香港理遺學會

會訊

主編：阮鳳姿
編輯：李偉娟　陳秀娟
顧問：梁萬福醫生

第七期：一九九九年四月

編者的話

阮鳳姿

一九九八年度的週年大會及學術會議經已在九月份舉行過了，當日參與的同事們有100人之多，學術匯報亦有7份，可謂熱鬧踴躍。為了進一步促進本港理遺服務的推展，本年度，香港理遺學會將會舉辦多個高水準的學習工作坊，更邀得國際知名的Dr. Paul Abrams 和Ms. Janette Williams主講，詳情將會登載於下一定期的會訊內。今期會訊的內容包括由律敦治醫院老人科余劍琴醫生贊稿寫的"女性失禁"及瑪麗醫院李偉娟姑娘講述何謂"結腸灌洗"(Bowel Irrigation)，此外，今期更新設一個"個案分享"的環節，由聯合醫院的陳秀娟姑娘分享她處理失禁個案的喜與悲。

農曆新年剛剛過去，今年的願望是理遺學會會訊稿源源源不絕，能按期在四月、八月和十二月如期出版。請各位會友踴躍投稿及提出建議、批評，使會訊內容維持水準，共同推動香港理遺服務的進展。

Bowel Irrigation

李偉娟姑娘　瑪麗醫院

What is bowel Irrigation?

Bowel irrigation is the practice of instilling a measured amount of lukewarm water into the colon via anus. The dilation of the colon is followed by a reflex contraction which expels both faeces and fluid from the colon via anus.

It is a method of controlling bowel action by enabling the large bowel to empty, so preventing further action until the next irrigation. It offers a method by which the fecal incontinence patients may exercise control over their incontinence problem.

Aim

The aim is for the fecal incontinence patients to have no further bowel movement between irrigations, usually every 24 hours, enabling him to be free from fecal incontinence.

Who is suitable for irrigation?

1. The medical facts
2. Home conditions

   A lavatory which has a hand-basin or similar washing facilities.
3. Emotional / Physical state

The patient must be well motivated and has good manual dexterity. Mentally and physically are capable of learning and performing the technique.

4. The stool is formed
5. Family cooperation is essential in providing support, privacy and time. Relatives can also participate in the procedure.

Contra-indication for irrigation

1. Inflammatory bowel disease, irritable bowel syndromes, diverticular disease
2. The patients with physical or mental limitations
3. The patients with cardiac or renal failure
4. The arthritis patients : for they lack the necessary manual dexterity.

Equipment

1. A reservoir and plastic tubing with clamp
2. A cone
3. Lubricating gel

Amount of water

The amount of water instilled may vary from 500 - 1000ml, depending on individual. Phosphate enema may be needed from the prescription of physician.

Before irrigation

The individual should choose a convenient time of day when he or she can occupy the bathroom for an hour without the risk of being disturbed.

Ideally, the irrigation should be carried out at the same time each day.

1. A bathroom containing both a lavatory and washing facilities.
2. Collect all necessary equipment and ensure the environment is warm and comfortable.
3. A hook is fixed next to the toilet, to hold the reservoir at head height of the seated patient.
4. Lay out the equipment within reach.
5. Pour lukewarm water into the reservoir and eliminate the air from the tubing.
6. The clamp on the plastic tubing should be closed to prevent water from flowing down.
7. The patient should sit comfortably on the lavatory or commode.
8. The patient can wear a disposable glove on one hand.

* If the patient is bed - bounded, he / she should lie on one side and bed sheets are protected. Someone else can do the procedure.

Introducing the water

1. Lubricating gel is applied to the cone.
2. The cone is inserted into the anus and held in place with the fingers of one hand.
3. Whilst holding the cone with one hand, the clamp can be slowly opened with the other and allow water to flow from the reservoir via the anus into the descending colon.
4. The amount of water used and the time taken for it to enter the bowel varies from patient to patient (about 10-15 mins)
5. If the water enters the bowel too fast, cramp may be caused.
6. If this occurs, the water flow can be turned off by the clamp. The patient can massage the abdomen for a few mins.
7. The patient may recommence the procedure when the cramp eases.
8. Cramp may also occur if the water is either too hot or too cold.
9. When the desired amount of water has been introduced into the colon, the cone can be removed.

Evacuating the fluid

1. In 5 - 10 mins, there will be a flow of faeces from the anus.
2. Evacuation of the fluid will be completed after a further 10 - 15 mins.
3. After the bowel is emptied, the patient can clean and dry up the perineal area.
4. The irrigation set should also be cleaned for use again.
5. The procedure takes about 30 to 40 mins.

Some hints for irrigation

1. For the first week, irrigation should be carried out daily. There may be some spillage of faeces or fluid due to incomplete evacuation.

2. If no spillage occurs between irrigations, irrigation can be tried every 48 hours.

3. If a patient is dehydrated, however, much of the irrigation fluid may be absorbed through the bowel, so this should be considered when deciding on fluid volume.

6. If the patient performs irrigation everyday, try to do it at approximately the same time.

7. Let the patient arrange the time of the

washout to suit himself / herself. He /she may like to do it in the evening instead of the morning.

8. You may find that if you have been a constipated person, irrigations are only necessary on every other day. Try this and see whether it will success.

9. Never do an irrigation if you are taut and tense. Wait until you have calmed down and relaxed.

10. If you are travelling a long way, your normal regime could be interrupted. Do a washout before you go and revert to your usual custom when you arrive your destination.

11.If you have what you consider to be an unsatisfactory washout, don't repeat it. Next day's washout will be excellent.

12. Don't use more water than necessary - about 750ml. If you use more, it will flow into the right side of your colon.

13. Very few foods and drinks will upset you. Onions will probably be one. Find out these and avoid them if possible.

16. If you are travelling abroad and the water is not drinkable, do not use it to irrigate. Boiled water should be used.

* Please ask Enterostomal Therapist for advice if problems arise.

專題一：Female Urinary Incontinence (Part I)

Dr. Yu Kim Kam, Teresa,SMO, Dept of Geriatrics, RH

Common Causes of Urinary Incontinence in Women

- Genuine stress incontinence
- Detrusor instability
- Overflow incontinence secondary to urinary retention
- Fistulae (vesico-vaginal, uretero-vaginal, urethro-vaginal)
- Congenital lesions (e.g. epispadias, ectopic ureter, spina bifida)
- Transient causes (DIAPPERS)
  - -Delirium / confusional state
  - -Infection, urinary
  - -Atrophic urethritis / vaginitis
  - -Pharmaceuticals (e.g. diuretics, anticholinergics, sedatives, antipsychotics, antidepressants, etc.)
  - -Psychological
  - -Excessive urine output (results from large fluid intake, diuretic agents and metabolic disorders e.g. DM, hypercalcaemia)
  - -Restricted mobility
  - -Stool impaction

Genuine stress incontinence is the commonest cause of urinary incontinence in women. Symptoms of urinary leakage associated with physical exertion with or without frequency, urgency or prolapse. Usually occurs following childbirth but may affect nulliparous women when there is congenital weakness of the support of the urethra. Post pelvic surgery, postmenopausal atrophy and increases intra-abdominal pressure such as a mass, chronic cough or constipation, can exacerbate the symptoms. Frequently,

but not always, there is co-existent prolapse of the anterior vaginal wall (cystourethrocele).

Detrusor instability is the second most common cause of female urinary incontinence. Patients with this condition usually complain of a multiplicity of symptoms including urgency, urge incontinence, frequency and nocturnal enuresis. Sometimes genuine stress incontinence and detrusor instability co-exists.

Overflow incontinence secondary to urinary retention may be due to poor detrusor contractility or outflow obstruction, and the underlying pathology may be neurological, inflammatory, post-surgical, drug related or pelvic pathology such as a prolapse or mass. Patients may complain of voiding difficulties like incomplete bladder emptying and straining during voiding.

Urinary incontinence may occur during ***pregnancy*** because of abnormal detrusor function, reduction in urethral sphincter competence, or an increase in intra-abdominal pressure. Stress incontinence due to urethral sphincter weakness is less likely to resolve postpartum, but detrusor instability occuring during pregnancy usually resolves. Vaginal delivery results in trauma to the pelvic floor, especially so for instrumental vaginal delivery. Although most pelvic floor damage during childbirth resolve spontaneously or aided by physiotherapy, some may have irreversible damage.

個案分享-慢性便秘

陳秀娟姑娘　聯合醫院

珊珊生於一個中下家庭，與祖父母及一姊一弟七人同住一個中型公共屋邨單位。八歲的珊珊有輕度弱智及言語遲緩，故就讀於特殊學校，自少有哮喘病歷，現已受控制。

珊珊在五歲時，發現有遺大便的情況，她有習慣性便秘，約七至十日才排便一次，約六至七個月需入院作清洗腸道。

經過全面評估，發現珊珊問題如下：

1. 進水量極少，祖母怕小孩玩水，故家中的水瓶高置廚房吊櫃內。

2. 少食高纖食物，祖母不相信水果的價值，只覺得食生果是奢侈及浪費，珊珊在進食晚餐時不會主動要求進食蔬菜，高纖食物只在學校中午餐時可進食少量高纖食物。

3. 不良排便習慣，珊珊有弱智，未能有定時排便習慣。故大便有時因滿溢而失去控制。

4. 少活動，課餘時間多呆坐家中，不作適當活動。因祖父母要合力照顧其小弟，無人有閒看顧珊珊的活動。

祖父母有古老的思想，重男輕女，加上珊珊有弱智，故對珊珊的照顧有所疏忽。每次覆診皆由其外祖母負責。

針對珊珊的問題作出以下的建議：

1. 每日進水約一千五百毫升，外祖母買一水壺，讓她每日飲足夠的水量。

2. 每日進食一至二個水果，蔬菜量約四兩一餐。

3. 定時排便，每日定時坐廁所，如不能排便，隔日給予甘油劑，每日進食口服輕瀉劑。

4. 增加活動量，三歲後要活動約10分鐘。

經過六個月的訓練，珊珊已無需使用甘油劑，只服食輕瀉劑，她約三至四日需外婆提醒按時排便，已無弄污內褲的情況。

再過三個多月，珊珊約三日便自行如廁排便，無需進食輕瀉劑及入院作腸道清洗。

經過九個多月，多方面合作情況，慢性便秘也可解決了。

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International Children's Continence Society (2nd meeting)
International Urogynecologic Association (24th Annual meeting)

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