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顧問：梁萬福醫生

第三期 一九九七年六月

## 理遺醫學廣場之

# 大便失禁

大便失禁較小便失禁為罕見，但是對患者的生活質素之影響較小便失禁嚴重，往往大便失禁會成為尋找老人院之主要原因。大部份大便失禁的患者都是有其病因，如果能夠作出適當的治療是有助於控制大便失禁的，以下會介紹一些常見的大便失禁成因及其治療方法：

### (一) 便秘及大便嵌塞

一些長期便秘的人士會產生大便嵌塞的情況，當大便硬嵌在大腸內形成會刺激到大腸內的黏膜，黏膜會分泌出一些糞液，這些糞液會不斷滲出體外，而構成大便失禁的形成。這種大便失禁最常發生於長期活動不足的人士，其中以長期臥床的老人為最常見。其主要徵狀是在一些長期住院的病者，在一段長時期便秘後發覺有糞液流出，這便多數是因為大便嵌塞而導致大便失禁。這一類患者的治療方法是要將大腸內糞便徹底清潔，然後該患者重新建立一個正常大便習慣。通常的處理方法是要用洗腸形式將糞便清理，因為一般的硬嵌都是十分堅實，一般的瀉藥是無法將之清理。談到使用洗腸法時，我們接觸的護理人員於一次洗腸有大量糞便排出後便會非常滿足，而停止繼續洗腸。

其實這些患者大腸內之糞便是十分多的，正確的處理方法是每天都為患者洗腸直至沒有糞便排出，完成治療後亦應為患者照腹部X光以確定大腸內糞便已徹底清除，然後加強患者食物的纖維如蔬菜、生果等。以避免便秘的情況再發生。

### (二) 病徵性失禁

病徵性大便失禁是由於身體一些疾病導致大便增加而引起大便失禁，這些病因包括大腸炎、大腸癌及藥物的副作用等。其治療方法當然是根據病因而進行治療，這樣大便失禁便得以控制。

### (三) 神經性失禁

排洩糞便是一個由神經系統控制的過程，當大腦不能壓抑大腸反射便會有大便排出，導致大便失禁。這類大便失禁主要發生於嚴重神經疾病患者，像大腦受損的情況如腦血管疾病、老年痴呆症或脊骨神經受損的人士。在治療這類失禁患者較為困難，主要的治療方式是靠教育及訓練患者如廁練習，使他們能於早上時候便把大便排出，日間時候便會減少大便失禁的可能性。

梁萬福醫生



# 專題

## Drug Treatment Of Urinary Incontinence

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### Introduction

Urinary incontinence is a common problem that adversely affects the quality of life of millions of elderly men and women and their caregivers. Most patients with urinary incontinence can be cured or helped by current treatments. Possible treatment approaches include behavioural therapy, drug therapy, surgery, and use of supportive devices.

Pharmacological therapy can have significant impact in the management of many forms of urinary incontinence. Drug selection is dependent on the cause of incontinence (Table 1). It is important to determine the type of urinary incontinence before attempting treatment. Conditions such as urinary tract infections which may mimic the symptoms of urinary incontinence should be excluded. Basically, drug therapy is directed at decreasing bladder contractility (detrusor instability), and increasing outlet obstruction (bladder neck and proximal urethra).

Table 1 Drug Therapy of Urinary Incontinence

Type	Treatment and dosage
Urge	Oxybutynin 5mg bd-tds; max 5mg qid <sup>1</sup> Flavoxate 200mg tds <sup>1</sup> Imipramine 10-25mg tds-qid <sup>2</sup> Propantheline 15-30 mg bd-tds <sup>1#</sup> Dicyclomine 10-20 mg tds
Stress	Phenylpropanolamine 50-75 mg qd-bd) <sup>+</sup> Pseudoephedrine 15-30 mg bd-tds <sup>+</sup> Imipramine 25 mg daily <sup>+</sup> Conjugated oestrogens 0.625 mg daily <sup>++</sup> Vaginal oestrogen cream 0.5-1.0 g 2 times/week <sup>+</sup>
Overflow	Prazosin 2 mg bd <sup>1</sup> Bethanechol 10- 25 mg tds qid <sup>1</sup> Carbachol 2 mg tid <sup>1</sup> Distigmine 5 mg daily or on alternate days <sup>1</sup>
Function	None



<sup>+</sup>Initial treatment doses

<sup>#</sup>Higher doses are occasionally tolerated and effective; should be given in the fasting state

<sup>++</sup>If a patient has uterus, consider cyclic therapy with a progestational agent to reduce risk for cancer

### Urge incontinence

In urge incontinence, also known as unstable bladder or detrusor instability, uninhibited contractions of the detrusor muscle occur without warning and overcome urethral sphincter resistance. Micturition occurs despite any attempt the patient might make to prevent it. Urge incontinence is the most common form of incontinence in the elderly and is often refractory to treatment<sup>4</sup>. No drug treatment has been found to be universally effective.

Anticholinergic agents are first-line pharmacologic therapy for urinary incontinence caused by detrusor instability<sup>5</sup>. They increase bladder capacity by diminishing unstable detrusor contractions but the incidence of adverse effects can be high. Based upon the literature and clinical experience, oxybutynin (Ditropan<sup>®</sup>) is the preferred drug for urge incontinence<sup>3,5</sup>, especially in the elderly. Oxybutynin is a strong independent smooth muscle relaxant with local anaesthetic activity as well as minor anticholinergic effects. It has fewer anticholinergic effects and more prominent detrusor relaxation than any of the other drugs. Flavoxate (Urispas<sup>®</sup>), another smooth muscle relaxant



with anticholinergic effects and local analgesic properties, has also been used with less marked side-effects but appears to be less effective than oxybutynin. Several studies have reported conflicting results as to the efficacy of flavoxate<sup>3</sup>. Propantheline is considered second-line<sup>5,6</sup> and its main use appears to be in patients whose only symptom is urinary frequency. Propantheline was formerly widely used in urinary incontinence but had a low response rate with a high incidence of side-effects, it is now primarily indicated in adult enuresis. Other antimuscarinics used include dicyclomine (Bentyl<sup>®</sup>) which also possesses antispasmodic properties.

As these agents can increase bladder volume they should not be used in patients with urinary retention. All these drugs may cause dry mouth and blurred vision and may precipitate glaucoma. The systemic anticholinergic side effects from oxybutynin, flavoxate, and dicyclomine are relatively mild when compared to propantheline.

The tricyclic antidepressants (TCA) imipramine, amitriptyline, and nortriptyline are sometimes effective in the management of the unstable bladder because of their antimuscarinic properties in urge incontinence but their main use has been in nocturnal enuresis and nocturia<sup>1,6</sup>. TCA should be used only after careful patient evaluation<sup>5</sup>.

### **Stress Incontinence**

Stress incontinence is the commonest form of incontinence in women. The patient usually has urethral sphincter incompetence and loss of urine is associated with increase in intra-abdominal pressure which may occur on standing or coughing. Alpha-adrenergic agonists such as phenylpropanolamine or pseudoephedrine is the drug of choice for women with stress incontinence (urethral sphincter insufficiency) if use is not contraindicated by other medical condition<sup>5</sup>. These drugs increase tone in the muscles of the urethra and at the base of bladder. All of them should be used with caution in the elderly due to side effects which include anxiety, insomnia, blood pressure elevation, headache, tremor, weakness, palpitations, cardiac arrhythmias, and respiratory difficulties. If single-drug therapy is ineffective, oral or vaginal oestrogen therapy can be given along with phenylpropanolamine to postmenopausal women with mild stress incontinence<sup>5,7</sup>. Unfortunately progesterone cannot be added to treatment to reduce the risk of endometrial carcinoma in woman with an intact uterus as it may exacerbate the incontinence. Imipramine (Tofranil<sup>®</sup>) may be an alternative if the first-line agents are not satisfactory. Imipramine is useful for increasing bladder capacity and increasing bladder outlet resistance. Weakness, fatigue, and postural hypotension are significant problems with imipramine.

### **Overflow Incontinence**

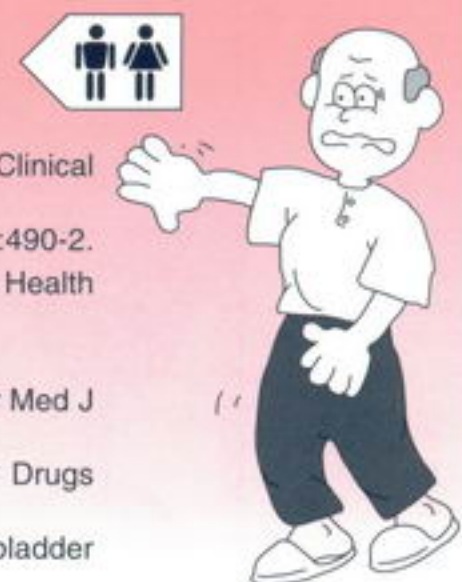
Patients with overflow incontinence suffer from a continuous dribbling of urine as a consequence of an overdistended bladder produced by urinary retention. It may result from urethral blockage or may be associated with drug treatment or conditions that reduce detrusor contractions or interfere with relaxation of the urethra. Overflow incontinence is uncommon in women and most patients are elderly men with urethral blockage due to prostatic hyperplasia. Treatment depends on the underlying condition. Patients with detrusor hypotonicity have been given parasympathomimetic agents such as bethanechol, carbachol, and distigmine to increase detrusor muscle contractions but there have been doubts about their efficacy<sup>8,9</sup>. They have also been used for the management of postoperative urinary retention, but have been superseded by catheterisation.

### **Conclusion**

Incontinence is not an inevitable consequence of ageing. It is a pathological condition that when rationally approached usually can be ameliorated or cured, often without invasive tests or surgery and almost invariably without an indwelling catheter. Treatment may involve environment support, behavioural modification, surgery, and drug therapy. Behavioural and drug therapies can reduce the need for surgery and can be considered for initial therapy.

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# 福博士信箱

陳姑娘：請問男性的導尿管(Foley catheter)和女性的導尿管有沒有分別？那一種比較好用？



當然有分別喇！主要分別在於長短和價錢。

	男性導尿管	女性導尿管
長度	40cm	20cm
價錢	Latex cath \$12-15 100% Silicone & 70-200 Silicone coated latex cath & 15-30	沒有
供應來源	1. 力圖洋行 2. 嘉文洋行 3. 嘉榮醫療有限公司 4. 上池行 5. 耀章股份有限公司	沒有

請問選擇合適的導尿管要注意甚麼地方？



除了價錢外，最重要是選擇合適的尺碼和質料，Fg10至Fg18不等，號數愈大，直徑愈大，尺碼的選取於使用者的體重而是取決於尿液內沉澱物的多少，一般可用Fg12-14，如果使用者剛進行手術，例如前列腺手術，常會出現一些血凝塊，尿導管的尺碼便要大些。

至於質料的選擇就要視乎使用者的負擔能力，Silicone coated latex的導尿管價錢只需\$16左右，而100% Silicone的導尿管需要\$70-200不等。當然100% Silicone的導尿管比Silicone coated latex的導尿管只能使用2-4星期致細菌感染誘因之一是經常更換導尿管，所以對於不便澄清者言，就算多付些金錢也值得使用100% Silicone的導尿管。





請問使用導尿管時，  
使用者要注意甚麼事  
項？



#### 要注意事項有4點

- (1) 使用者每天最少飲水1.5公升
- (2) 導尿管要固定在大腿內側
- (3) 如使用者每天要沖涼，便無須使用肥皂或消毒藥水抹洗外陰
- (4) 要留意所使用的導尿管的更換時限，這要視乎導尿管的質料和使用者尿液的混濁情況；一般的更換時限如下：

(a) 100% Silicone	3個月
(b) Silicone coated latex	4星期
(c) Latex	1星期
- (5) 長期使用導尿管者應使用腳袋 (Leg Bag) 以方便活動

常使用之尺碼，由  
擇通常並不是取決  
在正常的情況下，  
刮除術，尿液內通  
例如Fg16-18。

如一條Silicone  
Silicone的導尿管則  
可使用2-3個月，而  
一些研究指出，導  
一些體質較弱，小  
Silicone導尿管。

讀者如有問題，不妨來信《福博士  
信箱》福博士自當盡力解答。

來信請用 Fax : 2347 2325  
(Attn : Dr.M.F.Leung. UCH)

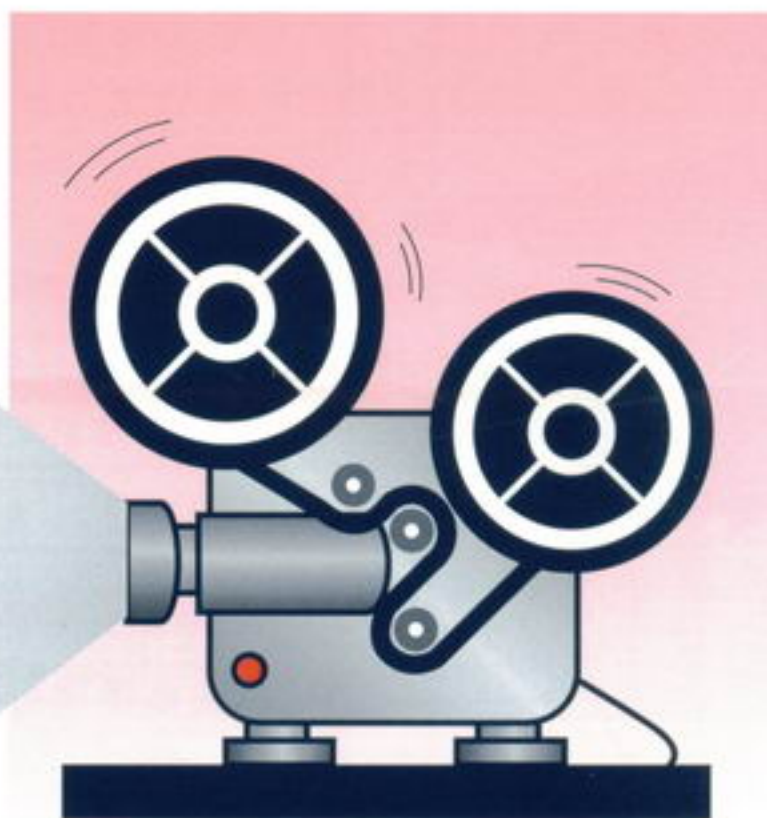


大家可能對造瘻治療師這名字很陌生，其實我們的工作大家都會很熟悉。造瘻治療師的工作範圍包括造口、傷口、瘻管以及失禁的護理。在五年前，香港的造瘻治療師寥寥可數，全港只得5至6位，但現時已增至三十多位，他們分佈於港九各大醫院護理有需要的病人。

作為造瘻治療師，我們的工作除了臨床護理外，還有對病人輔導，教育（包括病者、病者家屬及護理人員）及護理方面的研究工作等。由於我們在這方面有專業的知識，故此責任及工作量均很大。例如在造口方面，我們要替病者選擇適合他們的造口袋；在傷口方面，我們要有足夠的知識選用適當清洗溶液及敷料，以促進傷口癒合，在傷口有好轉的時候當然會有很大的成功感。但若傷口有負面的改變，便會花盡心思去處理，故此壓力非常之大。

其實我們的工作也需要很多醫務人員的輔助，在傷口護理方面，尤其是褥瘡或腳部潰瘍，傷口需要癒合的時間比較長，故此是極需要其他醫務人員的合作才可以成功。例如物理治療師教導病者運動；職業治療師幫助病者設計床墊、坐椅、適合的鞋及其他輔助器具，還有我們要指導病者家人如何幫助病人轉身、坐椅、飲食等等。故此若病者可以康復出院，其實是全體人員合作之成果。

此外，料理失禁病人也是我們工作的一部份，如指導病者作骨盆肌肉的運動以增強控制大小便的能力、選用適當的失禁用品、插小便喉放小便等等。均需要有耐性及毅力，而此等工作有時是吃力



不討好的。原因是我們大部份失禁病者均是老年人士，他們的聽覺、視覺及手部能力均可能衰退。故此在指導他們時一定要有耐心，也不乏有部份病者因自己年紀老邁而自願放棄訓練。另一方面，其實醫護人員對失禁人士的態度也對他們有很大的影響。因現時仍有大部份人認為失禁是不可治癒的，為了方便起見，只採用尿片或長期導尿管作為對失禁的處理方法。這樣會給失禁人士一個負面影響，引致他們放棄現有的治療方法，這樣使我們的工作困難重重。

我參與這份全職的工作已經差不多7年，在這7年間，工作所帶給我的滿足感與日俱增。雖然在失禁護理方面仍有障礙，但我仍希望留在這專科方面繼續發展。



# 活動預告

一九九七年九月廿三日至廿六日  
國際理遺組織  
International Continence  
Society  
將會在日本大板舉行  
週年舉大會

United Christian Hospital, Hong  
Kong & Royal Prince Alfred Hospital,  
Austria Jointly Presents Certificate  
Course on Continence Care for  
Health Care Professionals

Time : 27/10/97-8/11/97  
Venue: United Christian Hospital

## 健康講座

講題：如何面對失禁問題  
日期：一九九七年七月九月  
（星期三）  
時間：上午十時至十二時  
地點：西灣河文娛中心

## 『抗衡失禁』護理工作坊

日期：1997年5月24日至  
6月14日  
時間：逢星期六下午2:00pm-  
4:30pm  
深水埗李鄭屋邨  
地點：孝廉樓地下

## 活動匯報

黃埔花園家庭健康同樂日97'一九九七年  
三月九日  
香港理遺學會，聖若翰救傷隊救傷見習  
隊，與黃埔花園居民協會在黃埔花園聯  
合主辦家庭健康同樂日97'  
當日節目包括健康講座遊戲節目，表演  
節目及免費驗小便及量血壓，梁萬福醫  
生負責失禁講座，隨即由陳秀娟，李惠  
娟，李慧儀及葉綿田分別為個聽眾解答  
失禁問題。



甚麼是理遺科 — 理遺科是一個特別為照顧遺大小二便的人士而設立的服務。

香港理遺學會是由一群熱心於照顧大小二便失禁的專業人士所組成，學會的成員來自外科、婦產科及老人科的醫生，護士、物理治療師、職業治療師、及社會工作者等。

香港理遺學會組成的目標包括：

- (一) 為有失禁人士提供協助
- (二) 促進對失禁的研究及治療
- (三) 促進公眾人士對失禁的了解及認識



如有任何有關失禁的疑問  
歡迎致電香港理遺學會諮詢熱線

**2815 7390**