

PREVENTIVE ENEMAS FOR THE CONTROL OF FECAL INCONTINENCE©

by John Davis
August 2014

INTRODUCTION

As do many others, I suffer from moderate Fecal Incontinence (FI) (bowel incontinence) with severe chronic constipation which causes what is called overflow constipation or overflow diarrhea. This is a counter-intuitive malady because the underlying cause is constipation, but the resulting and very obvious symptom often is diarrhea. It is necessary to treat the constipation, rather than the diarrhea. If I do not take my enemas, I may have about 3 - 4 bowel accidents per week. Some of these occur during my morning exercise walks while others are scattered throughout the day.

It has been said that our doctors diagnose and treat our ailments but do not teach us how to live with them. This paper intends to do just that.

This paper discusses how preventive enemas have been so highly effective in controlling my own bowel incontinence. My use of enemas has permitted me to have a full and active social life, including international travel, without others becoming aware of my incontinence. For me, enemas are a safe, effective and doctor-approved means of controlling my FI and without any enema dependence.

“Preventive enemas” clear out the colon to prevent later fecal “accidents.” Unlike laxatives, enemas provide immediate and predictable results and always are effective. After the procedure there usually are no lingering side-effects. Motivated individuals usually tolerate the enema procedure well.

This paper results from extensive research I conducted to better understand and control my own incontinence. It strictly addresses the use of traditional bag enemas for the purpose of incontinence-related health and hygiene, and not for such unrelated purposes as fasting, general health, or as a fetish. This paper does not address the use of colonics or colon hydrotherapy, for which adequate information may be found on the Internet. In this paper I recommend a conservative approach to the use of enemas to control FI, based on published medical and nursing studies. Nota bene: the details in this article unavoidably may be TMI or offensive for some readers.

Much of what I have to say will apply to the many who are either Fecal Incontinent or double incontinent (both bowel and urinary incontinent). I have included some of the information below because it is not addressed in medical literature easily available to the layman or is difficult to find online in a single place. Much of the information falls into the category of enema “craft,” or procedures such as might have been found in a 1930’s, 1940’s, or 1950’s nursing manual, but is difficult to locate today. As most of this paper concerns low-level practical matters, rather than the practice of medicine per se, your doctor may not be aware of such patient-level details.

While this paper primarily is about enemas as a preventative for fecal incontinence, it

contains much practical detail that will be of value to those who are not bowel incontinent but suffer from severe constipation and are interested in information about administering a safe and comfortable enema to relieve their constipation. I do not address the use of enemas for bowel impaction, for which you absolutely must see a physician and quickly.

ORGANIZATION OF THIS PAPER

This paper is organized into the following sections:

- Introduction
- Organization of this Paper
- Fecal Incontinence
- Background
 - “Traditional” Enemas
 - Success with Enemas
 - Why I Use Enemas to Control My Incontinence
- Enemas to Control Fecal Incontinence
- 3-H’s – NOT!
- Equipment
 - Nozzles
 - Hose
 - Clamps
 - Bulb Syringe
- Retention
- Rinsing?
- Candlelight and Music
- The Enema Solution
 - Water Quality
 - Saline Solution
 - Water Temperature
 - Soap
 - Volume of Enema Solution
- The Comfortable Enema
- Simple Constipation?
- Location, Location, Location
- What to Wear?
- Best Body Positions to Take an Enema
- Discomfort
- “Go” Before you Begin
- Leaking
- “Clean” Colon?
- Saline Solution
- Lubrication
- How High to Hang the Bag?
- Practical Matters about Pressure and Flow
- Infusion (Filling)
- Cool or Cold Final Rinse
- Moving to the Toilet
- Expelling
- Stay Near a Toilet
- Late or Delayed Drainage
- Zone of Protection

Imodium
Number of Enemas
Daily Enemas?
Adapting to Enemas
Travel
Kegels
Cost
How Long Does It Take?
Cleaning Your Equipment
Electrolytes
Your Doctor and Enemas
Stigma
Enema Dependence?
Cautions
Diapers
Enemas for Those with Impaired Dexterity/Mobility
Discipline Required
Pro's and Con's of Enemas to Control FI
Recommended Equipment
Links to Vendors and Suppliers
Afterword
Final Caveat
Annex A – Pressure and Flow Rate
Annex B - Useful References

FECAL INCONTINENCE

When you were young, your parents probably told you that “life is not fair.” If you suffer from fecal incontinence you are sure to agree with that adage.

In addition to its disagreeable physical manifestations, FI can have an adverse impact on your emotional well-being. Severe FI cause sufferers to avoid leaving their homes and significantly impair their quality of life.

Partly due to the secrecy with which most people hide their fecal incontinence, there is disagreement as to the percent of the general population that suffers from FI. The Institute for Health and Clinical Excellence in 2007 estimated that 0.5-1% of adults experience regular bowel incontinence which impacts significantly on the quality of life. 10% of the population suffer bowel incontinence to a lesser degree. Another study found that 1.4 percent of the population have major fecal incontinence. Fecal incontinence is the second most common reason for nursing home admittance.

BACKGROUND

“TRADITIONAL” ENEMAS

Enemas are the oldest therapeutic device in the world. They date from before recorded history but were recorded by the Egyptians in 1500 b.c. and even earlier in India. The Greeks and Romans used a rudimentary form of syringe with a cylindrical barrel and a piston. On our continent, the Mayas of Central America and Mexico were knowledgeable of enemas and South American Indians invented a primitive form of the

rubber enema bag with a conical nozzle. From the 15th to the 17th century, the enema syringe was invented and developed in France.

Should you choose to do some research on your own, older names for an enema include “Enteroclysm” and “Clyster.” You may also search for “enemata.” The plural of enema is “enemata,” but I will use the more common term “enemas.”

“Traditional” enemas. When the word “enema” is mentioned today, most people automatically think of the pre-packaged bottles of Fleet’s enemas. Fleet’s enemas depend upon sodium phosphate chemicals to stimulate a bowel movement. Fleet’s chemical enemas are harsher to the body than bag enemas with saline water or soapy water. A Fleet’s enema will clear fecal material from the rectum and the lower portion of the Sigmoid colon (the portion nearest the rectum), but traditional enemas will clean much higher in the colon than will be cleaned by a Fleet’s.

In this paper I recommend old-fashioned or “traditional” enemas, containing a solution consisting of water, a little salt, and sometimes a small amount of mild soap, usually administered by means of a rubber bag or metal bucket, a hose, and a nozzle. The “traditional” enemas that I recommend contain no other chemicals. Although the frequency of occurrence is very small, more injuries have been reported as caused by Fleet’s enemas than by traditional bag enemas.

Before you react negatively to the unpleasant idea of taking enemas, ask yourself whether you want to 1) continue soiling yourself in public, 2) change messy diapers in a public restroom, or 3) restrict your activities and your quality of life because of your incontinence. Only you can decide whether the trade-off is worth it. I did. If you are willing to consider changing your lifestyle to the extent of using enemas, the information below will be of value to you.

SUCCESS WITH ENEMAS

The general public has a bias against enemas, probably because so many people have had a bad experience with an enema which was improperly administered by someone in a hurry or who did not know how to do it correctly. If you were sitting on a toilet they did not know how to do it properly!

Experiences with enemas are very personal and highly variable from individual to individual. The degree of success in controlling fecal incontinence involves such individual issues as rectal sensing, sphincter control, and transit time. Motivated individuals have more success with enemas - medical studies on the use of enemas to control bowel incontinence have demonstrated this.

Enemas are more easily accomplished with the help of an understanding significant other or a caregiver. However, they can be accomplished alone, as I describe below.

WHY I USE ENEMAS TO CONTROL MY INCONTINENCE

As have many others, I have been through the usual diagnostics, anal defecography, anal manometry, detailed digital anal mapping for nerve sensitivity, Kegel/trans-abdominal exercises, and rectal biofeedback training. Nothing which the medical community has been able to offer me so far has been anywhere as effective as the

careful use of enemas to aid in controlling the symptoms of my fecal incontinence.

On my own initiative, I began the use of enemas to control my fecal incontinence before I consulted with my primary care physician and, later, a series of specialists because, at first I was too embarrassed to talk about it - even with my doctor. My initial experience with the enemas was so positive that I later did discuss it with my physicians and, today, with the knowledge and approval of all three of my doctors, including my primary care physician (internal medicine), my primary gastroenterologist, and a gastroenterologist specializing in FI, I administer daily morning enemas to successfully control my bowel incontinence.

Through careful application of these cleansing enemas I have been able to attain a very high percentage of days on which I am pseudo-continent (approximately 94 - 97%), that is, I am able to control the symptoms, although not the underlying cause, of my incontinence. In addition to the physical benefits of using enemas to control my FI, I received a much-needed emotional boost from a marked reduction in anxiety caused by my concern about the possibility of having fecal accident, particularly during a close social situation.

I grew up in the southwest during the 1940's and 50's when the routine home use of enemas for digestive ailments was commonplace, and children often received a routine weekly Saturday night enema (then thought to aid general health). Accordingly, for me taking an enema is not as big a deal as it seems to be for many younger people. Actually, I was relieved to learn that they could play such an effective role in controlling my FI and so welcomed their use.

ENEMAS TO CONTROL FECAL INCONTINENCE

Enemas to control fecal incontinence, or FI, have been called preventive enemas, continence enemas, cleansing enemas, washout enemas, or clearing enemas. In medical literature about bowel incontinence, they often are referred to as reverse colonic irrigation (RCI), trans-anal irrigation (TAI), and anal irrigation. The term "reverse" indicates that the enema is administered via the anus, with the water flowing upward in the colon, rather than higher in the bowel via a stoma.

Preventive enemas are not quite the same as enemas for ordinary simple constipation as the objective is not only to clear out stool currently in the lower sigmoid colon and rectum, but also to remove other fecal matter higher in the colon that might result in an uncontrolled bowel movement later in the day or that evening. When the preventive enemas are highly effective, you will have fewer natural bowel movements - and fewer fecal accidents.

3-H's - NOT!

If you are older than a certain age, you probably have heard the phrase (and perhaps experienced the reality of) a 3H enema. The phrase translates to "High, Hot, and a Hellava lot." I would like to emphasize that a 3H enema is unpleasant and is not needed to control FI. The enema bag should not be hung high, the water temperature should not be hot, and the volume should not be a "hellava lot." More on this below.

The adjectives that should apply to a well-administered enema are "gentle" and

“soothing.” The entire experience should be gentle and as comfortable as possible. Standard saline water (salt water) enemas will be less harsh to your body than Fleet’s enemas or Bisacodyl laxative suppositories, while, at the same time, being more effective.

An enema is not a contest. There is no prize for greatest volume, most soap, longest retention, etc. Overdoing it usually is unnecessary and can be counterproductive or even dangerous.

Our objective is that your enema should be 1) safe, 2) comfortable, and 3) effective.

EQUIPMENT

The basic equipment for a traditional enema includes an enema bag or enema bucket, a hose with hose clamp, nozzle, enema soap, and salt.

THE BAG OR BUCKET

While small enemas may be administered with a bulb syringe, an enema bag is better suited for enemas of the volumes recommended for fecal incontinence, particularly if you are self-administering the enema. Although a drugstore-style combination hot water bottle/douche/enema bag can be used, a 2-quart open-top enema bag is much easier and quicker to refill. A bag with a thicker and wider reinforcement around the eyelet hole will enable to bag to last longer. The eyelet hole often is the weakest point of the bag and the point of failure. A good quality rubber bag should last for years, although the latex tubing may need to be replaced after two to four years. A somewhat thicker “S” hook is less likely to tear the eyelet hole. Tubing is inexpensive and readily available over the Internet. Nozzles are almost indestructible. Rubber enema bags occupy little space when empty and are easy to pack for travel.

For infrequent use or while traveling, disposable enema kits complete with bag, hose, nozzle, soap are convenient and inexpensive.

If you have an old-fashioned enema bucket with an attachment for the hose it will work fine. An enema bucket or can is durable and almost indestructible. It is easy to refill and easy to clean. The latex tubing is attached to an outlet on the bucket. An enema can usually is placed on a shelf or mounted on a wall.

I use a conventional open-top red rubber enema bag with 8’ of 5/16” diameter latex tubing, a roller-ramp style flow-control device mounted on the hose, a clamp, a check-valve, and an oversize nozzle. The 5/16” diameter hose (larger than on drugstore enema kits) is preferred, as it will accommodate a larger variety of nozzles available online from enema supply stores without requiring the use of an adapter. Additional tubing may be purchased separately over the Internet.

You will need towels or absorbent pads to lie on. One layer of towels may not be enough.

Plenty of paper towels also should be readily available to clean up any leaks, as well as disinfectant and plastic bags for disposal.

If a spouse, significant other, or caregiver is assisting you, you will want to have latex or vinyl gloves available for them. You may choose to wear them yourself.

A complete recommended equipment list may be found near the end of this paper.

NOZZLES

I distrust the safety of using the thin rectal pipe included with most enema sets as perforation of the intestinal wall has been reported in medical literature, although it is extremely rare. Many people find the standard douche nozzle, with its more rounded tip, to be safer and easier to retain than the thin rectal pipe. You may choose to use a short soft and flexible colon tube, which attaches to the end of the slender enema nozzle, but note that only a few inches need to be inserted.

Normally, it is not necessary, or even desirable, that the enema nozzle be large or of a long length. However, for those who need help, as I do, to retain the nozzle in the rectum (due to nerve damage), options are available. As I have poor sphincter control, I have to use a larger than usual "N-tip" or barium-style nozzle with a large flared bulbous head on the end in order to help me retain the nozzle and thus the enema solution. The thicker stem of the nozzle provides my sphincter with something to contract around, which makes retaining the water easier and reduces leaks. The large bulbous head (mine has a diameter of 1 1/4") serves as a plug against the internal sphincter [and yes, if you are wondering, I checked with my gastroenterologist regarding the use of this specific nozzle]. However, it is unlikely that you would need a nozzle of this diameter.

Only the head of the nozzle needs to be inserted past the sphincter, perhaps only a third of the overall length of the nozzle. If the head is inserted too deeply the desired plugging effect will not take place and you may leak. Be careful, inserting excessively large diameter nozzles (particularly those found on fetish equipment sites) may injure the muscles of the anus.

The use of a large plugging nozzle, plus a flow control device, frees you of the need to hold the enema nozzle in place and offers the benefit of hands-off operation. As I must use both hands to change positions and to stand up and get out of the bathtub or up from the floor when full of enema solution, for me this is essential.

When I am having cramps or am concerned about leaking on the floor, I leave my nozzle with its flared bulb tip inserted to act as a plug while I transfer from the bathtub or floor to the toilet (this is the reason for my longer hose). The nozzle is then removed or is expelled easily with the first enema returns and retrieved by the hose.

There also are inflatable nozzles that offer the advantage of a relatively slender nozzle for ease of insertion. After insertion an inflatable balloon-style cuff is inflated with air or water to keep the nozzle in the rectum until the cuff is deflated. This removes the need for the user to clinch his sphincter muscles to retain the enema solution. Nozzles with inflatable cuffs are effective in sealing off the anus for the purpose of retaining the enema solution. When the enema is complete, the nozzle is deflated and the enema is expelled. The private use of these nozzles is discouraged by some medical professionals who are concerned about injuries that could be caused by accidental over-inflation of the cuff. Check with your physician. These nozzles tend to be rather expensive.

If you are unable to retain a nozzle such as I have described, due to SCI or other medical issues, there are other options discussed near the end of this paper.

HOSE

A longer hose (tubing) (8 - 9 ft.) is highly recommended if you are going to take 3-position enemas as it permits more freedom of movement when in the tub or on the floor and turning from side to side. A longer hose also lets you retain the nozzle while transferring to the toilet.

You can buy extra hose from an enema supply house. Cut an appropriate length from your old hose. Connect the new hose to your enema bag. Connect the section of old hose to the end of the new hose. Use the end of the old hose for the nozzle. You may wish to use small plastic clamps to be sure that the hose will not come loose from the bag and that the old and new hose sections will not separate. I use a one-way check valve to connect the two sections.

CLAMPS

The standard hose pinch clamp is effective for releasing or stopping the flow of enema solution through the hose, but does not permit any fine adjustment of the flow. An inexpensive roller clamp flow control device, mounts onto the hose. It enables you to set your preferred rate of flow, and then forget about it. You continue to use the standard hose pinch clamp to start and stop the flow of the enema, but not to control the rate. A roller clamp flow control device is helpful when travelling and it is necessary to position the bag from a support that is higher than desired (creating more pressure). The flow control slows down rate with which the bag empties.

I recommend the use of a small inexpensive plastic clamp to prevent the hose from accidentally pulling off of the connector on the bottom of the enema bag. Should the hose come loose during the administration of an enema you will be faced with a dilemma. Clean enema solution will be running from the now hose-less enema bag while not-so-clean enema solution is running back out of your backside and onto the floor via the now disconnected hose and nozzle! You will find to your dismay that you cannot handle both leaking sources at the same time. I learned this lesson the hard way and hope you avoid doing the same. A nylon snap-grip enema hose and tube clamp is available for \$1.25 from the Optimal Health Network

BULB SYRINGE

If I need to take a small volume enema with a bulb syringe, I avoid cheap drugstore enema bulbs as I consider the usual thin, almost sharp, nozzle to be unsafe. Also, in some models the tip is not securely mounted onto the bulb. Once, while administering an enema with such a bulb, the tip popped off the bulb and into my rectum, a potentially dangerous situation.

I prefer to use the Stream Master enema bulb syringe that is very well made and should last for years. The nozzles screw safely and securely onto the bulb. The set comes with two nozzles, the tips of which both are blunt, rounded, and very safe to use. One nozzle has a considerably larger diameter. I have found it much easier to retain the water if I

use the larger diameter nozzle. The bulb and nozzle are easy to clean. The syringe is widely available online. I used Amazon.com.

RETENTION

It generally is recommended to retain a soapsuds enema (SSE) for a period of 5-15 minutes after infusion (this period often is stated as 5-10 minutes). A 15-minute retention time may be a goal, but it is not a requirement. Many people simply cannot retain a soapy solution for that long.

Should you retain an SSE for more than 10 minutes? That is a personal decision but generally is not necessary as the point of diminishing returns (pun intended) often will have been reached by that time.

If you cannot retain the solution for 10 or more minutes, just retain it for as long as you can and some benefit still will accrue. I do my best to retain the enema solution for a full 10 minutes, and less frequently for a little more, in order to achieve the most effective enema - but I am not always successful.

The ability to retain an enema for a specified period varies greatly between individuals based on such factors as the individual's experience with taking enemas, the volume and temperature of the solution, the amount of soap used, the position, and the nozzle. Some ignore the clock and instead try to wait until at least two waves of strong cramps have passed.

RINSING?

Following a soapsuds enema, a rinse is optional but highly recommended. A rinse particularly is recommended if a soapier solution has been used as it removes any remaining soap that could further irritate the colon and result in later cramps or possibly in an unexpected and embarrassing fecal discharge! If you take frequent or daily enemas a rinse is even more necessary.

After the first enema, subsequent ones usually will be much easier and quicker. For my rinse I often use the knee-chest position as the infusion is quick, the water runs downhill away from the anus, and it is easier for me to get out of my bathtub or off the floor from this position. I hang my bag just a little higher and adjust my ramp roller clamp to increase my rate of flow for the rinse.

Do you have to take more than one enema bag in a session? No, but, if you choose to take only one bag, first try using saline tap water only, with no soap.

Some prefer to add a little baking soda (sodium bicarbonate) to the final rinse enema, only one teaspoon per quart of enema solution. This small quantity of baking soda tends to reduce gas and bloating after the enema.

CANDLELIGHT AND MUSIC

Having selected a convenient time and place and having prepared the equipment and the environment for your enema, you have one last but very important task – to relax. It is difficult to take an enema comfortably when your body is tense. By relaxing, it will be

much easier for your colon to receive a safe and comfortable enema. To more easily relax, you should lock your door, turn off your cellphone, and let your family know not to disturb you. Many people light scented candles, play soothing music, or meditate while taking an enema. Allow plenty of time so that you will not feel rushed.

THE ENEMA SOLUTION

WATER QUALITY

Regarding the quality of the water for an enema, my recommendation is that you not use water that you would not be willing to drink. In most of the United States this will not be a problem. Remember, when you drink water it will be filtered through your stomach and kidneys. In contrast, the water you use for your enema will be absorbed by the colon and go directly into your blood stream. Some people use only filtered or distilled water for their enemas to avoid any chemicals in the tap water.

SALINE SOLUTION

To prevent excessive absorption of water by the colon, the enema should be an isotonic saline solution with 1 teaspoon (tsp.) of salt added per quart of water. Isotonic merely means that the water has the same salt content as your blood. Natural sea salt or kosher salt are preferred as they contain useful minerals but no iodine. Table salt sometimes contains undesirable chemicals. Too much salt is to be avoided as it will absorb water from the colon.

WATER TEMPERATURE

As warm water relaxes the colon, adjust the temperature of the enema solution to 103 degrees F to avoid cramps during infusion - use a water or scientific thermometer to check. If you do not have a water thermometer, test the water temperature by running it over the inside of your wrist (more sensitive than your hand) and be sure that it does not feel hot. If you fill the bag with water at three degrees higher than the desired temperature, e.g., 106 degrees F, it usually will cool to 103 F by the time you hang the bag, get into position, release the clamp, and begin taking the solution. At 103 degrees F you often may not even sense the water initially entering the rectum. Gradually you will feel a sensation of fullness, followed by an increasing sensation of pressure. Avoid high temperatures because solution at 115 degrees F can cause harm to the walls of the colon.

SOAP

Soap versus using no soap. The use of a small amount of very mild soap in the enema solution greatly increases the efficiency of an enema. The soap is not a cleansing agent, i.e., the soap does not wash or clean the colon in the conventional sense. Rather, mild soap irritates the lining of the colon to stimulate the peristalsis which moves the feces along the colon, resulting in defecation.

Too much soap may be counter-productive by stimulating such early and strong cramps that the enema must be expelled before it has had time to become most effective. Excessive amounts of soap are not necessary and are even undesirable as they can cause such irritation to the lining of the colon that it leads to chemical colitis. It is

important that those of us who must take frequent or daily enemas use the least amount of soap that still gives us effective results.

No-soap enemas consisting of only warm saline water may be sufficient for your needs. If you choose not to use soap, the enema still will be effective, but you can expect to see more solid stool in the returns from a second, or even a third, enema - in my experience, much more so than when used after a soapsuds enema. One advantage of the no-soap enema is that there is no need for the usual ten to fifteen minute holding time. It still may be helpful to hold a saline no-soap enema for a period from one to the traditional three minutes to allow the stool some time to loosen up.

Mild Castile soap traditionally has been used for enemas. Ivory soap once was popular but since has been reformulated. A small amount of Castile soap added to the enema solution not only mildly irritates the colon, prompting peristalsis, but also provides some lubrication both for stool and the walls of the colon. In my experience, an enema with Castile soap is at least 40% to 100% more effective than without. Soap makes an enema more effective, but also more difficult to retain.

Many pre-packaged hospital enemas contain a small packet of Castile soap. For home use it is recommended to add 1 teaspoon of mild liquid Castile soap per quart of saline water. Some prefer a slightly soapier solution, but your experience may vary. It is important not to overdo it.

Brands of Castile soaps safe for use in enemas include Dr. Bronner's, Kirk's, and Conti. I use Dr. Bronner's liquid peppermint Castile soap that usually can be found stocked at Whole Foods, Target, or Trader Joe's, or ordered in pints or quarts from Walgreens, REI, or from many other sources online. The peppermint oil in one of the Dr. Bronner's soaps imparts what I find to be a pleasant sensation and somewhat helps to deodorize the expelled returns. I recommend only the "plain," "Peppermint," or "Lavender" Dr. Bronner's Castile soaps. Note: do NOT use any soap with Eucalyptus for an enema as it contains harmful chemicals. Surprisingly, both Dr. Bronner's and Kirk's Castile soaps are available in bar form at Cracker Barrel restaurants. If used in bar form, dissolve about 1/10 of a bar in the warm saline tap water solution. While some other soaps can be used, they may be excessively irritating to the lining of the colon. Avoid detergents, liquid hand soaps, or soaps containing added lotions or perfumes.

VOLUME OF ENEMA SOLUTION

In deciding upon the volume of enema solution, or the number of enemas to take, first consider what your objective is, i.e., how many hours of protection against fecal incontinence do you need and how high a degree of confidence do you require?

Can you conveniently wait until later in the day to take your morning enema? If so, a lesser volume may be adequate.

Alternatively, are you willing to take a second (and usually smaller) enema later in the day and closer in time to an event for which you need more protection?

In the event of a bowel accident will toilet facilities be nearby and convenient to use?

Finally, will you be wearing a diaper (not everyone does)?

The volume of enema you can take on any given occasion depends in part on the amount of stool and gas in the colon. If you have difficulty taking the recommended volume of enema solution, begin by taking less until your body becomes more accustomed to the process. When first taking enemas your maximum capacity may be less than after you have gained more experience.

Some people, upon occasion, find their rectums to be so full of stool that it makes infusing the enema difficult. In that instance it helps first to infuse a smaller volume of enema solution, expel that with some stool, and then resume the enema procedure.

There is no need to take more volume than what is necessary for you, based on experimental trial and error. Begin with small volumes and increase the volume slowly and only as necessary.

How large an enema should you take? Specifically when used to control FI, some medical studies recommend a volume of as little as 500 ml (1 pint). Many recommend 750 ml (.8 quart) to 1 L (about a quart) and others recommend 1.5 L to 2 L (1.5 to 2 quarts) for adult males and a little less for females. In most medical literature that I have read the recommended volume of enema solution for adults with FI uses the standard formula of 20 ml (2/3 oz.) of solution per Kg (2.2 pounds) of body weight. In my case this conveniently works out to 1.9 liters, or 2 quarts, the size of most home-use enema bags. A 200-pound adult would take a 2-quart enema. Note that these volumes are larger than what is usually recommended for simple constipation.

Larger volumes of enema solution tend to stimulate more peristalsis and the hydraulic action of the greater amount of water flowing in the colon aids in the elimination of fecal matter. However, avoid unnecessarily large volumes of water.

While many adults are capable of taking an enema of greater volume, please note that more is not better - it is not necessary to completely fill the colon and that is not our objective. Trying to completely fill the colon may be both painful and even risky. You will be much more comfortable with a smaller volume and should use only what is necessary for you personally. The extremely large volume enemas claimed on some Internet sites are not necessary in the normal use of enemas for health and hygiene. Extremely large volumes without medical supervision can be dangerous and are to be avoided.

If you are taking an enema as preparation for a specific outing of only a few hours, a smaller and more comfortable enema should be quite adequate. You will need to experiment. When more protection is needed, my primary gastroenterologist told me that it would be o.k. for me to take another small enema before leaving the house later in the day, if I felt it was necessary. You should check with your own physician.

Until you learn to estimate accurately the amount of water you intend to use, it is helpful to have a container graduated in liters or quarts, and their fractions. One inexpensive container is a clear painter's plastic bucket available in quantities of 2 or 2 ½ quarts from almost any hardware store and marked in fractions of quarts and liters.

Never take an enema using a hose directly connected to a faucet. In that situation it is impossible to correctly control the rate and volume of the enema and you risk injuring or

even rupturing the colon.

THE COMFORTABLE ENEMA

For the many of us who are fecal incontinent and have impaired rectal/sphincter control, several things may help us to take an enema more comfortably. These include the location selected for the enema, the body position used, the temperature of the enema solution, the height of the bag above the anus, the rate of flow, the enema solution itself, and the choice of enema nozzle.

When first experimenting with enemas, you always should use "less" - that is, less volume, less soap, less height, and less retention time. If you use the maximum recommended parameters of volume, soap, holding time, and 3-positions for your very first enema you may be courting disaster - causing a very uncomfortable enema or completely losing control and causing a very messy cleanup.

SIMPLE CONSTIPATION?

If you are considering taking an enema to relieve simple constipation, and if enemas are safe for you to use, follow the above advice regarding "less." Use less volume, less or no soap, and less or no retention. A small 1 quart saline enema without soap, and with no holding time required, may be all that you need.

LOCATION, LOCATION, LOCATION

Obviously, you should select a warm and comfortable place for your enema. For some, their preferred place is on a bed covered with a rubber or plastic sheet and with plenty of towels or absorbent pads to catch leakage. It is easier to get up from a bed than from a bathtub or bathroom floor while holding an enema. However, before trying this, be sure that you have the necessary sphincter control to walk from the bed to the toilet while holding a 2-quart soapsuds enema and without having a major accident. Personally, I have never had the nerve to try this.

Because I often leak (and sometimes worse), during an enema, I sometimes choose to use a bathtub as my location, although many are not large enough to be completely comfortable. If using the bathtub, you may wish to place a towel behind your neck and shoulders so that you are not entirely lying on cold fiberglass.

I usually use the bathroom floor as it is relatively easy to clean up leaks and the toilet is nearby. If you use the bathroom floor for your enema, you will want to have towels, and absorbent pads available. I use ultra-large 36" x 36" absorbent pads capable of absorbing 40 oz. of liquid in case of a major leak, placed on top of a towel or bath mat for cushioning. Do note that any leaked soapy enema solution can make a tiled bathroom floor dangerously slippery.

If you choose to take your enema on the bed or bathroom floor and are concerned about those rare, but unpredictable, occasions when you just cannot make it to the toilet, you also may wish to have a bedpan or similar container within reach.

Bathtubs or shower stalls have convenient pipes from which an enema bag may be suspended. If you choose to take an enema on the bathroom floor or other location you

may need to use a door knob or provide a secure hook from which to suspend the enema bag. When a convenient hook is not available, some use an IV stand.

WHAT TO WEAR?

What to wear while taking an enema is completely a personal choice. Due to the possibility of soiling clothing by losing control during to an unexpectedly strong cramp I prefer to wear no clothing.

BEST BODY POSITIONS TO TAKE AN ENEMA

To reduce cramping and leaking, it is important not to fight gravity. It is difficult for anyone to take a full 2-qt enema while sitting on the toilet, as the water must fill the colon by moving upward, fighting gravity all the way. This not only will produce more discomfort and cramping, but, for those of us with little or no sphincter control, may be nearly impossible. While sitting on the toilet it will be even more difficult to hold the soapsuds enema for the 10 minute period.

It is most effective, and far more comfortable, to take an enema in either a horizontal i.e., supine (on your back,) or a “bottoms-up” knee-chest position.

Supine is the most relaxing, comfortable, and popular position for an enema. The position consists of lying on the back, usually with the knees bent to reduce the strain on the stomach muscles. It is easier to reach the nozzle in this position if the knees are bent. It is easier to maintain this position both during the enema and during the subsequent holding time. Most of the colon is approximately at the same level as the anus, so it is easy for the enema solution to flow through the colon. While in this position, raising your hips or legs slightly will take some of the water pressure off your anus and facilitate the flow of some water into the ascending colon. I find that this makes the position more comfortable.

A popular and helpful variation is the three-position enema. Medical studies on the efficiency of 3-position enemas as prep before barium enemas and X-rays, indicate that a properly administered 3-position enema can be equal to 3 or more regular enemas. To increase the effectiveness of any given volume of enema solution (I use 2-quarts), my first enema usually is a soapsuds enema (SSE) administered in 3-positions while lying in the bathtub or on the floor. If your physical and medical circumstances permit, begin on your left side with your legs bent in the traditional Sim's posture for approximately the first third of the enema, then roll onto your back for the second third, and finish the final third on your right side. This sequence reduces cramping and facilitates the flow of water first into your descending colon, then the transverse colon, and finally the ascending colon. Don't become obsessed about the positions. If you cannot comfortably assume the three positions, you should find just taking the entire enema while lying on your back, or either side, to be comfortable and effective.

For the most effective 3- position enema, after completing the fill while lying on your right side, remain on your right side for the first 2 minutes or so of your retention period. Then rotate from right to left sides, pausing for about 1 1/2 minutes for each side. This will cause the enema solution to flow back and forth in the colon, further loosening any stuck stool.

Knee-chest position - there are advantages and disadvantages to this position. As your rear is up and your head is down, the point of insertion of the enema nozzle, the anus, is elevated so that the enema solution flows downhill, away from the anus. In the absence of cramps, there normally will be little or no water pressure on the anus so that the receiver can completely relax the sphincter muscle. If you leak too much in a supine position you may leak less in a knee-chest position. A disadvantage is that some people find it difficult to maintain this position for an extended period. It can be difficult to keep the sphincter closed and resist strong spasms in this position and some say that the nozzle slips out more often in this position. It is more difficult in this position to reach the nozzle with a hand. Nonetheless many people prefer this position but you will need to experiment.

Should unusual circumstances require it (such as during travel), some find taking an enema in a standing position to be easier than when seated on the toilet. If seated or standing, the rate of flow of the enema solution should be slightly faster in order to complete the infusion and permit reasonable retention time before your sphincter muscles tire and you have to expel.

Remember, whenever possible, go horizontal or “bottoms up!”

DISCOMFORT

Do note that the sensations you experience during an enema, even though intense, are not necessarily equal to discomfort. It also is very important to distinguish between discomfort and pain. Some mild discomfort while taking an enema is normal for most people. You may experience this mild discomfort in the form of cramping, particularly during the period while you are retaining a soapy enema solution, but you never, ever should experience pain. If you do, stop immediately. When you feel full, quit – regardless of the volume taken. Listen to your body. Remember that normal peristalsis (cramping) is beneficial as it moves stool along the colon, exercises the colon and is good for the health of the colon.

“Pressure rises”. During a slow and otherwise comfortable infusion of the enema solution, you may feel an increase in pressure as the solution encounters a stool mass in the colon and builds up pressure until it distends the colon and finds a way around the blockage. Such an increase in pressure briefly can become uncomfortable, but usually lasts only for a few seconds. Once the enema begins to flow past the mass the pressure will drop to its former level. Although often referred to as “cramps,” such a pressure rise is not the same as the cramping associated with peristalsis.

“GO” BEFORE YOU BEGIN

Before beginning your enema, pause and try to have a bowel movement in order to eliminate any stool or gas low in the rectum before proceeding. It will make for a more comfortable enema. If you are taking frequent enemas to control FI it also will give healthy exercise to the rectal muscles.

LEAKING

It just happens.

Fortunately, most leaks during an enema will only be clear or slightly discolored water.

In my experience, the moments of greatest risk of leaking, or worse, is 1) when almost full with a 2-quart soapsuds enema, 2) when trying to retain the soapsuds enema for the latter part of the recommended 10 minutes, 3) when getting up from a supine position, and 4) when transferring to the toilet. If you are experiencing cramping, resist the temptation to get up and instead wait for a period between the waves of cramps before changing positions or moving to the toilet. Most cramps subside within 20 seconds.

“CLEAN” COLON?

The colon is not supposed to be “clean.” After the first enema is complete, the returns from the subsequent rinses usually will not be clear, but may range anywhere from slightly murky to dark brown. They should not contain any significant amount of solids (it is normal to have a few small solids).

As we are not trying to clean the colon (as for a colonoscopy), it is neither necessary nor even desirable to administer enemas until the returns are clear. That is not the objective - we need to maintain the healthy bacteria normally in the colon.

LUBRICATION

If you are new to enemas, apply a generous amount of lubrication to both the anus and the nozzle. As I take multiple enemas daily, I take extra care to avoid irritating the anus.

Avoid cross-contamination. After applying a lubricant to your anus, do not touch the tube or jar again. It is best to first place lubricant on a piece of gauze or tissue, or the back of your hand, and then transfer it from there to your anus or the enema nozzle.

The choice of lubricant is dictated by our choice of nozzle, the body position to be used for the enema, and how strong your sphincter muscles are. Some people who experience difficulties retaining the nozzle during the enema, find it helpful to use less lubrication or to lubricate only the nozzle and not both the nozzle and the anus. I have found this to be highly dependent upon the specific nozzle used, and the body position(s). If you do not have difficulty retaining the nozzle, lubricate both the anus and the nozzle.

As a lubricant, Vaseline or standard water-soluble KY surgical jelly (less expensive generic brands are fine) is quite satisfactory. Other water-soluble personal lubricants also will work. A disadvantage of KY is that it washes off of the nozzle relatively quickly once the enema has begun so that, if the nozzle pops out of your anus, it may require additional lubrication before reinsertion.

Regarding the use of Vaseline, as it is viscous it is easy to apply to the nozzle. Note that it is necessary to keep all petroleum-based lubricants away from the bag and hose, as they will cause the rubber to degrade. Vaseline will not harm plastic nozzles or silicon tubing and, because it is more viscous than KY, it often may last for several insertions. Some personal lubricants such as AstroGlide may be too slippery. If you have difficulty retaining the nozzle you may consider changing your lubrication to one that is less effective and lubricating only the nozzle.

Some prefer not to use petroleum-based lubricants and choose to use natural materials such as olive oil, coconut oil, or other vegetable oils. Some use the enema soap itself as a lubricant, but that is not recommended as it can be irritating to the anus.

HOW HIGH TO HANG THE BAG?

While there are safety concerns regarding positioning the enema bag too high, there is no minimum height so long as the water level in the bag is above the anus. As long as the water level is above the point of entry, the anus, it will flow into the colon, although perhaps too slowly. The lower the bag, and water level, the lower the pressure, the slower the flow, and the more gentle the enema.

Don't rush - keep it low and slow. Hang the bag low and take in the enema solution very slowly as this will avoid unnecessary cramping. Hanging the bag unnecessarily high will result in pressures that are not necessary, which may cause cramps, and even could be dangerous.

How high the bag should be hung is a matter of opinion - and your body. For the most comfort, the height of the bag ideally should be about **12" – 18"** above the anus to allow just enough pressure to go around minor obstructions of stool and reduce backflow. The maximum should be about 2 1/2'. Hanging the bag too low is not harmful, but there may be insufficient water pressure to enable the enema solution to flow around masses of stool in the colon.

Backflow - if the bag is hung too low, i.e., below the anus, the enema solution can flow back into the hose or even up to the bag. Similarly, if the bag is above the anus but hung very low (and the hose has not been clamped), the sharp rise in intestinal pressure caused by cramps can cause backflow of the enema - with waste material. The height of the bag is a compromise between the comfort of lower pressure from a low bag vice the insurance against backflow caused by the greater pressure from bag being hung higher.

After some experimentation to find your preferred height, it should not be necessary to raise or lower the height of the bag once the enema has begun. However, if the flow stops, you may need to raise the height of the bag. If you find the initial pressure to be uncomfortably high, simply stop and lower the bag.

(For a more technical discussion of Pressure and Flow Rate see Annex A.)

PRACTICAL MATTERS ABOUT PRESSURE AND FLOW

For the initial soapsuds enema, the chosen rate of flow should be sufficiently fast to permit the complete emptying of the bag and the desired period of retention before the onset of cramps makes the urge to expel irresistible.

During the administration of an enema, the water pressure of the solution coming out of the nozzle decreases markedly as the water empties out of the bag. When the bag is correctly positioned at a low height above the anus, i.e. 18", the water pressure during the second half of the enema becomes very low. I prefer to use bungee cords (shock cords) or a single short bungee cord with an 18" length of plastic chain to suspend the enema bag. A bungee cord, or combination of two or more cords, if properly selected for

length and strength, not only can be used to suspend the enema bag at the desired initial height above the anus but, during the administration of the enema, can maintain the water pressure at an almost constant level. As the water level in the bag goes down, the now lighter bag will be raised by the shock cord, keeping the water pressure on your anus almost constant. More flexibility in positioning the bag at a desired height may be attained by using a length of plastic chain. The spaces in the links of a plastic chain provide many attachment points from which you can hang the bag at the precise height desired. Plastic chain is available at many hardware stores, craft stores, or over the Internet.

As the water pressure from a bag mounted at the recommended height of 12 – 18” above the anus is quite low, during a very strong cramp it is possible to have backflow (reflux) of enema solution from your colon, up the hose, and possibly even into the bag. To avoid backflow, it is best not to drain all the water from the hose before clamping it. When the bag is empty, you may hear the gurgling or gulping sound or see the bag flatten or vibrate. Immediately clamp the hose to prevent backflow.

Should you experience backflow on a recurring basis, either slightly raise the height of the bag or install a backflow preventer (check valve), which may be ordered from an enema supply house online. One-way check valves are devices available to prevent this problem. They are small plastic devices, only a little thicker than 5/16” enema tubing. To attach the device it is necessary to cut the hose, usually near the nozzle end. You then insert the flanges of the check valve back into the two sections of the hose. With a check valve you should be able to hang an enema bag lower than otherwise would have been the case and still avoid backflow. One-way check valves are available for \$8-9 from Klystra.

INFUSION (FILLING)

Prior to administering the enema, it is important to let water run from the bag and through the hose and nozzle in order to purge any air in the line. Lock the clamp after purging the hose.

Infusion times. As my goal is to avoid cramping during the fill, for the first (soapy) enema I prefer a slow infusion time of 6-8 minutes for the 2 quarts. For the subsequent rinse, when the colon is empty, I prefer a faster fill, usually about 4 minutes, which will be comfortable and almost always without cramping.

Due to my 5/16” diameter hose and barium-style nozzle with large exit holes, my enema set has a fast flow rate. If the bag is positioned 2’ above the nozzle, and not inserted in the anus, it will empty itself in 1 minute 20 seconds - far too fast for a safe and comfortable enema. I therefore set my roller ramp-style flow control clamp to allow about 30% of the maximum flow, usually taking about 6 - 8 minutes, when inserted, to infuse a 2-quart bag, depending on my body position and fecal matter in the colon. The slow rate of fill is so comfortable that I almost never need to stop or change the flow once I have released the clamp. You will need to experiment to find the best setting for yourself.

Roller ramp clamps are available for about \$10 from Klystra.

Lock the hose clamp immediately once the bag is empty.

If the nozzle is left inserted to help act as a plug while transferring to the toilet, it is helpful to hold the hose near the nozzle. Hold the hose, not the nozzle, with one hand both to prevent pulling the nozzle from the anus as well as preventing the end of the hose from coming loose from the flange at the base of the nozzle. It usually is not necessary to hold the nozzle itself.

In contrast, if you are using a retention nozzle, which tends to remain in the rectum without being held, the clamp can be positioned further back from the anus in a more easily reachable position.

Plan for where you will put the nozzle after you withdraw it from your anus. Don't contaminate it by placing it on the bare floor as you may need to reinsert it for a second enema. Use the sink, a paper towel, or a washcloth.

COOL OR COLD FINAL RINSE

A cool or cold final rinse (second rinse) will not aid much in preventing fecal incontinence, but it can help avoid annoying, embarrassing, and much dreaded late drainage after the enema is over. This is an old nurse's trick.

It is helpful to make the final rinse of saline water cool or cold in temperature (never use ice water) - cool water is 65 to 85 degrees F; cold water is considered to have a temperature of 50 to 65 degrees F. I must emphasize that this final cool or cold rinse (a third enema), is totally optional as it primarily affects possible late drainage from the previous enemas rather than incontinence itself.

The cooler water stimulates the colon to contract and release any remaining water from the previous warm enemas - and very often additional waste. After the cool water is expelled, you then may feel warmer water remaining from the previous enema also being expelled.

The rate of fill for a cool water enema may be noticeably slower than with a warm water enema as the walls of the colon do not relax as they do with warmer water.

A cool or cold water enema can be smaller in volume than the primary soapsuds enema or the rinse – often 500 ml to 1.0 L (1 pint to 1 quart). The smaller volume may be infused by repeated insertions using a bulb syringe, if desired.

Excessively cold water is unnecessarily uncomfortable and very difficult to retain. As a cold water enema can produce almost immediate peristalsis with very strong results, no period of retention is necessary. By using this technique I was able to experience 180+ enemas sessions without any late drainage after leaving the bathroom. Your success may vary.

MOVING TO THE TOILET

If you are worried about losing control while getting up and moving to toilet, first change from your horizontal position into the knee-chest bottoms-up position and wait for 30 seconds. This lets much of the enema solution drain away from the anus and relieves the pressure. Then wait until sure you have a period with no cramps before getting up

and moving to toilet.

We want to keep the nozzle clean, particularly after the soapy enema as we will use it again for the rinse. Have a clean surface available on which to place the nozzle on when it is withdrawn from the rectum. A paper towel or washcloth will suffice. Wipe it clean before reuse.

EXPELLING

Do not strain to expel the enema solution. Straining is not necessary and increases the risk of hemorrhoids. If you encounter difficulty expelling the enema, it may help to get up and move around. I multitask by using the time to set up for the next enema or to clean equipment, and then return to the toilet to complete expelling.

If you think that you have not expelled all of the enema solution, what should you do? You have options. First, you can wait and nature eventually will have its way. Other options are to lie down to allow the solution to flow more easily to the anus. Massage your upper abdomen toward your left and then down toward your pelvis. Get up and walk around (but, of course, never far from the toilet). What you should not do is sit on the toilet for a prolonged period and strain to force the solution out.

STAY NEAR A TOILET

To avoid accidents due to possible late draining, it is advisable to remain near a toilet for a minimum of 15 minutes after an enema. If you shower and dress immediately following your enema, 15 minutes probably will have passed and a last attempt to expel any remaining returns is advisable at that time - before you put on your diaper. One probably should not leave the house, or enter into a social situation, for at least 45 minutes. Some sources recommend much longer.

LATE OR DELAYED DRAINAGE

Are you worried about the possibility of the dreaded late- or delayed drainage after your enema is over? There are two useful tricks you can use to avoid that problem.

- 1) A quick cold water flush (previously discussed)
- 2) Before finishing 3-position or other horizontal enema, turn onto your left side for one last time for about 1 - 1 1/2 minutes. This gives the enema time to drain from the ascending colon before you get up.

ZONE OF PROTECTION

This paper is all about controlling fecal incontinence. The big question is 'how long will an enema protect you against a fecal accident?' As our bodies are so different, it is very difficult to generalize, so I will speak about my own experience.

Protection from an enema (its effectiveness) depends greatly on the overall thoroughness of the enema procedure which itself is a function of the volume of enema solution used, its temperature, type and quantity of soap, retention period, flow rate, rinses, the body positions used, how easily your body receives the enema (relaxation,

etc.), and the time allowed for expelling.

After a thorough enema I may wait anywhere from 15 to 36 hours before having my next major natural bowel movement (many report 24 to 48 or more hours). Nevertheless, I can only count on having 6-7 hours with almost 100% guaranteed pseudo-continenence. My personal assessment of risk increases slightly at 8 hours, becomes moderate at 10 hours, and high at 12 hours. At 14 hours I do not count on having any protection at all as experience has shown that I frequently have stool in the rectum. Of course, this does not mean that I necessarily will have a fecal accident, but only that the risk becomes uncomfortably high for me personally. You will have to calibrate your own protection levels through trial and error. I always wear a good quality plastic-backed diaper with plastic pants, but it now has become my backup safety net and emotional security blanket, rather than my primary defense.

IMODIUM

If I know that I will be away from toilet facilities, or in a close social situation, more than 10 hours after my morning enema, I sometimes take a single 2 mg dose of Imodium for additional protection by slowing bowel activity. I do this with my doctor's approval, but reserve it for special situations and do not take Imodium daily. 2 mg of Imodium, in addition to my normal enema, will give me a high degree of confidence that I can remain pseudo-continent for at least 15 hours. In that amount of time I usually am back home at the end of the day. Check with your physician first.

NUMBER OF ENEMAS

Do you need a fourth enema? No, for our stated purpose you should not need a fourth enema. The smaller second rinse (the cool third enema) was purely optional and a fourth enema is neither necessary nor even desirable except on the advice of medical personnel.

DAILY ENEMAS?

Do you have to take enemas daily? No – it is your choice. You could reserve enemas only for those days with special activities when you need extra protection. If your intestinal tract has a slow transit time you may find an enema every other day to be sufficient to control your FI.

Should you find yourself in circumstances where a regular enema would be difficult, or at least inconvenient, a laxative suppository, or even a Fleet's enema, temporarily may better meet your needs. Of course, you also can choose to do nothing and just rely upon your diaper.

ADAPTING TO ENEMAS

To some extent, as your body adjusts over time to taking enemas, it will become easier both to infuse and retain the enema solution. The improved retention will make the enema itself more effective, which in turn will provide you with a longer period of protection against incontinence.

TRAVEL

The ability to successfully self-administer an enema in different body positions provides an enhanced ability to adapt to unusual situations while traveling, such as a small bathroom with no tub. I successfully made it through a 24-day cruise on a small ship with only a very cramped shower by taking my enemas in the knee-chest position. My rear was in the shower, to catch any leaks, while my upper body was outside the shower propped on a towel on the floor. I looked ridiculous, but it worked - and I stayed continent for the entire voyage!

To hang the enema bag at a convenient height, I use an "S" hook, one or two shock cords of different sizes, and a small length of plastic chain, so that I can adapt to almost any bathroom situation when I travel. If a bungee cord is not available, you may be able to use your S-hook and one or two clothes hangers to hang your bag from a shower fixture. A doorknob may work if you take your enema lying on the floor. Towel racks may work but note that some will not support the weight of the filled bag.

When traveling, it may be wise to take your enema in a bath tub as you probably do not have all the absorbent pads or the necessary cleanup items in the event of a major leak or total loss of control. It would not be good to use a hotel's beautiful white towels for a messy cleanup.

While traveling, if no bathtub is available, I use the shower and assume a knee-chest position with my head down and my rear sticking up in the air. My 9' long latex tubing permits me to move from the bathtub to the nearby toilet without removing the nozzle from the anus (in order to avoid leaks). Note that the purpose of the longer tubing is NOT to enable you to hang the bag higher.

During travel I slightly reduce the amount of soap used to avoid loss of control when getting up and moving to the toilet.

Regarding travel, if you rely upon enema equipment to control fecal incontinence, it will be necessary to take it in your carry-on baggage when you travel. If traveling on commercial aircraft with enema equipment in your carry-on bags, a signed note from your doctor on letterhead stationery may be helpful at security checkpoints, particularly for foreign travel. I have such a signed letter that explains the medical requirement both for the enema equipment and diapers.

On those occasions when an enema is impractical or even impossible, I sometimes use Bisacodyl laxative suppositories. They are predictable and usually act in 15 minutes to half an hour. Although bisacodyl is a strong and very quick-acting stimulant laxative and is excellent for ordinary constipation, it still is not nearly as effective as an enema. It may provide me with about 4 - 5 hours of protection, but I cannot count on more.

If I know that I will be unable to take an enema, I may slightly increase my dosage of Miralax (or its generic) ahead of time. Miralax acts as a stool softener that makes it easier to "go" without making you "go." In its recommended doses it is not like a laxative that causes you to experience sudden urgency.

A problem during travel can be the lack of enough time to dry out the enema bag. For this, I recommend that you use a 4- quart bag. The much larger neck on the 4-quart bag lets you insert your hand and a washcloth or paper towels to dry the inside of bag.

NOTE: I am not recommending that you take a 4-quart enema!

In a hotel or aboard a cruise ship, you may hide the bag (or at least keep it out of sight) by hanging it from loop inside a thick robe. Tie the belt and hang the robe, with the bag, in the back of the closet.

If you must pack only the essentials for travel – take the s-hook, soap, salt, and lube. You can skip the baking soda. You can use only one lube – probably Vaseline. You can skip the thermometer if you use only warm water. You also may skip the bungee cord if you use coat hangers to hang your bag at a safe height.

The careful administration of enemas, sometimes supplemented by small doses of Imodium, enabled me to participate in a lengthy vacation tour of Italy by motor coach. On some days, the motor coach did not have a toilet, which added considerably to my anxiety! That is an extreme example, but with proper planning, travel in such a close social situation can be possible, although it is a bit nerve wracking.

I have found vacation travel by cruise ship to be easier than ground travel, although more costly, despite the often very small bathrooms. I most recently completed a 32-day vacation trip beginning with several days in Istanbul, Turkey, followed by a 26-day cruise of the Mediterranean and trans-Atlantic back to Florida. Following the advice I have given above, I was totally continent for the entire trip - zero fecal accidents! That is a good track record for any one with bowel incontinence. I worked out in the fitness center on sea days and when in port I was fully active in taking long shore tours, often away from toilet facilities. Had I suffered an accident it would have been extremely embarrassing as I often had to use a shuttle bus or a ship's tender to return to the ship. The only concession I made to my incontinence was to avoid a few shore tours that would have kept me ashore more than 12 hours after my enema when my risk of an accident sharply increases. I even rode a camel in Morocco (diapers and all)!

KEGELS

Your physician or therapist probably told you to practice Kegel or trans-abdominal exercises - which you may have ignored. Kegel exercises are necessary both to enable you to better contain leaks and for the best efficiency of your enema. They strengthen your pelvic floor. If you have bowel incontinence you should be doing these for the rest of your life.

Several times a week, I practice both Kegel and TA (trans-abdominal) exercises to strengthen my sphincter muscles and my pelvic floor. I am pleased to report that, during months of practicing these admittedly boring exercises, I achieved some useful and visible benefits during my enemas – slowly I became better able to retain the nozzle, leaked less, was able to retain the soapsuds enema longer, and more frequently was able to make a “dry” transfer from the bathtub to the toilet. The end benefit was a longer period of protection. My morning enemas have become my “Kegel Olympics.”

If you begin Kegel exercises, you will see the results of your own efforts within a few weeks.

COST

For those with FI only, the cost of purchasing and maintaining ordinary enema equipment is minimal when compared to the cost of good quality diapers. My equipment, from an enema supply house, cost a total of about \$60, including the bag, hose, flow control, and oversize nozzle.

Drugstore combination hot water bottle/douche/enema kits may be purchased inexpensively – for about \$15 - \$20, but have short hoses, slim (almost sharp) rectal nozzles, and often leak. It is better to purchase slightly higher quality equipment for about \$50 - \$60 from an online specialty store.

The expense of Castile soap and lubricants annually may exceed the initial cost of the enema equipment, but will be defrayed by the savings from the diapers, latex or vinyl gloves, wipes, and lotion that are not used for changing messy diapers. As a generality, the average daily total of all costs for the enema series will roughly equal the cost of one cheap drugstore diaper.

HOW LONG DOES IT TAKE?

The total time required for enemas as part of my normal morning routine, including my shower, is about 80 minutes. This time includes the time necessary for setup, and cleaning and putting away enema equipment, cleaning the area, taking a shower and putting on a new diaper. The time required just for the typical two quart soapsuds enema (SSE) followed by a saline rinse is about 45 minutes (measured from first insertion of the nozzle to final expulsion).

My breakout of time is approximately: 15 minutes setup and prep + 45 minutes for two enemas and expelling + 5 cleanup = 65 minutes. I take a quick shower after my enema (as most do) and put on a diaper, requiring another 15 minutes. Total time: 80 minutes.

To save some time you could skip the second rinse enema. If really hard-pressed for time, you also could skip the soap and reduce the retention time. If you have a caregiver your times may be a little faster.

On a positive note, you will be saving some time which otherwise would be required either for normal bowel movements or to clean up from one, or more, messy diapers.

For convenience, I schedule my enemas for the early morning, after my exercise walk and immediately before my shower. This has become so routine that I give it little thought.

CLEANING YOUR EQUIPMENT

Because enemas to control FI are administered frequently, it is particularly important to carefully clean your enema equipment after each session. While holding the enema solution, if the hose clamp has not been shut, strong cramps can cause backflow in which the enema solution can go from your anus, back up the hose, and even into the bag. After each use, sniff the bag to determine whether any backflow may have reached that high.

For cleaning, first rinse the bag with hot tap water, then flush hot water through the bag, hose, and nozzle. If Vaseline was used to lubricate the nozzle, carefully wipe it off with a

paper towel.

Next, thoroughly soap the nozzle, hose, clamps, and the outside of the bag.

Then fill the bag with hot soapy water and flush the soapy water through the hose and nozzle. Let the bag, hose, and nozzle soak in hot soapy water for at least 20 minutes.

If there was backflow, you also may wish to soak the bag, hose, and nozzle in a bleach solution of one tablespoon of bleach (Chlorox) per quart of water.

After thoroughly rinsing the bag, hose, and nozzle with hot tap water, hang the bag upside down to air dry overnight. It will take more than one day to thoroughly dry the inside of the bag and hose. Pipe cleaners are very helpful in cleaning the exit holes of nozzles.

ELECTROLYTES

After my enema, shower, and getting dressed, I drink an electrolyte replacement beverage to better preserve my body's electrolyte balance.

YOUR DOCTOR AND ENEMAS

Do not be surprised if your doctor (particularly if a young GP) is relatively uninformed about traditional enemas - or even hostile to the idea. Although traditional enemas remain common in Europe, today they are outside the medical experience of many physicians in the U.S. who resort to the chemical Fleet's enemas for convenience and to save money or time.

STIGMA

Life is not fair. Unfortunately, just as there is a stigma associated with fecal incontinence and the wearing of adult diapers, there may be an even greater stigma associated with the chronic use of enemas. This is not a subject you will want to bring up in a public setting! Most people just cannot be expected to understand and often too much explaining is required. I must confess that I still am in the closet on this topic to all but closest family and doctors.

ENEMA DEPENDENCE?

Some have voiced concerns that the continued use of enemas will cause them to become enema-dependent. That is not correct. The often used, and usually misused, claim that the use of enemas necessarily will lead to "enema dependency" may be attributed to a misunderstanding of what can cause dependency on an artificial means of emptying the rectum and Sigmoid colon.

Dependency can occur when stool habitually, and over a protracted period, is removed from the rectum and lower Sigmoid colon without causing the distention of the rectum that triggers peristalsis. In the absence of defecation or other normal workout by peristalsis, the muscles of the colon can become dependent upon an artificial means of evacuation. "Enema dependency" can be caused by the chronic use of small mini-enemas, including Fleet's enemas, because they deny the muscles of the colon a

chance to exercise by normal peristalsis (cramps).

In contrast, if peristalsis is stimulated, the muscles of the colon will exercise normally. A standard bag enema will cause the distention of the colon and prompt the peristalsis needed to prevent enema dependency. With larger volume enemas the colon experiences healthy full body peristalsis with each enema.

Although I administer daily enemas, I usually have a bowel movement each morning, before the enema. After stopping the use of enemas you can expect to resume normal bowel movements within a couple of days. This is highly dependent on our individual digestive systems and diets.

CAUTIONS

Avoid fad enema solutions that you have not discussed with your doctor. They probably do not help with incontinence and some can be harmful.

Do not mix the use of laxatives and enemas on the same day, or dissolve laxatives in the enema solution, unless you first have checked with your doctor.

As previously discussed, unnecessarily large volumes of enema solution can be dangerous as well as hanging the enema bag unnecessarily high.

DIAPERS

If you are reading this paper, it is likely that you wear diapers. When my enema series is complete, although I am reasonably confident in the effectiveness of my protection, I always don my usual taped-on, plastic-backed diaper. If I am leaving the house I add a plastic or PUL diaper cover. To preclude my diaper tapes becoming unfastened, I am sufficiently confident in my level of protection that I reinforce the usual tapes with duct tape. The diaper is not going to come off until bedtime unless I have an unexpected and infrequent bowel accident.

ENEMAS FOR THOSE WITH IMPAIRED DEXTERITY/MOBILITY

If you have severe SCI, other problems affecting sphincter control, or mobility/agility issues, other options are available. With a doctor's prescription, Coloplast now markets in the U.S. their FDA-approved Peristeen portable rectal irrigation unit, which uses a bulb-style hand pump and tap water. This unit allows either self-administration of the enema or use by a caregiver. Although there are similarities between the Peristeen system and a bag enema, there also are marked differences. The Peristeen device is intended for use while seated on the toilet by someone with impaired mobility and manual dexterity. After insertion, a small cuff around the nozzle automatically inflates with water to help retain the nozzle in the rectum without the need to hold it in place. It is not a gravity-fed system. It relies on a small hand pump connected to the hose to infuse the enema solution. The unit is convenient in that it does not require being hung from a hook and may be set at bedside, on the toilet, or on the floor. The enema catheter (inflatable nozzle) is described as single-use, and the bag is good only for 15 uses, which may make the system's use more expensive. However, the equipment may be covered by your insurance.

Another option is the inexpensive cone enema system, usually a simple disposable unit, which employs a conventional gravity-fed bag with the hose ending in a cone-shaped nozzle. One hand is used to press the cone against the anus to maintain a seal so that the enema solution will not leak out. The system is frequently used with incontinent children. Cone enema sets are available from medical supply houses or on the Internet.

DISCIPLINE REQUIRED

The use of enemas for fecal incontinence is not for everyone. You have to decide that the benefits outweigh the inconvenience. Once the novelty wears off they soon become another chore for which a certain discipline is required. Admittedly, when you first wake up sleepy-eyed in the early morning, they are guaranteed to jump-start your day! Remember to consult your doctor, listen to your body, and be safe.

PRO'S AND CON'S OF ENEMAS TO CONTROL FI

In summary, below are what I view as the Pro's and Con's of using enemas to control fecal incontinence.

PROs – Enemas return to you some positive and personal control over your FI, and allow you to select a convenient time and place for their administration. Enemas help avoid the problems of public uncontrolled bowel incontinence, including messy diaper odor, having to stop and immediately change a messy diaper, and the problem of having to dispose of a messy diaper in public. You may find enemas to be less unpleasant than having to change messy diapers. If you are FI only, with enemas you should use fewer diapers than previously. The equipment can be relatively inexpensive and should last for a long time. The money saved from diapers not used should pay for the equipment, soap, lubricants, etc. Through the use of preventive enemas, those of us with FI can attain a higher degree of functional pseudo-continance. The effective use of enemas may encourage many to participate in activities that they previously avoided and enhance their confidence.

CONs – You will have to purchase the enema equipment. Many find the enema procedure to be unpleasant. Unfortunately, many with FI may find it difficult to take an effective enema. Mobility or SCI difficulties may make it impossible to take an enema without the assistance of a caregiver.

RECOMMENDED EQUIPMENT

My recommended equipment is:

- Enema bag
- Hose
- Nozzle
- Bulb enema syringe
- Absorbent pads or towels
- Lubricant (Vaseline, KY, etc.)
- Castile soap
- Sea salt
- Baking soda
- Latex or vinyl gloves
- “S” hook

Measuring teaspoon
Paper towels
Plastic bags for waste disposal
Disinfectant spray
Bleach (Chlorox)
Water thermometer (optional but highly recommended)
Roller ramp clamp (optional)
One-way check valve (optional)
Bungee cords (shock cords) (optional)
Plastic chain (optional)
Bucket, graduated in liters & quarts (optional)
Container/Bed pan for emergencies (optional)

LINKS TO VENDORS AND SOURCES OF ENEMA EQUIPMENT

Optimal Health Network - www.optimalhealthnetwork.com

Klystra – www.klystra.com

Google Shopper – www.google.com

Amazon – www.amazon.com

Coloplast -

http://www.coloplast.com/products/urologyandcontinencecare/peristeen/features_benefits/

AFTERWORD

I hope that this paper will be useful to the reader. Although more should be said on this topic, it would begin to wander away from our primary focus, which is the use of enemas to cope with FI.

My cup is half full. One of my gastroenterologists has said that I have done a good job of coping with my FI and have reached a point of balance where I probably should accept my current FI situation and leave well enough alone. As I have decided to do just that, it means that I may be taking preventive enemas for the rest of my life. As I am an optimist, I continue to plan for an active lifestyle, including long international trips.

FINAL CAVEAT

I have no medical training and offer no medical advice. The only advice that I offer is to discuss the use of enemas for fecal incontinence with your physician. You should check with your physician before attempting any use of enemas. Our bodies and personal medical situations vary greatly and I cannot allow for our special needs in this paper.

Best wishes to all.

John Davis (JDinVirginia)
(Revised August 2014)

©John Davis 2014. You are free to repost this paper online, or to pass it on to any

person or group who may have an interest in it. My only requirement is that its authorship be credited and that it be disseminated without changes

If you have questions or wish to provide useful feedback, please email me at [jdinvirginia \(at\) yahoo.com](mailto:jdinvirginia@yahoo.com).

ANNEX A

PRESSURE AND FLOW RATE

Many people confuse the water pressure of the enema with the flow rate. I will attempt to clarify that.

The **flow rate** is the volume of enema solution that passes through the hose and enters the rectum in a specific amount of time, e.g., 1 pint per minute. The flow rate of the enema solution will be determined by the water pressure and the total area of the cross-section of the most constraining aperture along the path to your anus (usually in the nozzle). The flow will continue until the pressure in the colon equals the pressure at the point of injection, the anus.

If the rate of flow through a standard enema hose is too fast, it may cause the enema to be uncomfortable but, by itself, is unlikely to be dangerous. For example, a high rate of flow from a bag hung low e.g. 12", will not cause a ruptured colon.

Pressure is the force that water exerts against your colon expressed here in pounds per square inch (psi). For enema safety, it should be emphasized that the most important parameter is water pressure in the colon. A bag hung extremely, and unnecessarily, high can cause pressure of such force that it can be dangerous to the colon, even though a small diameter hose restricts the rate of flow.

The water pressure is determined by one thing only - the height of the bag, or more exactly, the height of the water level in the bag above the anus.

What does not affect pressure? The diameter of the hose or nozzle has no effect on the pressure - only on the flow rate. Also the volume of solution in the bag, e.g. 1 pint or 2 quarts, has no effect on pressure (except as it causes the height of the water in the bag to be higher).

For an effective enema, there needs to be only enough water pressure to accomplish two things: 1) resist backflow from the colon and 2) enable the solution to distend the colon in order to flow past masses of stool.

[Note: the following on pressure may be TMI for many readers, but is included for those with an interest in more information.]

What is a desirable water pressure for an enema? Colonic pressure of approximately 1 psi will provide a comfortable enema. How much pressure is too much? Discomfort is likely to begin with a pressure of 2 psi. 3 psi is an absolute maximum pressure that must not be exceeded for safety!

Hydrostatic pressure is measured in terms of pounds per square inch (psi) or millimeters of mercury (mm Hg). Each vertical foot of a tube of fresh water will exert a pressure of 0.433 pounds per square inch (psi) - saline (salt water) is 0.44 psi, a negligible difference.

We can calculate the following approximate pressures resulting from hanging the bag at different heights above the anus:

2 ft - .9 psi
2 1/2' - 1.1 psi
3 ft - 1.3 psi
4 ft - 1.75 psi
4 1/2 ft - 2 psi
5.08 ft - 2.3 psi

As long as the water is flowing into your anus, the colonic pressure of the enema will not be as high as the pressure calculated from the height of the bag. The colonic pressure only reaches its calculated pressure when the flow stops. The final pressure in your colon will be determined by the final height of the water remaining in the bag or hose after the bag is empty or when you are completely full and stop taking in any more water. Blockages can increase the pressure, however, the pressure still will not be more than what is determined by the height of the bag.

ANNEX B

USEFUL REFERENCES

The Internet is useful for research on enemas, but I would encourage you first to look for data from medical and nursing publications and to exercise caution regarding much of the material found on many online sites. While there is useful information on fetish sites, misinformation also abounds. The documents below in Adobe Acrobat format (files ending in “.pdf”) require that you have an Adobe reader program installed on your computer. The free Adobe reader program may be downloaded from the URL below: <http://www.adobe.com/products/reader.html>

Below are URL links to some helpful medical publications regarding the use of enemas specifically to control incontinence:

“Managing Bowel Disorders with Rectal Irrigation”:
www.lowrectalcancer.com/PDF%20Files/Bm%20Enema%201a.pdf

“Anal plugs and retrograde colonic irrigation are helpful in fecal incontinence or constipation”:
<http://www.tkrcd.org.tr/files/bolum10.pdf>

“Exploring the Benefits of Anal Irrigation”:
<http://www.nursingtimes.net/Journals/2012/04/27/r/q/m/120501-PrRev-anal.pdf>

“Rectal Irrigation in the Management of Functional Bowel Disorders: A Review”
<http://nursingstandard.rcnpublishing.co.uk/archive/article-rectal-irrigation-for-patients-with-functional-bowel-disorders>

“Nonoperative Management of Fecal Incontinence”:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2780124/>

“Constipation and Fecal Incontinence”:
http://www.wfneurology.org/cache/downloads/em8a8s6vxu88w4o8cco4cco4c/Munsat_chapter3.pdf

“Outcome of Transanal Irrigation for Bowel Dysfunction in Patients With Spinal Cord Injury”:
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2607129/>

Some useful sites for enema equipment and supplies are:

Optimal Health Network:
<http://www.optimalhealthnetwork.com/Colon-Cleanse-Enema-Equipment-and-Accessories-s/4.htm>

Klystra:
<http://www.klystra.com>

The nozzle with the oversize tip that I use is the Barium 3 (\$9.00):

<http://www.klystra.com/store/enema-nozzles/tips/barium-3>

I have no relationship to the above vendors except as a customer.