BOWEL WASHOUTS AND ENEMAS

PRACTICE GUIDELINE©

DOCUMENT SUMMARY/KEY POINTS

- This document provides guidelines to assist nursing staff in bowel preparation prior to elective colorectal surgery, for management of constipation and after barium studies.
- A recommended regime is included to guide nursing staff in determining the type and amount of solution used for bowel preparation.

Note: CHW Grace Centre for Newborn Care (GCNC) performs rectal washouts to decompress distal bowel for **Hirschsprungs Disease**. Refer to: http://webapps.schn.health.nsw.gov.au/epolicy/policy/3858

In GCNC this procedure is performed by members of the Surgical Team.

CHANGE SUMMARY

- Added definition of terms
- Added a diagram of a loop and divided ostomy
- Update recommended regimes
- Review and update of literature

READ ACKNOWLEDGEMENT

- Training may be provided by CNC Stomal Therapy (CHW) or CNC Surgical (SCH) and Clinical Nurse Educators.
- New surgical RMO's and new surgical Registrars should read this document.
- Nurses caring for patients requiring bowel washouts or enemas should read and acknowledge they understand the contents of this document.

This document reflects what is currently regarded as safe practice. However, as in any clinical situation, there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgement to each individual presentation.

Approved by:	SCHN Policy, Procedure and Guideline Committee	
Date Effective:	1st April 2018	**Review Period:** 3 years
Team Leader:	CNC Stomal Therapy	**Area/Dept**: Surgery

TABLE OF CONTENTS

Bowel Washout or enema[1, 2-4]

The purpose of a bowel washout or enema is to clean out the faecal matter from the colon. This procedure is often required in the management of:

- Constipation / faecal incontinence
- After barium studies to prevent impaction
- Neonatal distal bowel obstruction
- Enterocolitis
- Pre-operative bowel preparation for:
  - Duhamel rectosigmoidectomy/ Soave Procedure
  - Antegrade colonic enema via caecostomy

In the neonatal area, bowel washouts are performed to decompress and deflate the bowel by removing gas and stool for babies with Hirschsprungs Disease (HD) to relieve low intestinal obstruction due to meconium plug and stool. It is usually used as a mode of temporary management in proven cases of HD (after a rectal biopsy) while waiting for a definitive surgery. This may be for at least 4 – 12 weeks depending on each case.

Definition of Terms

Hirschsprung's Disease: Also known as Congenital Aganglionic Megacolon is a rare disorder of the bowel, most commonly of the large bowel where the nerves known as ganglion cells are absent in the bowel wall. This prevents effective peristalsis and results in intestinal obstruction. It affects four times as many boys as girls with increased incidence reported in infants with Downs Syndrome.

Meconium Plug: This condition is the most common and mildest form of mechanical distal obstruction of the newborn.Inspisated (what does this mean?) and immobile meconium causes a transient form of distal colonic or rectal obstruction.

Intestinal Pseudo-obstruction: The term intestinal pseudo-obstruction denotes a syndrome characterized by a clinical picture suggestive of mechanical obstruction in the absence of any demonstrable evidence of such an obstruction in the intestine.[5]

Principles

- Bowel washout procedures must be ordered by the Surgical Team following patient review[6]. The team should indicate in the patient's medication chart the frequency, , volume of solution to be used, and type of solution e.g. Glycoprep™. Nursing staff should refer to the Guidelines section of this document for additional information. The size should be documented in the patient notes (I don't think the electronic med chart will allow for this?)
- The procedure is performed by Registered nursing staff, except in Grace Centre for Newborn Care (GCNC)[7] where
  - The *Surgical Registrar* performs the procedure for bowel decompression in babies with Hirschsprung's Disease. The planned time for the procedure will be negotiated with the Surgical Registrar and nursing staff to ensure a nurse is available to assist.

Sucrose is administered two minutes prior to the procedure and throughout as required.
Registered Nursing staff in GCNC can perform distal loop colostomy washout (non-functioning end of colostomy) to clear distal colon prior to the distal loopogram procedure.

- The irrigation solution commonly used is normal saline. The solution **must** be lukewarm to prevent colonic spasm.
- Staff should be familiar with any medical or surgical history that may affect the bowel washout (e.g. cardiac problems, previous bowel resection/s, and difficulty with the previous washout procedure)
- Some children may require appropriate analgesia prior to the procedure.
- **Rectal washout:** patients should be placed in the left lateral position with knees flexed to facilitate insertion of rectal tube and delivery of solution. In neonates it is also acceptable to position infant on their back with legs in the frog position.

Bowel Washout equipment and procedure

Equipment required

- Prescribed solution
- Water soluble lubricant
- Gloves
- Plastic apron
- Bowl with warm water for heating solution
- 50mL catheter tip syringe/funnel
- A length of suction tubing (40 – 45cm) when using a funnel. (This is optional for older children as the funnel can be connected directly into the rectal tube/catheter)
- Rectal tube (Nelaton catheters 16Fg, 18Fg, 22Fg, 25Fg) for rectal washout as per medication chart.
- Nelaton catheter (10/12Fr for small babies, up to 14Fg for older children) for colostomy washout
- Collecting device (bedpan or kidney dish)

Glycoprep - C - Electrolyte gastrointestinal lavage solution acting as an osmotic agent to induce watery diarrhoea. It is used for bowel emptying for severe constipation and bowel preoperative preparation including gastrointestinal examination (colonoscopy, barium enema, intravenous pyelogram/ IVP)[8-12].

The solution is given orally or by nasogastric tube.

The Surgical Team decides whether Glycoprep-C is required and should indicate in the patient's medication chart the dose and frequency.

The usual recommended dose is 20 – 30mL/kg given over 4 – 6 hours.

Staff should follow the recommendation on how to prepare the solution according to the instructions in the packet

Guidelines for Bowel Washout [13]

Note: Check the child's weight to determine maximum volume for the procedure. (as per Surgeon/Consultant)

Surgical Intervention	Dietary Restrictions	Site & Frequency	Solution	Volume	Evaluation
Duhamel Rectosigmoidectomy / Soave Operation	Clear fluids 12 hours prior to surgery NBM as per orders	Distal Loop and Rectal Washout Twice Daily	Sodium Chloride 0.9% (normal saline)	30mL/kg for washout	Fluid return is clear
Constipation	Diet as ordered – usually normal	Rectal Once Daily	Sodium Chloride 0.9% + / - Glycoprep – C (to be ordered by the team if required)		Fluid return is clear
Irrigation Caecostomy	As per colostomy closure	Rectal Twice Daily	Sodium Chloride 0.9% (normal saline)	30mL/kg for washout	Fluid return is clear

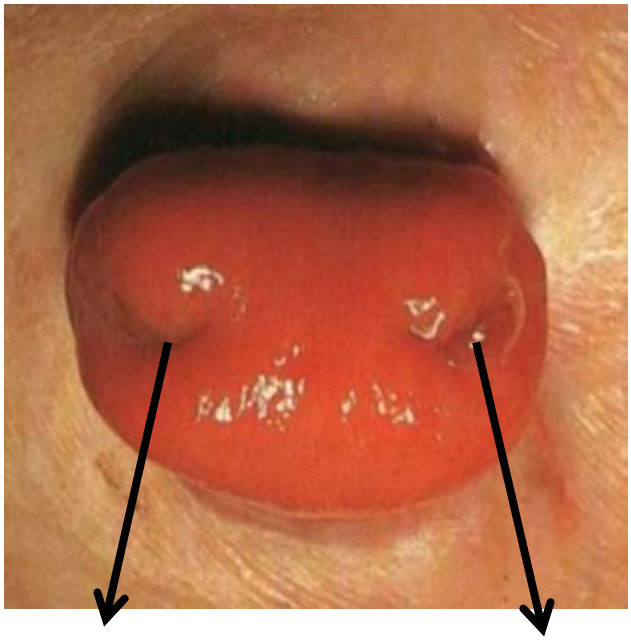
Rectal Washout

1. Explain the procedure to the child and/or parent/carer. Encourage the parent/carer to assist if possible.
2. Warm solution in a jug or bowl of hot water until lukewarm. Do not heat in the microwave as the fluid become unevenly heated and may cause burns
3. Place the child in the left lateral position with the upper leg flexed at the hip and knee. This position facilitates introduction of the solution due to the anatomical position of the descending colon.
4. Remove plunger from syringe.
5. Connect the syringe to the rectal tube and fill syringe and tube with required solution to expel air. Commence with 30mL to 50mL of solution.
6. Slowly insert the well-lubricated rectal tube approximately **5 – 6cm** (**2 – 3cm in small children**) into the rectum. **Do not force the rectal tube**.
7. Ensure saline is delivered slowly by holding the syringe /funnel just above the child's buttocks. You may need to gently insert the plunger into the top of the syringe and then remove immediately to start the flow of solution, allow the solution to gravity feed into the rectum
8. Invert the syringe/ funnel into the bedpan so fluid and faecal matter can be siphoned back.
9. Repeat the process of filling up the syringe/ funnel until all the solution is used or the desired result is obtained.
10. At the end of the washout, gently remove the tube.
11. Leave the child clean and comfortable.
12. Dispose equipment and waste appropriately.
13. Document the procedure, results of washout (clear return) monitor after effects and report abnormal findings immediately.

Colostomy Washout

1. Ascertain which loop/end of stoma is to be irrigated. This should be written on the medication chart with the order
2. Explain procedure to child and/or parent/carer. Obtain assistance from the parent/carer if possible.
3. Place the child in a supine position.
4. Remove the bag/appliance then locate/identify the proximal and distal loop. The proximal end is from where faecal matter discharges (working end of stoma).

5. Connect a catheter tip syringe to the catheter, and then run the solution (prime) through the catheter to expel air.
6. Gently introduce the well-lubricated (use KY Jelly) catheter approximately **2 - 3cm** into the desired stoma. **Do not force catheter**.
7. Run the solution slowly by gravity. Each time, for the below age groups, fill:
   - Children over 2 years of age: 100 – 200mL
   - Infants and small babies: 20 – 40mL.
8. The fluid is returned by lowering and inverting the catheter/ syringe Repeat the above procedure until all of the desired solution is used.



Proximal loop (working stoma) **Distal loop** (non-working stoma)

Loop Colostomy with proximal and distal end

Enemas

Olive Oil Retention Enema

Equipment

- As for washouts **plus**:
  - Olive Oil (room temperature)
  - For children 6 months to 1 year of age: Use 20mL
  - For children over 1 year: Use 50mL - 100mL

Procedure

- As for washouts **plus**:

- After instilling the correct amount of olive oil into the colon, the child should remain in bed for at least **20 minutes** to aid the retention of the oil.
- Allow the child to use a bedpan or toilet.

Medicated Enemas

- Must be charted on medication chart.

Bowel Preparation for Malone Procedure and Caecostomy[1]

The aim of a caecostomy procedure is to achieve colonic emptying and prevent soiling in children with intractable constipation and faecal incontinence. The procedure involves accessing the proximal colon (caecum) and placement of a gastric feeding device (gastrostomy button) or using the appendix to form a cutaneous appendicostomy (Malone Procedure) to deliver antegrade colonic enemas. *Chait*™ *buttons are also used to access the caecum through an appendicostomy.*

Pre-operative bowel preparation may be ordered by Surgeon/Consultant

(See Guidelines for Bowel Washout table)

- Free Fluids 48 hours prior to surgery
- Clear fluids 24 hours prior to Surgery
- Nil by mouth (NBM) as per anaesthetist

Note: Bowel washout is to commence at the day of admission. Some children may need to commence daily washouts a week prior to admission.

Special Precautions[14]

For patients with Spina Bifida and those patients with known neurogenic bladder/bowel and renal impairment the following is recommended:

- Baseline electrolytes to be done preoperatively
- Renal function tests/GFR may need to be done preoperatively.

Parent/Carer Education

SCHN Constipation Fact Sheet

- http://www.chw.edu.au/parents/factsheets/constipj.htm

CHW Irrigation Regime following Caecostomy Homecare Guideline (CHW-only)

- Provides instructions for parents/carers caring for a child in the home post-caecostomy: http://webapps.schn.health.nsw.gov.au/epolicy/policy/278

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