Safe methods of suppository insertion and minimising discomfort of enemas

Medications administered via the rectum are absorbed through the rectal mucosa. Reasons for choosing this route include:

- Oral administration contraindicated because of obstruction or swallowing difficulty
- Medication irritates the stomach mucosa
- Severe nausea or vomiting
- Patient fasting
- Altered consciousness level
- Constipation.

Suppositories conventionally have been inserted pointed end first. However, proposed reasons for inserting blunt end first are:

- The external sphincter opens more easily when a large area is pressed against it.
- The suppository is more likely to be rejected with the blunt end pressing against the internal sphincter.

Manufacturers’ instructions should be consulted and the end to be inserted first should be lubricated with 5ml water-soluble lubricant. Using one finger, the suppository should be advanced 5cm past the anal sphincter to ensure that it reaches the rectum. If the patient has been given the suppository to relieve constipation he or she should retain it for 15-20 minutes. If it has been given for other reasons the patient is unlikely to feel the urge to expel it.

When giving enemas the air should be purged from the tube and the end lubricated with water-soluble lubricant. The tube should be gently inserted into the anus and advanced 10cm. The fluid should be administered by rolling up the tube. Reports of cramping or pain by the patient may indicate that the fluid is being administered too quickly. Warming the enema to body temperature in a bowl of water before installation may also help prevent discomfort.


Some simple steps to alleviate the discomfort of restless leg syndrome

Restless leg syndrome (RLS) is a common movement disorder that remains under-diagnosed and under-treated. It can affect people of any age but is more often seen in middle-aged and older people.

The neurological cause of RLS is unknown and no anatomical pathology has yet been linked to the condition. However, studies indicate changes in the neuronal excitability of the motor cortex in that the motor cortex is disinhibited. The key feature is akathisia – an uncontrolable urge to move the legs. This may be accompanied by deep pain, which may be perceived as throbbing, bubbling, a ‘creepy crawly’ sensation, or an itch with no evidence of rash or other skin disorder. Symptoms are worst at rest and relieved by movement. Sleep quality is poor and may be associated with jerking limb movements when asleep.

Around 40 per cent of patients have a family history of the condition and 25 per cent have iron deficiency anaemia. Other clinical associations include renal failure, diabetes and rheumatoid arthritis. RLS is worsened by caffeine or excessive alcohol consumption, and by medicines including antidepresants, beta blockers, antihistamines and anticonvulsants.

Drug therapy with a dopamine agonist, in doses much lower than that used to treat Parkinson’s disease, is needed in only 20-25 per cent of cases. Pergolide, ropinirole, pramipexole and cabergoline alleviate symptoms in most patients.


Creating opportunities for health professionals to combat ageism

Ageism has been described as the third great ‘ism’ following racism and sexism. But unlike racism and sexism, ageism has the potential to target everyone if they live long enough. Older adults are frequently labelled in negative ways, such as senile, sad, lonely, poor, sexless, dependent and disabled, and people are socialised into believing these labels are true.

Most of the participants in this study reported that they had been told a joke or sent a birthday card poking fun at older people. Many also said they had been ignored or ‘talked down to’ because of their age.

The authors hope that using surveys to highlight the extent of ageism in local areas will help health professionals to play a major role in combating it.


Multidisciplinary team approach helps patients awaiting hip replacement

Although this randomised controlled trial lacked sufficient numbers of participants...
from which to draw strong conclusions, and would have been improved by use of the the Harris or Oxford Hip Score, this article does provide descriptive data from the intervention of introducing a multidisciplinary team approach to improve the quality of life of patients awaiting hip replacement.

The introduction of occupational and physiotherapy services into the pre-operative assessment clinic helped determine post surgery requirements. Physiotherapy can offer strengthening and gait training while waiting for surgery so that excess strain is not placed on unaffected joints. An occupational therapist can advise on correct use of aids while nurses can recommend pain control and identify other medical conditions.


Appropriate assessment of wounds determines care and treatment

Deep pressure sores are regarded as cavity wounds because they extend deep into the tissues and are chronic. Such wounds will heal by secondary intention because of tissue loss meaning the sides cannot be brought together with closure materials such as sutures, staples, clips or tissue adhesive. All wounds heal in three stages:

- The immune response which begins clearance of debris and bacteria
- Growth and migration of new cells to replace lost tissue with granulation tissue
- Deposition and refinement of extracellular matrix which strengthens over time to form scar tissue.

Wound assessment should include:
- Size, shape and depth
- Type of tissue in the wound bed
- Type and amount of exudates
- Signs of infection such as heat, erythema (redness), pain, pus.

Slough or necrotic tissue increases risk of infection by restricting white cells. An infected wound is managed with systemic antibiotics, removal of necrotic tissue and good nutrition and hydration. A moist wound environment aids proliferation and migration of cells, but too much moisture may displace cells and damage surrounding skin.

Cavity wound management products include absorbent foams, alginates (seaweed) and hydrofibre dressings in forms of ribbons or fillers. Secondary dressings are needed to retain the primary dressing and frequency of change is dictated by the level of exudates. It is vital to protect surrounding skin. Many dressings include silver to treat infection.


PEG does not help the appetite of end-stage patients with dementia

Some patients with end-stage dementia cannot or will not eat. One reason for this may be neurological dysphagia with an inability to co-ordinate the muscles involved in swallowing. Alternatively, it could be because the patient no longer recognises or understands what food is or how to eat it.

Percutaneous endoscopic gastrostomy (PEG) involves the placing of a tube allowing direct access to the stomach so bypassing the oropharyngeal tract. This article describes a study of nursing home residents and compares those who were given PEG with others of similar cognitive impairment status who were not referred for tube feeding. Follow up for two years showed that survival did not differ between the two groups.

The authors suggest that the failure to demonstrate a significant improvement in survival may reflect the fact that the loss of the ability to eat is associated with end-stage dementia, and that neurological dysphagia is a pre-terminal event.

A number of strategies exist that may help people with dementia to eat. These include music and touching. It may also be helpful to discontinue certain medications such as anticholinergics, which may be used for incontinence but can also give the patient a dry mouth and impair eating.

The decision to place people with advanced dementia on PEG feeding needs to be made with caution. The authors describe a specially devised referral form, careful discussion with family so they are able to make an informed decision and a one week ‘cooling off’ period between referral and PEG insertion.


Diagnosing vision impairment before the onset of adverse effects

As we age we experience natural changes in the structure of our eyes with drooping lids, changes in colour perception and difficulty adjusting to light. The prevalence of ocular diseases such as glaucoma, cataracts, wounds retinopathy and macular degeneration also increase with age. Despite its inevitable and common occurrence, vision impairment is often undiagnosed and untreated. This could lead to adverse effects such as falls, medication non-compliance and general accidents.

The Snellen chart, which consists of rows of black letters on a white background, is the standard eye test but it is not always suitable for older people. It can be challenging for those who are dysphasic, deaf, illiterate or confused. The test is normally taken in well lit conditions and uses high contrast, but visual impairment for older people is greater in reduced light and contrast.


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