Clinical Practice Guideline
Guideline coverage includes NICU KEMH, NICU PCH and NETS WA

Bowel Washout

This document should be read in conjunction with the Disclaimer

This procedure is for bowel/rectal 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 postoperative 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 required.

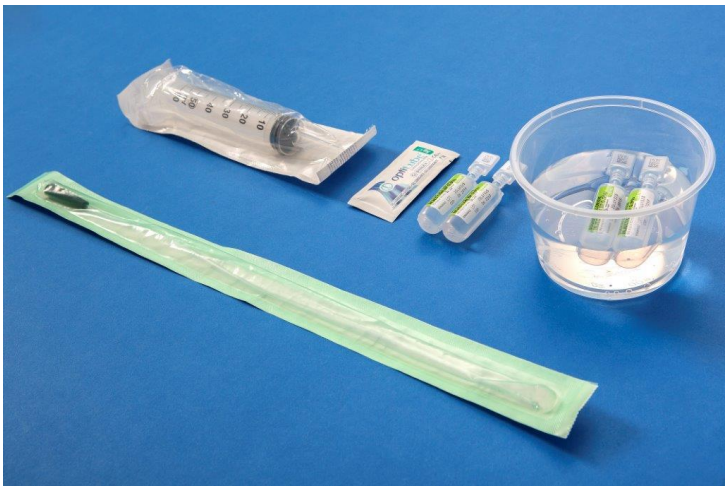
Equipment

- 50mL catheter tip syringe
- 100mL normal saline for irrigation
- Rectal catheter:
  - Term – 14FG or as directed by surgeon
  - Preterm – as directed by surgeon
- Lubricant
- Chux/Gloves/Bluey

Procedure

1. Position infant on his/her back with legs in lithotomy position on a clean nappy and bluey (as if changing a nappy).
2. Prime catheter, lubricate tip of catheter and gently insert into rectum at the length ordered.
3. Instil saline in aliquots/volumes of 20mL. Instil by pushing in the plunger gently. There should be no resistance while injecting the saline. Repeat up to a **maximum** of **100mL**, until the saline is clear of all faeces.
4. Remove syringe and let fluid/stool run into nappy.
5. If there is saline retention, notify medical staff and record the volume of saline retained.

6. Remove catheter from rectum and ensure infant is left clean and dry.
7. Record results of bowel washout accurately on fluid balance chart.
8. Watch for signs of increasing abdominal distension, tenderness, discolouration and any features suggestive of perforation.
9. In preterm infants there is a risk of re-absorption of saline especially if most of the solution is not expelled.



Document owner:	Neonatal Directorate Management Committee		
Author / Reviewer:	Neonatal Directorate Management Committee		
Date first issued:	June 2006		
Last reviewed:	15th December 2017	Next review date:	15th December 2020
Endorsed by:	Neonatal Directorate Management Committee	Date endorsed:	23rd January 2018
Standards Applicable:	NSQHS Standards: 1 Governance		
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