



NCCU CLINICAL GUIDELINES
SECTION: 13

SURGICAL CONDITIONS

Section: 13 Surgical Conditions
Bowel washout
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Neonatology Clinical Guidelines
King Edward Memorial/Princess Margaret Hospitals
Perth Western Australia

BOWEL WASHOUT

This procedure may be followed for rectal or stomal washouts.

Aim

1. To clean the distal portion of the bowel, decompress the bowel and deflate the abdomen by removing air and faeces. Bowel washout facilitates surgery and has been shown to prevent or reduce the risk of post operative enterocolitis and as such can be used as a mode of temporary management in proven cases of Hirschsprungs until definitive surgery.
2. This procedure is also performed to relieve low intestinal obstruction due to meconium plug, meconium ileus or intestinal dysmotility of prematurity.

This procedure must be ordered after review by either the Surgical team or the Neonatologist. Orders should be clearly documented and should include:

- Frequency
- Length catheter to be inserted
- Amount of saline to be used.
- Dose of Mucomyst if this is required

Equipment

- 20ml syringe & normal saline or solution ordered, warmed to body temperature.
- Rectal catheter size 8FG for < 2kg or 10FG for > 2kg
- Lubricant
- Catheter adaptor
- Kidney dish
- Chux / Gloves / Bluey

Procedure

1. Position infant on his / her back with legs in frog position on a clean nappy and bluey.
2. Prime catheter, lubricate tip of catheter and gently insert into rectum.
3. Instil saline 10 – 20mLs by pushing in with plunger over 1 – 2 minutes.
4. There should be no resistance while injecting the saline.
5. Remove syringe and let fluid run into nappy / kidney dish
6. Procedure may be repeated if return is not clear.
7. If there is saline retention inform medical staff
8. Remove catheter from rectum
9. Ensure infant is left clean and dry
10. Record results of bowel washout accurately on fluid balance chart.
11. Watch for signs of increasing abdominal distension, tenderness and any features suggestive of perforation.
12. In preterm infants there is a risk of re-absorption of saline especially if most of the solution is not expelled.

In the case of retention: Inform the medical staff & record the volume of saline retained.

