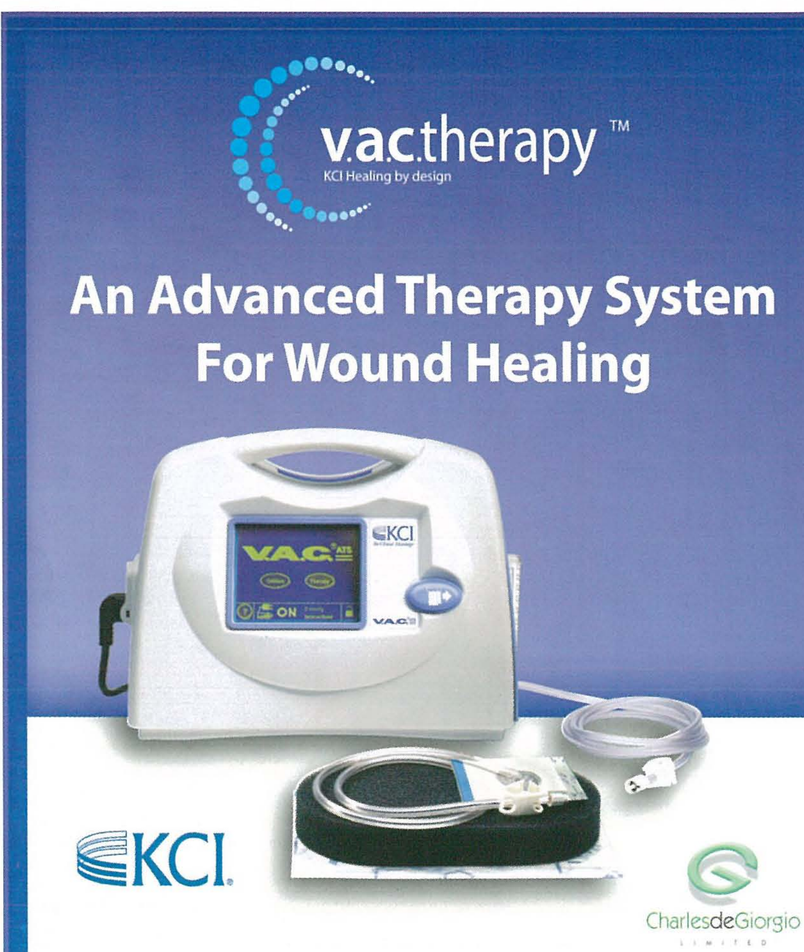
From our diary
Mid-djarju tagħna...

1. Il-Group Committee tal-Pensjonanti mmexxija miċ-Chairman Paul Bezzina organizzaw ħarġa oħra għall-membri tagħhom fejn żaru il-gżira sabiħa ta' Għawdex. Nieħdu l-opportunità sabiex nawguraw l-isbaħ xewqat għal dawn il-ġranet tas-sena lill-pensjonanti kollha membri f'dan il-Group Committee.
2. F'dan ir-ritratt jidher is-Sur David Benton, CEO ta' l-International Council of Nurses ħdejn il-President, s-Segretarju Ġenerali u l-Viċi Presidenta tal-Union waqt żjara li s-Sur Benton għamel fl-Uffiċċju Ċentrali ta' l-MUMN marbuta ma l-organizzazjoni tal-konferenza li jmiss ta' l-ICN f'Malta.
3. F'egħluq id-90 sena anniversarju mit-twaqqif ta' l-MUT, l-MUMN, permezz tal-President u s-Segretarju Ġenerali tagħha, ppreżentat rigal ta' tifkira lill-President ta' l-MUT.

4 & 7. Il-Group Committee responsabbli mill-organizzazjoni ta' l-attivitajiet tal-Union, reġa' organizza l-attività prinċipali tal-Milied. Madwar 160 persuna attendew għad-Dinner Dance ta' l-MUMN.

5. Il-Malta Association of Psychological Nurses (MAPN), immexxija mill-President Kevin Gafa ingħaqdu ma l-MUMN sabiex flimkien niċċelebraw il-festi tal-Milied.
6. Fl-istess attività, kif qed naraw f'dan ir-ritratt, attendew ukoll iċ-Chairman il-ħdid ta l-MCH Group Committee Chris Siegersma u l-Membru ġdid fil-Kunsill tal-Union Noel Camilleri.



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RESEARCH vs. INTUITIVE BASED ACTIONS

This is an issue that has been debated for some time within the Nursing and other healthcare professionals arena, most often ending up without a conclusion since both sides do seemingly understand that one goes in hand with the other. Or does it?

We all agree that this issue is more relevant when it comes to nursing in particular. We have all gone through it at some stage, wondering if the thought or action we have just experienced was something we studied about or actually a hunch that hit us like a lightning bolt.

Many articles were written about Nurses having the Sixth Sense – is it fact or fiction?
After twenty eight years in Nursing this is still a phenomenon which I can't explain. Reflecting back, I have been involved in many situations and occurrences where though I reacted 'knowledgeably and proficiently', it still was a mystery since I was positively sure I never dealt with the subject academically. This I can apply also onto many colleagues of mine within this same profession. What made Joe, my friend at the Psychiatric hospital, anticipate a fit way in advance, just by looking at his patients. How could Thomas know that within the next half hour, his patient would have an MI by not even looking at an ECG, or my colleague Alan at preparing for a polypectomy for the next Colonoscopy patient just by looking at the patient's facial features. The list can go on and on.

Yet the new novices joining the profession tell you that they don't believe in these tales – "if not scientifically proven, it is not doable". Maybe they are right, because that is how the 'trend' is at the moment, but than could their lack of practical, hands-on inexperience be the reason for this judgment. Yet again, is there still space for 'hunches' or intuitions in this day and age?

This viewpoint was recently an exercise carried out on the net between US and International endoscopy nurses through a reflective approach forum. I would like to share this 'concept' with colleagues and local Nurses, and maybe we can all share opinions. I do not intend to find the right conclusion, yet to stimulate some lateral thinking and have wisdom shared.

Joe Garzia CGN RN
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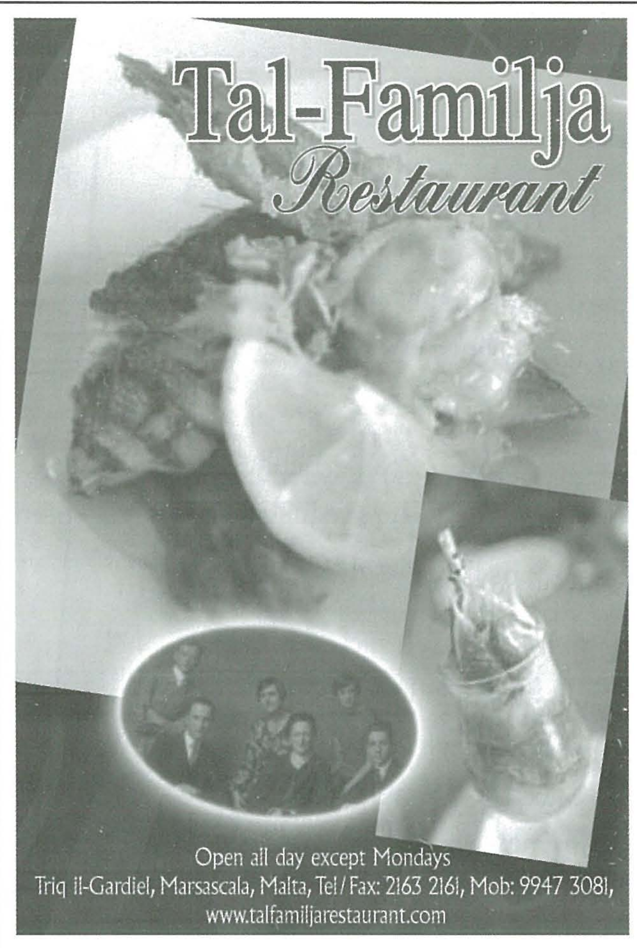

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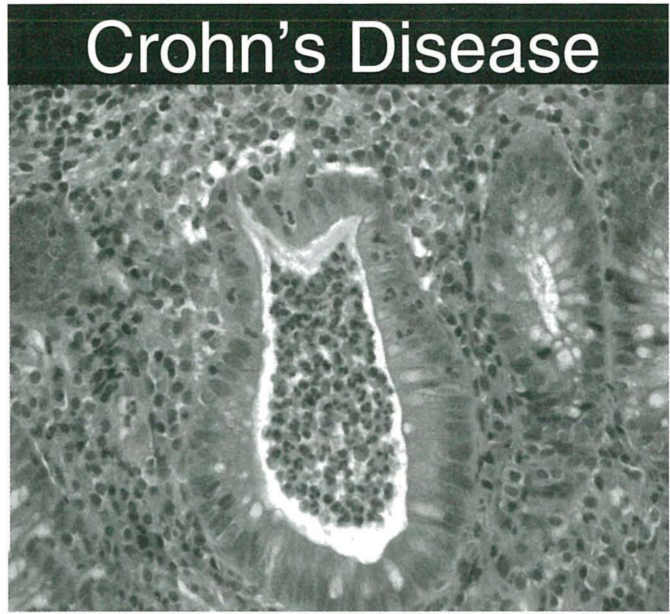
Crohn's Disease



Definition

Crohn's Disease is named after Dr. Burill Bernard Crohn, who first described a group of people suffering from specific inflammation of the bowel in the 1930's. It is characterized by episodes of remission and relapse that are unpredictable. It can affect any part of the digestive system, from the mouth to the anus (Simmons and Jewel, 1998). It is categorized as an inflammatory bowel disease (IBD), the general name used for the diseases that causes inflammation of the intestines. Because the symptoms of Crohn's are similar to other intestinal disorders, such as irritable bowel syndrome and ulcerative colitis, it can be difficult to be diagnosed.

(Jackson 2008) states that due to recurrent inflammation of the lining of the bowel, eventually, the bowel may become ulcerated, the wall thickened, narrowed or obstructed and surgery would be needed. Normally, the colon easily fights this off as its immune defenses are so robust and strong. In Crohn's Disease, however, this does not occur.

Risk Factors

Crohn's Disease is most common in North America and northern Europe and has incidence or 5-10 per 1000 000 of the population in the Uk (Carter et al, 2004). It can strike at any age, but one is more likely to develop the condition when one is young. Most people are diagnosed with Crohn's between the ages of 20 and 30. Although Caucasians have the highest risk of the disease, it can affect any ethnic group. Individuals of Jewish and European descent are four to five times as likely as other people are to have Crohn's Disease. People living in an urban area or in an industrialized country are more likely to develop Crohn's disease. Because Crohn's disease occurs more among individuals living in cities and industrial nations, it is possible that environmental factors, including a diet high in fat or refined foods, may play the role (Mayo clinic 2008). According to studies of Simmons and Jewel (1998), it shows that there is a 12-18% chance of a second person in a family having the disease

However Cummings JR, et al, states that, "The incidence is 6.7 (range 1.6 to 14.6) cases per 100,000 annually and the prevalence is 140 (range 10-199) cases per 100,000." The onset of Crohn's disease also has an age limit to distribute. The first and largest peak occurs between the ages of 15-30 years; the second much smaller peak is between 60-80 years. (Rubin GP, et al).

Being a smoker also increase the risk of higher rate of recurrence and repeat surgery (Cosnes at al, 1996).

Signs and symptoms

Signs and symptoms of Crohn's disease can range from mild to severe and may develop gradually or come on suddenly. The severity of symptoms and how frequent they occur, vary from person to person. The first episode is often the worst. A general feeling of unwell with loss of appetite, weight loss, fever, and tiredness initiate symptoms. The disease usually begins with ulceration of the mouth; recurrent abdominal pain which depends on the part of the gut involved (B.M.J 1986).

The inflammation causes cells in the infected areas of the intestine to secrete large amounts of water and salt. Because the colon cannot completely absorb the excess fluids, diarrhea develops. Intensified intestinal cramping can also contribute to loose stools. In mild cases stools can be looser or more frequent than usual. Inflammation and ulceration may cause the walls of the bowels to swell and eventually thicken with scar tissue. One might notice bright red blood in the toilet or darker blood mixed with one's stools, or the bowel may also bleed on its own. Anemia may occur if a patient looses a lot of blood. Inflammation from Crohn's disease may tunnel through the wall of the bowel into adjacent organs, such as bladder or vagina, creating an abnormal connection called a Fistula. This can lead to an abscess, a swollen pus-filled sore. This fistula may also tunnel out through the skin and the common place for this type of fistula is around the anus. This is called Perianal Fistula. People with severe Crohn's disease may experience fever and fatigue as well as problems that occur outside the digestive tract, including arthritis, eye inflammation, skin disorders, and inflammation of the liver or bile ducts. (NCCID,2006) Children with Crohn's disease may present with delayed puberty or poor growth.(Stange EF, et al;)

How is Crohn's disease Diagnosed?

The doctor will require an in-depth history, and perform a thorough physical examination and a combination of laboratory, endoscopic, and radiological investigations. The disease is particularly difficult to diagnose in children.

Blood Tests: A full blood count (FBC) may show a low hemoglobin and albumin. A raised white blood count indicates a sign of inflammation somewhere

in the body. A deficiency in the number of red blood cells and in the amount of hemoglobin may indicate bleeding in the intestines or nutritional deficiency. Erythrocyte sedimentation rate (ESR) and a C-reactive protein (CRP) are also taken.

By testing a stool sample the doctor can tell if there is bleeding or infection and help to identify the presence of several micro-organisms that can mimic inflammatory bowel disease.

Sigmoidoscopy or Colonoscopy

For both of these tests, the doctor inserts a long, flexible, lighted tube linked to a computer and TV monitor into the anus. A sigmoidoscopy allows the doctor to examine the rectum and the left colon, while colonoscopy allows the doctor to examine the lining of the entire large intestine. He will be able to see any inflammation or bleeding during either of these examinations. The doctor may also take a biopsy, which involves taking a sample of tissue from the lining of the intestine to view with a microscope.

Barium Enema

A barium enema is a rectal injection of barium given to coat the lining of the colon and rectum. The barium enema procedure may additionally use air in the large bowel to give a double contrast technique. Barium is run into the colon under gravity via a tube inserted into the rectum, which coats the lining of the large intestine, before the x-rays are taken. The barium shows up white on x-ray film, revealing inflammation or other abnormalities in the intestine. (Royal College of Radiologists, 2007).

Computerized Tomography (CT)

This is a special X-ray technique which is more accurate since the doctor can look at the entire bowel as well as at tissues outside the bowel that can't be seen with other tests.

Magnetic Resonance Imaging (MRI)

This scan is the most widely used in the assessment of perianal disease, highlighting perianal abscesses and the tracks of fistulas.

Treatment and Management of Crohn's disease?

Treatment may include drugs, nutrition supplement, surgery, or a combination of these options. The goals of treatment are to control inflammation, correct nutrition deficiencies, and relieve symptoms like abdominal pain, diarrhea, and rectal bleeding. Treatment also depends on the location and severity of disease, complications, and the person's response to previous medical treatments when treated for reoccurring symptoms.

Someone with Crohn's disease may need medical care for a long time, with regular doctor visits to monitor the condition.

Drug Therapy

Anti-Inflammatory Drugs: Most people are first treated with drugs containing mesalamine, a substance that helps control inflammation. Sulfasalazine is the most commonly used of these drugs.

Cortisone or Steriods: These are called corticosteroids – these provide very effective results. Intravenous hydrocortisone or methylprednisolone is the most widely used. These are best taken in the morning with food to reduce toxicity and gastric irritation. Prednisone is a common generic name of one of the drugs in this group of medications.

Immune System Suppressors: Drugs that suppress the immune system are also used to treat Crohn's disease. Most commonly prescribed are 6-mercaptopurine or a related drug, azathioprine. Immunosuppressive agents work by blocking the immune reaction that contributes to inflammation.

Aminosalicylates: these drugs may play the role in reducing the risk of colonic cancer (Sibartie and Feagan, 2006).

Antibiotic: Antibiotics are used to treat bacterial overgrowth in the small intestine caused by stricture, fistulas, or prior surgery. For this common problem, the doctor may prescribe one or more of the following antibiotics: metrodinazole or ciproflaxine (Sutherland et al, 1991).

Anti-Diarrheal and Fluid Replacements: Diarrhea and crimpy abdominal pain are often relieved when the inflammation subsides, but additional medication may also be necessary. Patients who are dehydrated because of diarrhea will be treated with fluids and electrolytes.

Nutrition supplement: The doctor may recommend nutritional supplements, especially for children whose growth has been slowed. Special high-calorie liquid formulas are sometimes used for this purpose, especially during a relapse where it is important to ensure adequate calorie and protein intake.

Enteral Feeding: Griffiths at al (1995) concluded that Enteral diet was effective in inducing remission in Crohn's disease, although less effective than steroid treatment. On the other hand similar findings – in some cases, primary nutritional therapy and steroid treatment were equally effective (Zoli et al, 1997). A small number of patients may need to be fed intravenously for a brief time through a small tube inserted into a vein of the arm. This procedure can help patients who need extra nutrition temporarily, those whose intestines need to rest, or those whose intestines cannot absorb enough nutrition from food.

Surgery for Crohn's Disease

It is estimated that 87% of patients with ileocolonic Crohn's disease will eventually require surgery (Kamm, 1999).Surgery becomes necessary when medications can no longer control symptoms. Surgery is used to correct complications such as blockage, perforation, abscess, fistulas, or bleeding in the intestines. Surgery does not eliminate the disease, and it is not uncommon for people with Crohn's disease to have more than one operation, as inflammation

tends to return to the area next to where the diseased intestine was removed.

Some people who have Crohn's disease in the large intestine need to have their entire colon removed in an operation called colectomy. A small opening is made in the front of the abdominal wall, and a tip of the ileum, which is located at the end of the small intestine, is brought to the skin's surface. This opening is called stoma, is where waste exits the body. A pouch is worn over the opening to collect waste, and the patient empties the pouch as needed. The majority of colectomy patients go on to live normal active lives. Sometimes only the diseased section is removed and no stoma is needed. In this operation, the intestine is cut above and below the diseased area and reconnected.

Because Crohn's disease often recurs after surgery, people considering it, should carefully weigh its benefits and risks compared with other treatment. Surgery may not be appropriate for everyone. People should get as much information as possible from doctors, nurses who work with colon surgery patients, and other patients. (For pre and post operative care see Appendix 1)

Nursing Management

Patients who have received appropriate and adequate psychological preparation recover more quickly from surgery than those who have not. The nurse should start assessing the "whole person", taking into consideration physical, mental and social factors, and determine the requirements of the patient in each of these areas. Crohn's disease is a chronic condition that can be embarrassing, distressing and full of anxiety about continence. They therefore need support and guidance, especially around the time of diagnoses (Hall et al, 2006). The stoma care nurse must be there to assist and teach the patient and his family, and must be prepared to offer herself as a 'counselor'. A stoma referral form is filled up end sent to the appropriate clinic for their specialized help (See Appendix 2). She will help the patient to express his inner feelings. She will make all the arrangements for the patient's follow-up visits by the community nurses.

Special high-calorie liquid formulas are sometimes used for this purpose. There is no evidence showing that stress causes Crohn's disease. However sometimes they feel increased stress in their lives from having to live with a chronic illness.

There is no evidence that stress causes Crohn's disease. However, people with Crohn's disease sometimes feel increased stress in their lives from having to live with a chronic illness. For people who find there is a connection between their stress level and a worsening of their symptoms, using relaxation techniques, such as slow breathing, and taking special care to eat well and get enough sleep, may help them feel better.

Conclusion

Whether you're newly diagnosed, or have lived with Crohn's or colitis for years, it's important to understand the impact of these diseases on day-to-day life. One should know where to find support groups, online community, websites or by correspondence that can be of great help and the patient feels that he is not alone with this chronic illness. Sharing your feeling with others will help in managing one's condition (See Appendix 3).The patient will learn about the role of nutrition in his condition, coping with the emotional impact of these diseases; how the patient can have fulfilling social and sexual relationship and more. By learning and sharing the patient will cope better, he will be taking a giant step in taking charge of his own illness – his own life. It is in the nurse's responsibility to help the patient to know where to turn to find help.

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Appendix 1

Pre-operative Care

Preparation for colon surgery needs to start a few days prior to the procedure, unless the surgery is being done on an emergency basis, such as intestinal bleeding. The colon contains bacteria and waste products that can cause infection, thus, oral antibiotics are started several days before the operation is scheduled. Blood tests, chest X-ray and abdominal CT scan may be ordered. An ECG may be taken normally to patient's over 45 yrs of age or according to the patient's condition and the anesthetist's requirements.

The procedure for colon cleansing depends on the patient's health. According to Stanley J, (2001), generally 2 or 3 days prior to surgery, a liquid diet is started. Patients are given laxative solutions to drinks to cleanse the colon which are given over two days or according to the consultant's decision. This will cause severe diarrhea. Intravenous infusion is usually set up to prevent dehydration, but it should be set up in diabetic patients. Nothing to be given by mouth four hours prior operation. Urinary catheterization is also performed.

The Anesthesiologist introduces himself to the patient and performs a physical assessment. He must be aware of the medications that are being taken, and any history of allergies.

A consent form must be signed, making sure that the patient understands the procedure, the potential risks and that certain medication will be given. A sedative is usually given intravenously to induce drowsiness.

Post-operative Care

The patient is kept in the recovery area until he is fully conscious and is closely monitored until the anesthesia wears off. The IVI remains in place for nourishment, hydration and medication. The catheter is removed after 24 hours. Pain relief is needed. Nothing can be given by mouth until bowel movements are present. In some cases a nasogastric tube is inserted, and remains there until bowel movements are present. When bowel function returns, NG tube is removed and clear fluids are given. When liquids are tolerated, the diet slowly progresses to solid food. Mobilization is important from day 1 after the operation, to stimulate bowel function and to help circulation, thus preventing complications such as DVT.

The most difficult part of the operation is adjusting to the colostomy. The stoma is red, and when stools start to come out through the stoma, the colon is functioning. Stools are normally softer and looser if an ileostomy was performed, but formed stools are present if colostomy was carried out. The pouch is changed after a bowel movement. (Stanley J. Swierzewski, 2001). The process may vary as it all depends on the progress of the patient and the consultant's opinion.

Appendix 2

Referral form for stoma clinic

Appendix 3

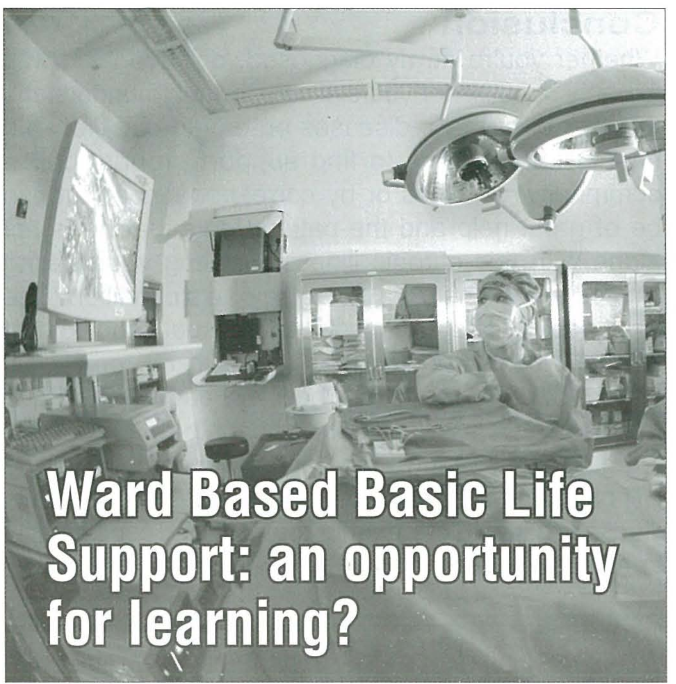
Stoma Care Unit MDH , Speciality Clinic Level -1 Tel: 2545 4432 / 2545 4431.

The Crohn's & Colitis Community

This is an organization that gives this help. Last updated was March 28, 2008, and is found as:
Crohn's & Colitis foundation of America, 386 Park Avenue, 17th floor, New York, NY 10016-8804

Email: info@ccfa.org Internet: www.ccfa.org

(No associations are available in Malta)



Carmel Grima
Practice Development Nurse - Mater Dei Hospital
email: carmel.grima@gov.mt

The need for hospital staff to be proficient in this skill cannot be overemphasised enough. Figures from the United States and Canada state, that, out of a total of 330000 deaths from sudden cardiac arrests, a quarter of a million occur out in the community (A.H.A., 2005). The fact that in most instances emergency services tend to take longer than five minutes to get to the scene, do not seem to augur well for matters to improve. While one surely cannot extrapolate any findings from these data to the local setting, it will be difficult not to reflect on the local situation. Admittedly no local studies seem to be available highlighting the total incidence of sudden cardiac arrests and their occurrence location. But this does not mean that the ward staff does not need to be well conversed in the knowledge and skill of this important aspect of our care. Coming from an inpatient area, this write up will mainly focus on the ethical aspect of the intervention and how the knowledgeable nurse may be of a contribution towards the appropriate environment within which the decision is to be taken.

A miniscule ethical tinge to cardio pulmonary resuscitation

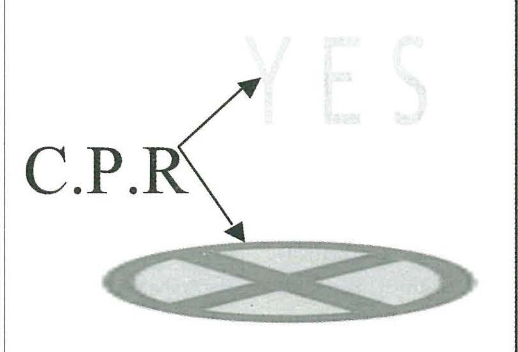
Many often successful resuscitation attempts bring extended, useful and precious life to many. This of course is in line with what after all medical therapy is there for. But should this intervention (cardio pulmonary resuscitation) be resorted to in all circumstances? This is where the qualified nurse needs to assess on the actual utility of the intervention; whether it will serve its purpose or merely prolong unwarranted suffering and delay the process of dying. Preferably these decisions are not to be taken when the intervention is needed. Notwithstanding whether the decision is taken in advance, the preferable option, or when the need actually arises, the nurse is to be in a position to take the appropriate action.

Several questions arise as to what entails for an informed decision process to take place. These include the issue of advance directives; when to start or to stop resuscitation attempts; who is to be informed and consulted in the decision making process and when, amongst others (E.R.C. guidelines 2005). As nurses the issue need not be so challenging, if one adheres to the four key ethical components including beneficence, non-maleficence, justice and autonomy. For these components, when coupled with the needs of an informed consent, will possibly lead one, towards the uptaking of most appropriate counsel.

Where is the patient?

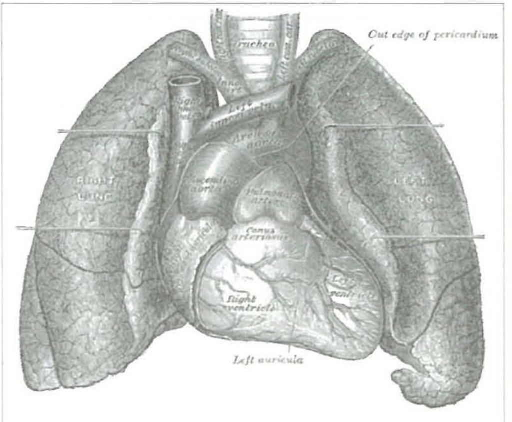
This part will attempt to bring in the patient as a playing part in the whole picture. Several countries do have guidelines, which provide a structure within which this skill may be practised, with the patient as the main focus. Given the limitations of this write up, one will be only addressing the role of the patient in one's care. This, the involvement of the patient and significant one/s, is standard practice in several countries, although it is not yet a practice which is widely resorted to locally, as yet. Although, there are still considerable variations in the medical attitude towards written advance directives (Basket 2004; Lim 2004). In fact it is affirmed that, whereas in some countries an advanced directive is legally binding, in others, when the medical officer is not in sync with the contents, they are abysmally ignored.

But if one were to bring the ethical issue of autonomy to the fore, the notion soon finds its snug fit. This brings all into focus when one considers the ethical notion of informed consent and how this (concept) relates to this practice in reality. One may ask, how is one involving the patient in the decision making process of such decisions? For if autonomy requires that the patient is adequately informed, competent and is free from undue pressure (Declaration of Helsinki, 1964) and that there is sufficient participation for the patient and significant ones in the planning and delivery of their own care (Nursing and Midwifery Board Code of Ethics, 1997), what is the role that the Maltese nurse is actually playing as an active advocate of the patient?



This in the knowledge that, a study determining the willingness of patients to discuss do not attempt resuscitation

(D.N.A.R.), clearly showed that patients would like to be consulted on any decisions to be taken and are very willing to discuss them. This, prior to themselves, becoming critically ill (Gorton; Jayanthi; Lepping; Scriven 2008).

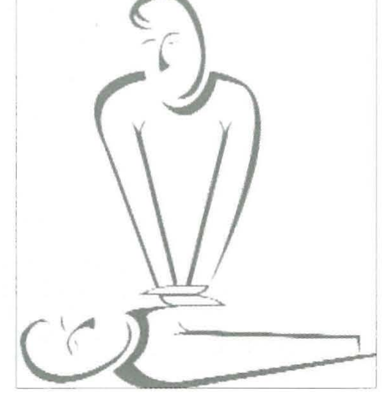


The facilitation process

Needless to say, but the way forward will be through acknowledgement of a humanistic path where a respect for participants in the teaching learning transaction and the educational value of life experiences will be the overriding imperative, whilst possibly side lining the organisation's profit margin essence notion (Elias & Merriam, 2005, p. 217). But one may claim this will not necessarily be enough, especially when one will possibly require the individual nurse on the ward to challenge assumptions, which until now were foregone conclusions. This goes without saying, if one desires that what will be learnt, will be effectively transferred into the clinical area proper. For if one was to expect the nurse to encourage participation in decision making through the involvement of the patient, then collaboration with the rest of the interdisciplinary team members will have to be acquired.

For if, as asserted by Mezirow (1991), adult learning involves an interpretative process in which decisions are made that may result in "confirmation, rejection, extension or formulation of a belief or meaning scheme or in finding that belief or scheme presents a problem that requires further justification", one will have to essentially guide the participants through a perspective transformation, where one will be able to re-think whether to continue calling the cardio pulmonary resuscitation team by default and how far and in what medical conditions will one intervene. For, if one is to take the patient's wishes as a guide, this will have to be the way forward. For, as claimed previously in the study by Gorton et al, it was in only 10% of respondents that claimed discussing advance directive like D.N.A.R. would upset them.

One may rightly ask, but what has this got to do with the process of learning? I will attempt to explain why. Brookfield (2005) goes to great lengths in convincing one, that for learning to take place the adult has "to learn to challenge ideology, contest hegemony, unmask power, over alienation" amongst others. For if the nurse were to commence questioning the practice one will be effectively challenging the incumbent ideology; if one will be differing from other areas within the same practice context one will possibly



be reversing the hegemony; for if one was to assert that the nurse is essentially there to care (and not necessarily cure) one will be effectively being drawn out of the mystifying alienation.

One may rightly question this line of thinking and question where it will eventually lead one. One may leave this explanation again to Brookfield where it asserted that "post modernism contends that the world is essentially fragmented and what passes for theoretical generalisations are really only context specific insights produced by particular discourse communities" (2005 p.1). If there was any evidence for the individualisation of care, this may be it, coupled with the need of meeting the particular patient's wishes and the walk towards actualising of the patient's autonomy will be in the process of facilitation by the nurse's advocacy traits.

Conclusion

One would say, but were we not supposed to be facilitating these learning sessions? What learning needs will there be if one will be practically seeking ways of not going for the resuscitation option. And this is where one may be drawing hurried conclusions. For, with knowledge gained, nurses in the clinical area, would be in a position to differentiate between appropriate candidates for the intervention and others. With the insight into the patient's and relative's wishes, they will be able to guide and act as advocates of the patient wishes with the rest of the multi-disciplinary team. The resulting empowerment would, possibly have the desired effect described by Brooks (1986), where adults will have "the emotional strength to challenge behaviours, values and beliefs accepted uncritically by a majority".

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Climate Change 'Major threat to Human Health'

by Catherine Jacob

Climate change is the biggest threat to human health this century, according to a new report in The Lancet.

The medical journal commissioned a team of experts from **University College London** to compile a dossier of evidence showing the effects climate change will have on our health.

They said fatal heatwaves, food shortages, water scarcity and extreme weather events will all increase if global warming is allowed to continue.

The global health service will carry the biggest cost burden.

For example, they said events like the European heatwave, which killed around 70,000 people in 2003, will be more common. That means in Britain, the number of skin cancers and cataracts will increase.

And mosquito-spread diseases like **malaria**, traditionally common in the tropics, will be more widespread.

Dr Richard Horton, editor of **The Lancet**, said doctors have been in denial over climate change and need a wake-up call.

He explained: "What I hope it does is to make them realise that **climate change** is an urgent and dangerous issue that effects the patients they see on a daily basis.

"Their patients might not die tomorrow because of climate change but for them, their children and their grandchildren, climate change is going to be a danger to all of us."

The report pointed to scientific evidence that the 12 warmest years on record so far, have occurred in the last 13 years.

They said most scientists now agree that limiting temperature rise to a relatively safe level of two degrees by the end of the century is highly unlikely.

And they said food and water shortages - both a huge problem for the health service - were already increasing in certain parts of the world where the poorest will be hardest hit.

But while inaction could cost our NHS billions, the report also said, if we act now to cut our emissions, the health cost could decrease dramatically.

Professor Mark Maslin, director of UCL's Environment Institute, told Sky News Online: "If we redesign our cities so people walk more, cycle more, use public transport, suddenly we drop the incidence of obesity, heart disease, strokes and stress-related illness.

"So what we can see is that there are huge amounts of win-win solutions. If we lower the carbon emissions of our cities, we increase our health."

The authors hope their report will have the same sobering effect on health professionals as the Stern Report on the cost of climate change had on economists.

Above all, they say the Department of Health needs to start working with other government departments, to ensure action is taken now.

A Department of Health spokesperson said: "We welcome any initiatives that highlight the health impacts of climate change, and encourage the health sector's role in reducing emissions."

Source: http://news.sky.com/skynews/Home/World-News/Climate-Change-Is-Biggest-Threat-To-Human-Health-This-Century-Says-Report-By-UCL-Experts/Article/200905215281395?lid=ARTICLE_15281395_ClimateChangeIsBiggestThreatToHumanHealthThisCentury,SaysReportByUCLExperts&lpos=searchresults

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Cow's Milk vs. Toddler Milk

The term toddler is usually applied to children between the ages of 1 and 3. It is a stage in growth and not a specific age- the time between infancy and childhood when the child learns and grows in many ways. During this phase, growth rate is markedly less than in the first year of life. However, this period remains important because growth is still rapid and many tissues including central nervous systems are continuing to develop. Therefore, an appropriate energy and nutrient intake are required.

Young children or toddlers have many interests and their appetite may also fluctuate accordingly. Several large scale surveys conducted in Europe have also demonstrated that the nutritional status of many toddlers is less than satisfactory. In the short term, nutrient deficiencies can result in impaired growth and sub-optimal cognitive development affecting brain development and influencing learning ability and behaviour patterns later in life. In the long term then there is increasing scientific evidence to suggest that nutrition during the early formative years has a significant influence on the level of disease risk in adult life.

Cow's milk which compliments the solid food diet can provide significant quantities of energy and protein plus several minerals and vitamins, however, there are nutritional limitations. The level of protein in 500ml of cow's milk provides 13% of the recommended dietary allowance of protein. This is way too much and could be harmful to the still developing kidney functions of the toddler who cannot tolerate such large amounts of protein. Moreover, research ahs shown that too much protein in toddlers and young children may be linked to obesity later on in life. There exists the erroneous idea that since fresh cow's milk is 'watery' then this is not fattening. However, it has to be understood that actually cow's milk contains too much protein, salt and saturated fat making it much less ideal to form part of the diet of a still developing toddler.

Another important factor to bear in mind is that cow's milk is very low in iron, and iron is such an important element in influencing healthy brain and body development. Indeed 500ml cow's milk can provide only 2% of the recommended dietary intake of iron. And we all know how many young children eat too little red meat and certain vegetables which can provide adequate iron supplies. So it is of the utmost importance that toddlers are given the adequate amount or iron in their diet to ensure that they do not develop anaemia, a condition which is a vicious circle in itself because if a child is anaemic he/she is usually lethargic and develops a lack of appetite leading to even less intake of the right food.

Among the numerous biological effects of iron, there is considerable evidence that iron is very important for neurogical functioning and development and chronic iron deficiency- an irreversible effect- may lead to long term cognitive defects with possibly poor school performance later on in childhood.

These nutritional shortcomings in a young child's diet can be corrected by replacing cow's milk with a nutritionally balanced growing up milk. Such milk formulas are widely available and used correctly in conjunction with a balanced solid food diet will give parents peace of mind that their growing toddler is getting the best type of nutrition for healthy growth and development.

Teachers Blast 'Over-The-Top' Safety Rules

Almost half of all teachers believe health and safety regulations negatively affect students' education, a poll has found.

Teachers also believe draconian guidelines can affect a child's personal development.

Almost 600 education professionals took part in the poll by Teacher TV.

Some cited extreme examples of health and safey regulations such as the mandatory use of goggles when using Blu-Tac and the banning of running in the playground.

Others pointed to a five-page document outlining the dangers of using Pritt Stick and the cancellation of football due to a risk of falling and injury.

Andrew Bethell, chief executive of Teachers TV, said: "The more extreme examples are thankfully not the norm, but schools still need to take into consideration the workforce's concerns when trying to protect pupils."

Peter Cornall, from the Royal Society for the Prevention of Accidents (RoSPA), said a fear of legal action by parents was causing some schools to ban activities that have even a small risk of injury. He said: "Teachers need the confidence and training to know that they aren't going to be blamed and shamed if things go wrong."

He added that many teaching professionals were using health and safety issues as an excuse to avoid participating in activities that stretched the school budget.

The Health and Safety Executive has called for a common sense approach to health and safety in schools.

Chair Judith Hackitt said: "Health and safety is blamed for a lot of things not going ahead, but they're often about something else - high costs, an event that requires a lot of organising or fear of getting sued.

"Stop worrying about the "conkers stories" and help children learn how to handle risk by doing things and going on visits.

"Concentrate on the real risks - not the trivia - by putting measures in place to manage them as far as is reasonable, but don't try to eliminate all risk and don't stop the activity."

Source: http://news.sky.com/skynews/Home/UK-News/Teachers-Have-Blasted-Health-And-Safety-Guidelines-In-A-New-Poll-Conducted-By-Teachers-TV/Article/200906315311679?lid=ARTICLE_15311679_

'Social Networking Sites Pose Health Risk'

Social networking sites like Facebook could be harming people's health by reducing levels of face-to-face contact, a leading biologist has claimed.

The sites are set out to enrich social lives but end up keeping people apart, according to Dr Aric Sigman.

He argues lack of "real" social networking, involving face-to-face interaction, may have wide-ranging biological effects.

Evidence suggests it could alter the way genes work, upset immune responses, hormone levels and the function of arteries, and influence mental performance.

This in turn could increase the risk of health problems as serious as cancer, strokes, heart disease and dementia.

Dr Sigman spells out his warning in the latest issue of ***Biologist***, the journal of the Institute of Biology.

It's probably an evolutionary mechanism that recognises the benefits of us being together geographically. **– *Dr Aric Sigman***

He maintains social networking sites have played a significant role in people becoming more isolated.

The doctor says: "A quarter of British children have a laptop or computer in their room by the age of five and they have their own social networking sites. It's causing huge changes."

Research suggested that the number of hours people spent interacting face-to-face had fallen dramatically since 1987 as the use of electronic media had increased.

Interacting "in person" had affects on the body not seen when writing emails, Dr Sigman claims.

He says: "When we are 'really' with people different things happen. It's probably an evolutionary mechanism that recognises the benefits of us being together geographically."

Source: http://news.sky.com/skynews/Home/UK-News/Facebook-Health-Risk-Social-Networking-Sites-Bad-For-Peoples-Health-Says-Study-By-Dr-Aric-Sigman/Article/200902315225607?lid=ARTICLE_15225607_FacebookHealthRisk:SocialNetworkingSitesBadForPeoplesHealthSaysStudyByDrAricSigman&lpos=searchresults

One In Three 'Never Discuss Sexual Health'

by Dave Edwards

Millions of people are risking their health by not talking about sexually transmitted infections, according to a poll.

The worrying research shows 31% of people never discuss sexual health with their partners.

More than a quarter admit to being too embarrassed to ask the questions they would really like to, while 62% say they turn discussions about sex into jokes.

The Government surveyed 2,000 people aged 16 to 50 to highlight misconceptions around safe sex.

One in six respondents were unaware that some infections, such as herpes and genital warts, cannot be cleared up with antibiotics.

Lisa Power, head of policy at sexual health charity Terrence Higgins Trust, said: "Ignorance is just as transmissible as chlamydia or HIV and we need to take firm steps to prevent all of those things from spreading."

The research also found almost one in five people do not realise a woman can get pregnant during her period or if the man withdraws before ejaculation.

And 11% do not know that having sex standing up can also lead to pregnancy.

But more than three quarters of us would offer sexual health advice to a friend - even without being sure of the facts.

Psychologist Dr Pam Spurr said: "In spite of our love of talking about sex and relationships, the survey suggests it's our lack of knowledge that is causing confusion.

"We've still got some way to go before we swap jokes and banter for the open, honest and informed conversations about sexual health and relationships that most of us would like."

Source: http://news.sky.com/skynews/Home/Sexual-Health-One-In-Three-People-At-Risk-By-Never-Discussing-STIs-With-Their-Partners-Survey-Says/Article/200911315459184?lid=ARTICLE_15459184_SexualHealth:OneInThreePeopleAtRiskByNeverDiscussingSTIsWithTheirPartners,SurveySays&lpos=searchresults

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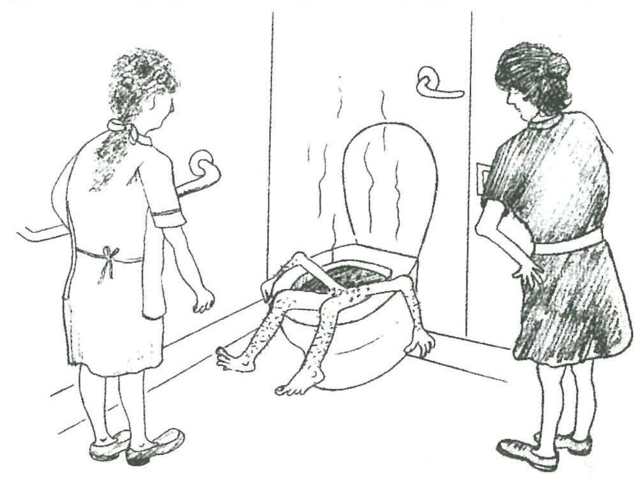


"How many enemas did you give him ?"

A nursing assistant, floor nurse, and charge nurse from a small nursing home were taking a lunch break in the break room. In walks a lady dressed in silk scarfs and wearing large polished stoned jewlery.

"I am 'Gina the Great'," stated the lady. "I am so pleased with the way you have taken care of my aunt that I will now grant the next three wishes!" With a wave of her hand and a puff of smoke, the room was filled with flowers, fruit and bottles of drink, proving that she did have the power to grant wishes before any of the nurses refute her.

The nurses quickly aurgued amongst themselves as to which one would ask for the first wish. Speaking up, the nursing assistant wished first.

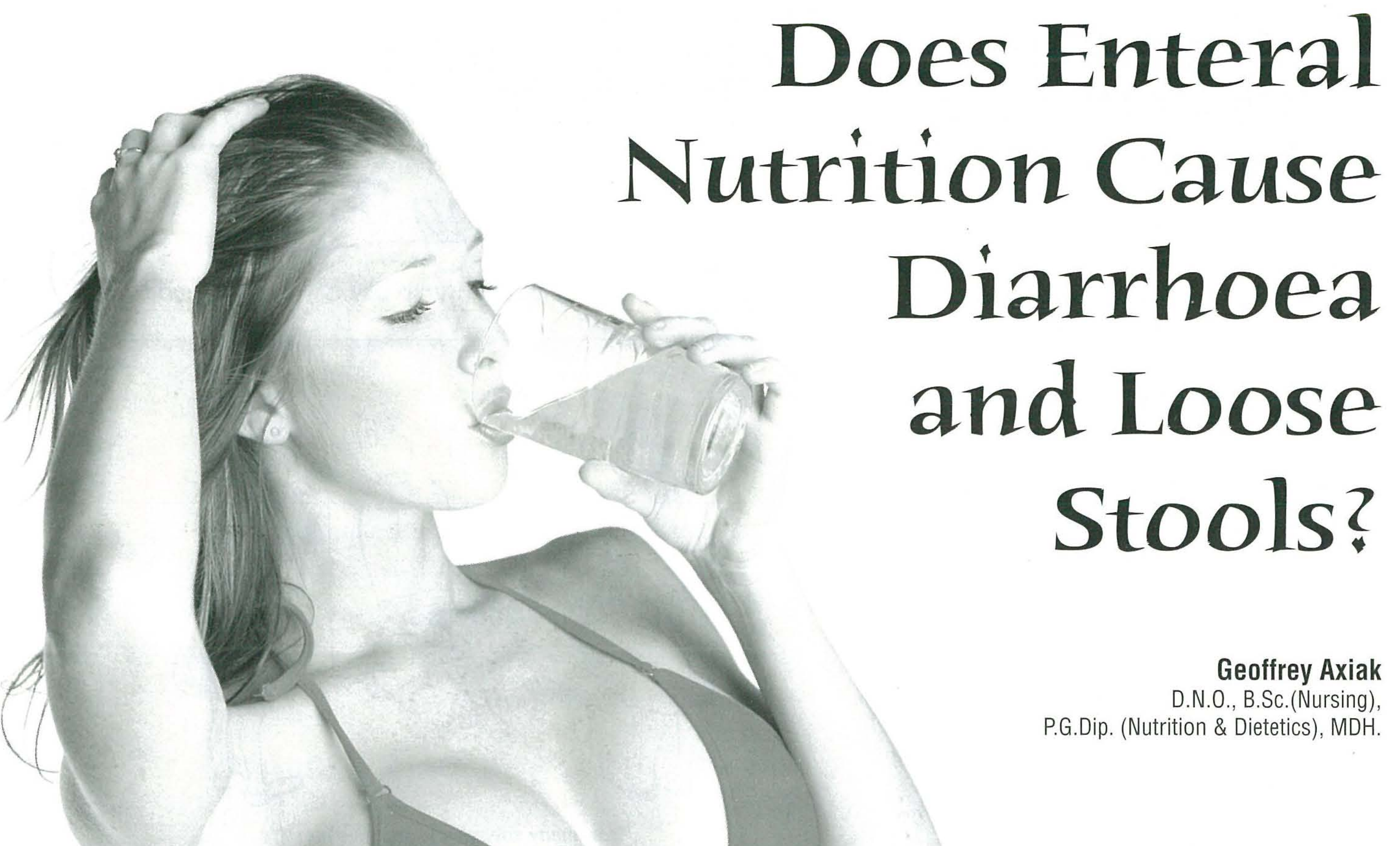
"I wish I were on a tropical island beach, with single, well-built men feeding me fruit and tending to my every need." With a puff of smoke, the nursing assistant was gone.

The floor nurse went next."I wish I were rich and retired and spending my days in my own warm cabin at a ski resort with well groomed men feeding me cocoa and doughnuts." With a puff of smoke, she too was gone.

"Now, what is the last wish?" asked the lady.

The charge nurse said," I want those two back on the floor at the end of the lunch break!"

"If we gave you nice food, you'd want to stay here instead of going home to your loved ones."



Does Enteral Nutrition Cause Diarrhoea and Loose Stools?

Geoffrey Axiak
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Many healthcare professionals think that enteral feeds, whichever is used, automatically causes diarrhoea and loose stools. The aim of this article is to show what the reality in this respect is.

First of all diarrhoea, as a definition, means "frequent loose or liquid bowel movements"[1]. This loss of fluid can cause severe dehydration due to loss of salts, water, electrolytes and nutrients. When one considers in which cases enteral feeding is used, one finds that this is most often where patients are malnourished or critically ill, after operations or when they are suffering from severe pancreatitis. Statistics show that 25% of patients on enteral nutrition experience diarrhoea[2]. Stroud *et al.* (2003)[2] mention a 30% incidence in enterally fed patients in medical and surgical wards and more than 60% in patients on intensive care units. This demonstrates that the percentage of diarrhoea does not depend solely on the feed. Although the feeds were the same, in different units, the incidence of diarrhoea varied. This means that the cause of diarrhoea was something other than the enteral feeds.

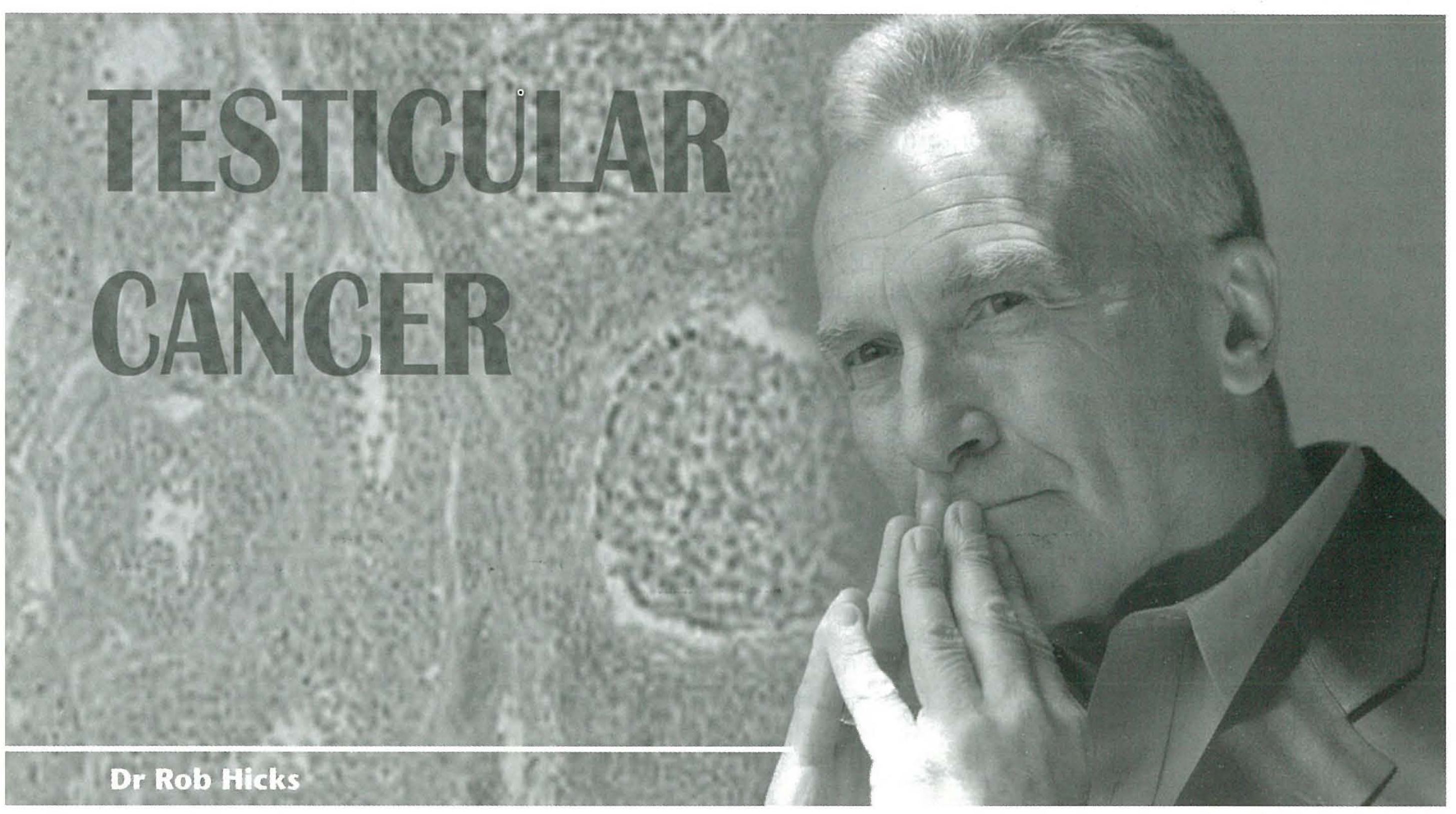
There are various factors which can cause diarrhoea, other than the enteral feeds themselves. The rate, mode and site of delivery of enteral feeds is one factor. If a patient is fed too quickly, i.e. when the rate is too fast, or when too much feed is administered in a short time, these cause diarrhoea due to malabsorption of the feed. Also, if a patient is feeding through his jejunum, where absorption is slower than in the stomach, here a slower rate is required to prevent malabsorption and consequent diarrhoea. Certain drugs, such as laxatives, antiobiotcs, NSAIDs, antiarrhythmics, antihypertensives, protein-pump inhibitors, anti-cholinergic drugs, thyroxine and drugs containing magnesium or sorbitol fillers, cause drug reactions[3]. Deficiencies, such as lactase deficiency, where most feeds contain lactose, would cause malabsorption due to the body's inability to absorb lactose. The same goes for other constituents of the feed where a patient might be allergic to one or more constituent and therefore gets cramps, stomach and intestinal pains and diarrhoea. Fat malabsorption, for example in cases of coeliac disease, food allergies, short bowels, liver disease and pancreatic dysfunction, also causes diarrhoea and loose stools[4]. Feeds may and may not contain fibre. Fibre-less feeds cause diarrhoea due to the absence of bulk-forming fibre in the diet. A feed containing fibre would therefore be beneficial to the patients in decreasing the incidence of diarrhoea. Finally, contamination is another very important and common issue. Contaminated feeds

or feeding equipment cause bowel bacterial overgrowth. Also 20-50% of patients with antibiotics suffer from diarrhoea caused by *Clostridium difficile*. This is why diarrhoea is more common in intensive care units, as suggested by Stroud *et al.* (2003). These last two factors (contamination and antibiotics) disrupt the patients' intestinal flora and precipitate diarrhoea.

So how can we treat or prevent diarrhoea in our hospitals? Using fibre feeds when available, and administering prebiotics and probiotics, as sachets or yogurts, would help build the patients' healthy intestinal flora, thus increasing absorption of the food and decreasing diarrhoea. The rate and mode of feeding should be monitored closely, starting new feeds slowly and increasing the rate or feed content in the regimens gradually, making sure the patient is given time to absorb the amount of feed he is being given before increasing the rate or feed. Drugs should be monitored. Where drugs react with the feeds or cause diarrhoea as a side-effect, one should consider whether it is wise to change the drug, administer it with water rather than during the administration of the feed. In cases of allergies to the feed, semi- or fully-digested feeds exist where the fact that the protein content of the feeds are broken down, this eliminates the allergy-causing proteins providing amino acids instead. In cases of allergic reactions, this solves the problem most of the times. Finally, some authors state that feed temperature may be another cause. This is doubtful, as these studies are not conclusive and opinions vary in this respect.

All these factors can cause diarrhoea. Hence when a patient is on enteral feeding, rather than stopping feeding as soon as a patient has some diarrhoea, one has to consider all these factors and see whether there is one (or more) of these other factors involved. One must keep in mind that most times, the enteral feed is the only source of nutrients for certain patients, so if we were to stop feeding a patient for every little excuse, we would be leaving the patient deprived of all nutrients and therefore more susceptible to infections, malnutrition and less able to heal and recover from an operation or disease. Hence, feeding should not be stopped unless absolutely inevitable.

1 Wikipedia (2009). *Diarrhoea.* Available at: http://en.wikipedia.org/wiki.Diarrhoea [accessed on 22nd August 2009].
2 Whelan, K., Gibson, G.R., Judd, P. & Taylor, M.A. (2001). The role of prebiotics in the management of diarrhoea associated with enteral tube feeding. *Journal of Human Nutrition and Dietetics*, **1**(6) December 2001: pp. 423-433.
3 Stroud, M., Duncan, H. & Nightingale, J. (2003). Guidelines for enteral feeding in adult hospital patients. *Gut*, **52** (Supplement VII): pp. vii1-vii12.
4 Asian Intensive Care (2009). *Diarrhoea. Aetiology.* Available at: http://www.aic.cuhk.edu.hk/web8/diarrhoea.htm. [accessed on 22nd August 2009].



TESTICULAR CANCER

Dr Rob Hicks

What are the symptoms?

The first sign is usually a painless swelling of one of the testicles or a hard pea-size lump on the front or side of the testicle. Sometimes there may be a dull ache or a sharp pain felt around the testicle or in the scrotum.

Self-examination

Self-examination is best done in or after a bath or shower when the scrotum is relaxed. Holding your scrotum in the palms of your hands, use your fingers and thumbs to examine the shape, consistency and smoothness of the testicles.

It's not unusual for one testicle to be slightly smaller than the other or for one to hang lower. But if something doesn't feel right, get it checked by the doctor - don't ignore it.

How common is it?

Testicular cancer affects one in 450 men before the age of 50 and is the most common cancer in men between the ages of 15 and 45. In the UK, the number of cases has doubled in the past 20 years and around 2,000 new cases are diagnosed each year.

There are several different types of testicular cancer. Although the commonest, teratomas, occur more in younger men, aged around 20 to 30, other types such as seminomas are more often found in men in their 40s or 50s, and testicular lymphoma can occur even later. So testicular lumps or other symptoms should not be ignored in men for all ages.

What causes it?

Its cause isn't known, but men who've had undescended testicles and those with a close male relative who's had testicular cancer are more at risk. In the USA , it's five times more common in white men compared to other ethnic groups. There is no link to having had a vasectomy but there is a slightly increased rik if you have had mumps affecting your testes and a much higher risk if you have already had testicular cancer in the other testicle.

There are no guaranteed ways of preventing testicular cancer. However, if undescended testicles are corrected before a boy is ten years old, his risk of developing testicular cancer drops back to the average level. Regular exercise may also reduce the risk.

What's the treatment?

Testicular cancer is one of the most curable cancers, with around 80 per cent of men making a full recovery even if the cancer has spread. The affected testicle is removed surgically. If the cancer hasn't spread, further treatment may not be necessary.
If it has, **chemotherapy** is usually given. **Radiotherapy** is sometimes used in the early stages.

Having a testicle removed shouldn't affect a man's sex life or his chance of becoming a dad.

Source:
http://www.bbc.co.uk/health/conditions/testicularcancer1.shtml

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