ENEMAS AND OSTOMY

Defecation—several times per day to 2-3 times per week, all normal.

Repeated inhibition can result in expansion of rectum, loss of sensitivity to the need to defecate, eventual constipation.

Normal feces 75% water, 25% solid.

Review factors that affect defecation—Techniques page 562-563.

Characteristics of normal and abnormal – K & E pg 1325, (Table 49-1)

Constipation - passage of small, hard, dry stool or no stool at all for a period of time.
  Decreased frequency of defecation
  Hard, dry, formed stools
  Straining at stool, painful defecation
  Reports of rectal fullness or pressure or incomplete bowel evacuation
  Abdominal pain, cramps, or distension
  Use of laxatives
  Decreased appetite
  Headache

Types of Enemas
  ▪ Cleansing- stimulates peristalsis by irritating colon and rectum and/or by distending intestine with volume of fluid introduced.
  ▪ Carminative- to expel flatus, releases gas, which distends rectum and colon, thus stimulating peristalsis.
  ▪ Retention- introduces oil to soften feces, lubricate rectum and anal canal.
  ▪ Return flow (Harris flush or colonic irrigation) - to expel flatus, alternates flow of fluid into and out of large intestine, stimulates peristalsis.
  ▪ Therapeutic enemas- deliver nutrition or medication (corticosteroid, antibiotic, and kayexalate.)

Dangers of enemas
  ▪ irritation of rectal mucosa by too much soap
  ▪ hypertonic or hypotonic solution causing shifting of body fluid and electrolytes.
  ▪ Hypotonic (tap water) can cause high blood volumes and produce water intoxication
  ▪ Enemas as still clear- limit three.

* Commonly Used Enema Solution, Techniques Box 21.2, pg. 568.
Guidelines
- Physicians order - may be specific for O.R. or tests, often on PRN basis
- Give at 105-110 degree, high temps damaging to bowel mucosa, cold uncomfortable, and may trigger spasms of sphincter muscles.
- Force of flow determined by:
  1) Height of solution.
  2) Size of tubing.
  3) Viscosity of fluid.
  4) Resistance of rectum.
- Time - 1000 ml may take 10 to 15 minutes to instill.
- Retain - oil retention 1 to 3 hours, other enemas 5-10 minutes.

Procedure:
- Lubricate tubing 2 inches.
- Clear tubing of air.
- Left lateral (Sim’s) position.
- Insert 3-4 inches toward umbilicus.
- Resistance at internal sphincter - encourage client to take deep breaths, release more fluid.
- Never force entry.

Administer enema:
- Low enema, 12 inches above rectum.
- High enema, 18 inches container above rectum.
- If there is pain or cramping, stop flow for 30 seconds and restart at a slower rate.
- Plastic commercial container (Fleet’s) and roll up as instilled.
- After all solution is instilled or patient can’t hold any more, withdraw.
- Encourage patient to remain in supine position.
- Retain cleansing (5-10 mins.), retention (30 mins.)

Remind client to not flush if client uses toilet.
Review variations and age related considerations.

Fecal impaction - mass or collection of hardened feces in rectum
- From prolonged retention and accumulation of fecal materials.
- Symptoms may include loose stool-leaking around impaction.
- Oil retention enema > digital removal > cleansing enema > suppository.

Procedure:
- Breaks up fecal mass using finger and remove in portions.
- Contraindicated when vagal stimulation may cause cardiac arrhythmia.
- Usually oil retention enema held for 30 minutes immediately prior to removal.
- If agency permits, 1-2 ml topical lidocaine inserted into anal canal 5 minutes before procedure.
- Right or Left lateral or Sim’s position.
  - Right side sigmoid colon uppermost and gravity assists.
  - Left side allows easier access.
- Linen saver pad and bed pan.
- Lubricate gloved index finger.
- Encourage slow, deep breathing.
- Insert finger toward stool-helps dislodge, stimulates peristalsis, relaxes anus.
- Break up mass with finger, or use 2 fingers scissor style.
- Work stool down and remove in small pieces.
- Assess for: pallor, faintness, SOB, perspiration, and changes in pulse rate.

**Bowel Diversion Ostomies**

- Ileostomy- liquid fecal drainage cannot be regulated, be alert for skin breakdown, digestive enzymes, and order minimal.
- Ascending- drainage liquid, digestive enzymes present, cannot be regulated, and odor is a problem.
- Transverse- drainage malodorous and mushy as some liquid reabsorbed, usually no control and cannot be regulated.
- Descending- increasingly solid fecal drainage, frequency of drainage can be regulated, and odors can be controlled.

**Stoma Types**

- **Single**- arises from end of proximal portion of bowel.
- **Loop**- loop on abdomen supported with plastic rods, if two openings present-proximal (functioning) opening discharge fecal material and distal opening (non-functioning) end discharges mucus.
- **Double barrel**- two separate stomas adjacent to each other.
- **Divided**- two stomas, separated.

**Ostomy appliance**

- Skin barrier.
- Flange or wafer
- Pouch

**Access**

- If more than one stoma, know which one is functioning.
- Type and size appliance currently used.
- Tape allergy.
- Stoma color-red, moist and similar to mucosal lining of mouth
  - Very pale-anemia.
  - Dare with purple or bluish hue-impaired blood circulation.
- Stoma size and shape-protrudes
  - Slightly from abdomen.
  - New swollen for first 6 weeks.
- **Bleeding**- slight bleeding from stoma.
  - Normal.
- Peristomal skin 2 to 5 inches surrounding stoma.
- Amount and type feces (A.K.A. “effluent”)
  - Amount, color, consistency pus or blood abnormal.
- Complaint - burning, abdominal discomfort or distension.

Review Technique 21-4, pg. 576-579 – Changing a Bowel Diversion Ostomy Appliance