

PATIENT GUIDE

The Use, Care and Management of Your Short-Term and Chait Cecostomy Catheters



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About this Patient Guide

This patient guide has been provided by Cook Medical to help patients and caregivers understand fecal incontinence. It provides basic information about the placement, use, and care of Cook Medical's cecostomy catheters.

The treatment of fecal incontinence may vary according to specific situations and the physician's assessment. As with any surgical or medical procedure, **the best source for information and advice is your physician.**

Refer to the glossary at the end of this booklet for help in understanding the terms used throughout this guide. These terms can be found in **bold** the first time they appear.

We hope this information will be helpful to you and your loved ones.

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Introduction

What is fecal incontinence?

Fecal incontinence is the loss of normal control of the bowels. This leads to **stool** leaking from the **rectum** at unexpected times. This condition is often caused by an underlying medical condition for which treatments are often available.

Fecal incontinence is a socially uncomfortable disorder that affects tens of millions of people globally. Many people with fecal incontinence are hesitant to discuss the issue.

Causes

What causes fecal incontinence?

People of all ages suffer from fecal incontinence. It may result from one or more of the following:

Constipation

Constipation is a condition in which a person has fewer than three bowel movements a week. Constipation can cause large, hard stools to get stuck in the rectum. Watery stool collects behind the hard stool and may then leak out around the hard stool. Constipation can also stretch and weaken the **anal sphincter muscles** over time, which reduces the rectum's ability to contain the stool.

Diarrhea

Loose stools fill the rectum quickly and are more difficult to contain than solid stools.

Loss of elasticity in the rectum

Usually the rectum expands to hold stool until a person has a bowel movement. Radiation treatment, rectal surgery and inflammatory bowel diseases, such as **ulcerative colitis** and **Crohn's disease**, can cause scarring that hardens the rectal walls, reducing the rectum's ability to expand.

Nerve damage

If the nerves that control the anal sphincter are damaged, the muscles that they control won't contract and expand properly. Also, if the nerves that sense stool in the rectum are damaged, a person may not feel the urge for a bowel movement. Giving birth, repeatedly straining to pass stool, spinal cord injuries, strokes, and diseases or birth defects that affect the nerves (such as multiple sclerosis or spina bifida) can all cause nerve damage.

Muscle damage

When the external or internal anal sphincter muscles are weakened or damaged, they may not be strong enough to keep the anus closed, which can cause stool leakage. Trauma and previous surgeries on the anus or rectum can cause injury to the sphincter muscles.

Treatment

How is fecal incontinence treated?

Successful treatment of fecal incontinence addresses the underlying problem. Treatment could include one or more of the following options.

Diet and nutrition

The type of food affects how quickly stool passes through the digestive system and stool consistency. Foods and drinks that contain caffeine, such as coffee, tea and chocolate, may worsen fecal incontinence by relaxing the internal anal sphincter muscles.

▶ Note

Dietary changes that may improve fecal incontinence include eating the correct amount of fiber and drinking plenty of liquids.

Bowel management program

Bowel management programs combine medication, enemas and/or bowel training to control fecal incontinence.

Medication

Medication may be prescribed to control diarrhea or constipation.

Enemas

Enemas are used to flush fecal contents out of the large intestines. They can be administered via an antegrade or retrograde method.

Antegrade enemas are routines in which liquids are introduced via a **catheter** through a tract that has been created in the abdominal wall leading into the intestines. The liquid then travels through the intestine and exits through the anus.

Retrograde enemas are routines in which liquids are introduced into the rectum and colon via the anus in order to flush the large intestines of fecal contents.

Bowel training

Bowel training involves attempting to have bowel movements at specific times of the day. The body, over time, becomes used to the regular bowel movement pattern, reducing constipation. Achieving a regular bowel pattern can take weeks to months.

Surgery

Surgery may be an option for fecal incontinence if other treatments fail or if the fecal incontinence is caused by injuries to the anal sphincter or pelvic floor.

Electrical stimulation

Electrical stimulation involves placing electrodes in the anal canal and rectal nerves, stimulating the nerves continuously with electrical pulses.

What is a cecostomy procedure?

A **cecostomy** procedure is a procedure in which your physician creates an open tract, called a cecostomy, from the abdominal wall to the intestines for the purpose of providing enemas or other treatments.

A direct, or **percutaneous** (meaning “through the skin”) cecostomy allows a catheter to be placed through a tract that leads from the abdomen directly into the **cecum**. The catheter is then used to allow access for **ACE routines**.

A Malone Procedure is a cecostomy procedure in which the appendix is connected to the abdominal wall in order to form the tract, often through the belly button. This is also referred to as an **appendicostomy**. ACE routines that are performed through this type of tract are commonly called MACE routines.

The ACE routine is a common type of antegrade enema (described under “Enemas” on page 8) during which liquids are introduced via a catheter through a tract that has been created in the abdominal wall leading to the intestines. The liquid then travels through the intestine and exits through the anus.

▶ **Note**

Throughout this booklet the ACE procedure is often referred to as your “enema routine.”

Cecostomy Catheters for an Enema Routine

Who should receive a cecostomy catheter for an enema routine?

You may be a candidate for a cecostomy catheter-based enema routine if you:

- Experience fecal incontinence with troublesome soiling.
- Don't respond well to rectal enemas or other bowel management programs.

You may not be a candidate for a cecostomy catheter-based enema routine if you:

- Have had previous abdominal surgical procedures.
- Have a disease that affects blood clotting.
- Have known medical problems that could pose risks during the procedure or sedation.
- Have excessive soft tissue between the skin surface and the cecum.

What are the benefits of receiving a cecostomy catheter?

A cecostomy catheter-based enema routine makes bowel management simple, effective and easy to perform independently. Patients may become more socially active, independent and confident after receiving a cecostomy catheter for their enema routine. Ultimately, the decision to receive a cecostomy catheter for an enema routine is between you and your physician.

What is a Chait Cecostomy Catheter?

Cook Medical offers a low-profile catheter, known as the Chait Percutaneous Cecostomy Catheter, that allows the patient to perform their enema routine. This catheter is referred to throughout this booklet simply as the Chait.

The Chait catheter is a soft, flexible, low-profile plastic tube that is inserted into the patient's cecum through the open tract of a cecostomy in the lower right part of the abdomen.

A short-term standard profile catheter is often placed into the tract for a period of time before the Chait is inserted. The time allows the cecostomy tract to develop before the Chait catheter is inserted (Figures 1a and 1b).

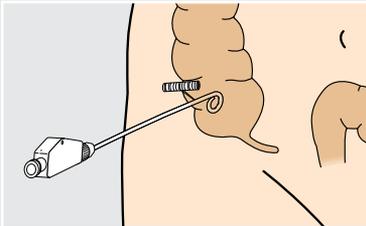


Figure 1a – Short-term standard profile catheter

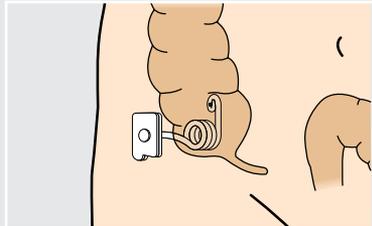


Figure 1b – Chait Cecostomy Catheter

Once placed, the Chait remains in the cecum and provides a comfortable, convenient way to cleanse the bowels via an enema routine. The enema is given through the Chait and exits the body through the anal opening along with the bowel contents.

Emptying the colon in this regular, predictable way gives individuals more control over their bowels and helps prevent unexpected soiling, allowing one to become more independent, socially active and confident.

How is the Chait Cecostomy Catheter inserted?

The placement of the Chait typically involves two separate procedures that take place about six weeks apart. The procedure for placing the Chait may vary based on physician preference and patient assessment. Please discuss specific procedural approaches with your physician.

Procedure #1: Initial placement of a short-term standard profile catheter

The physician inserts a short-term catheter through the newly established tract of a cecostomy into the cecum. Approximately 3-4 inches of the catheter remains outside the body and is fastened to the skin with tape or a bandage (*Figure 2*).

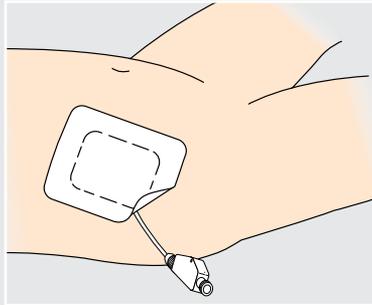


Figure 2

Procedure #2: Chait catheter placement

After the temporary catheter has established a clear tract into the abdomen—about six weeks after the first procedure, or when the physician determines the tract is mature—the short-term catheter is replaced with a long-term Chait, which has a far lower profile and is less visible than the short-term catheter.

The Chait features a small, soft access Trapdoor™ port that lies flat against the skin. A hinged cap opens for access to the internal part of the catheter (*Figures 3a and 3b*).

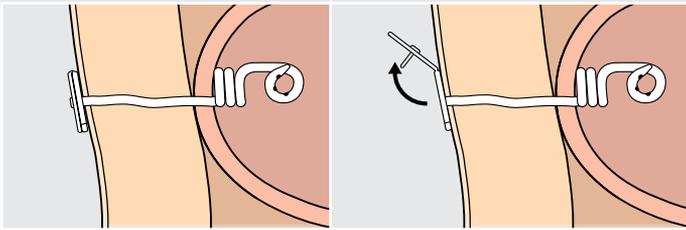


Figure 3a

Figure 3b

When the Trapdoor is closed, the Chait can be worn under clothing (even under a bathing suit) without a large, noticeable bulge.

Procedures 1 and 2 are described in more detail beginning on pages 20 and 38, respectively.

The Short-Term Standard Profile Catheter

Procedure #1: Placement of a short-term catheter

Two days before the short-term catheter insertion, the patient is typically put on a clear liquid diet.

The night before admission to the hospital, the patient takes a special bowel medication to completely empty the colon.

On the morning of the procedure, the patient is admitted to the hospital and given intravenous antibiotics. This is done to help prevent any infections related to the insertion procedure.

In some cases, an anesthetic cream is applied to the patient's right lower abdomen approximately two hours before the procedure in order to numb the skin.

Immediately before the procedure, the patient may be sedated, and the physician may also inject a local anesthetic into the abdominal wall.

The physician uses a needle to create a tract between the skin and the bowel. Then a catheter is inserted through this tract into the cecum (the first part of the large bowel, as shown in *Figure 4*, below). The external part of the catheter is secured in position on the patient's abdomen.

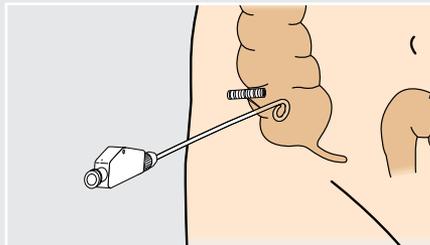


Figure 4 – Short-term standard profile catheter

Once the catheter is in place, it is flushed with a saline or another solution chosen by the physician.

The entire procedure normally takes 30–45 minutes. The patient remains in the hospital until the physician determines the patient is stable and able to be discharged.

Possible complications with the short-term catheter

The short-term catheter insertion is usually free of complications, but the following complications are possible and should be discussed with your physician:

- Discomfort around the catheter site.
- Minor skin irritations.
- Infection around the catheter or within the abdomen.
- Fever and nausea.
- Granulation tissue (a build-up of harmless, red, raised tissue where the catheter enters the body).
- Dislodgment of the short-term catheter.

If any of these complications are observed, refer to the Troubleshooting chart on page 50 of this guide.

Leaving the hospital

Before you are discharged from the hospital, a nurse will tell you how to:

- Change the dressing.
- Recognize and troubleshoot problems, along with the actions that should be taken if the catheter falls out of the cecostomy tract.
- Flush the short-term catheter with saline solution.
- Administer enemas as part of your enema routine.

▶ **Note**

It is very important to understand and follow the care instructions and take any medications exactly as prescribed.

It is also important to communicate regularly with your nurse or physician to establish an enema routine that works.

Catheter care and use

The short-term catheter will be in place for about six weeks. During that time, there are a few simple ways to care for the short-term catheter.

General guidelines

1. Flush the short-term catheter with 10 mL of warm tap water twice every day for the first week, using a 10 mL syringe. (See page 30 for detailed instructions on how to flush the short-term catheter.)
2. After you are discharged from the hospital, continue a regular bowel routine or **rectal enema** every other day for the first week. After about one week, begin an enema routine through the short-term catheter.
3. Always keep the short-term catheter site clean and the catheter taped to the skin.
4. Ensure a diet with plenty of fiber and water to keep stool soft and to prevent constipation. The best source of information about diet and bowel control will always be your physician or nurse.

Foods You Can Eat	Foods to Avoid
Wheat or Bran	Bananas
Breads	Cheese
Cereals	Rice
Raw Fruits	Yogurt
Vegetables	Peanut Butter
Beans	Apple Juice
Popcorn	Applesauce
	Milk Products
	White Bread

5. Be careful not to pull the short-term catheter out. This is especially important during the first six weeks, because the catheter is establishing a clear passage through the abdomen to the stomach.

If the short-term catheter falls out, go to the Troubleshooting chart on page 50 and contact your physician or nurse immediately to arrange to have the short-term catheter re-inserted.

Bathing precautions

During the first two weeks after the short-term catheter has been inserted, avoid taking a bath. Showering may be permitted with physician approval. It is important to change the dressing immediately after showering. After two weeks, it should be possible to bathe, shower and even swim. Your physician may suggest covering the catheter and access site completely with a waterproof dressing to keep water out.

Cleaning and caring for the exit site

The dressing should initially be changed twice a day (morning and night).

In addition to routine changes, the dressing should be changed promptly if any of these are experienced:

- Moisture under the dressing.
- A loose dressing.
- A wet or soiled dressing.

Removing the dressing

1. Gather the supplies recommended by your physician for cleaning the **exit site** and applying a new dressing, such as:
 - Sterile 2 x 2 inch gauze pads
 - Bandaging tape
 - Antibiotic cream
 - Soap and water
 - Scissors
2. Wash your hands well with soap and water and dry thoroughly.
3. Carefully remove the old dressing, making sure not to pull on the short-term catheter when removing the tape (*Figure 5*).

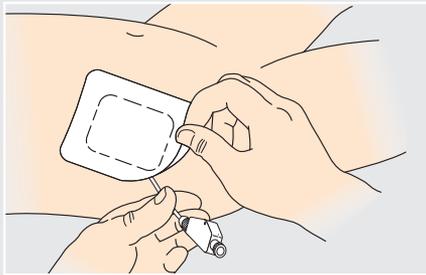


Figure 5

► Note

Never use scissors near the short-term catheter or to remove the dressing in order to avoid the risk of damaging the catheter.

4. Inspect the exit site and the area around the short-term catheter. Look for redness, swelling, pain, discharge or loose sutures. If any of these are present, notify your physician immediately.

▶ **Caution**

Your physician has wrapped your sutures in a roll of gauze near the catheter. The roll of gauze should not be removed or changed. If the sutures become free from the roll of gauze, re-roll them in new gauze and secure to skin with surgical tape, then notify your physician.

Cleaning the exit site

1. Wash your hands again.
2. Carefully clean the exit site with soap and water using clean cotton swabs or a washcloth. Clean around the exit site using a circular motion, working outward from the center (*Figure 6*).

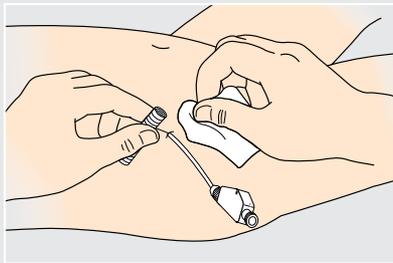


Figure 6

3. Wipe again with wet cotton balls or a washcloth to remove the soap and then pat dry.

Applying a clean dressing

1. For the first two weeks, apply a thin layer of antibiotic cream over the short-term catheter exit site.
2. Cut a slit into a gauze pad as shown (Figure 7).

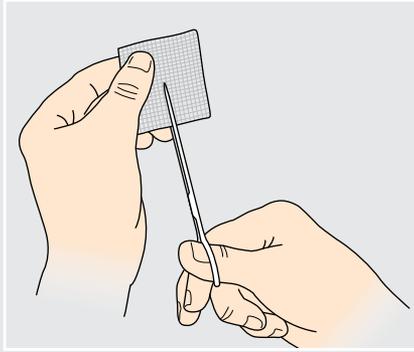


Figure 7

3. Slide the cut piece of gauze pad around the catheter and under the rolled gauze and suture (Figure 8).

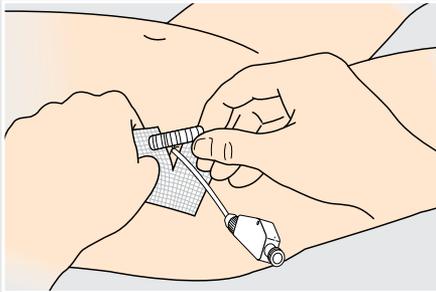


Figure 8

4. Cut a second piece of gauze pad as before and apply around the catheter exit site and over the rolled suture gauze (*Figure 9*).

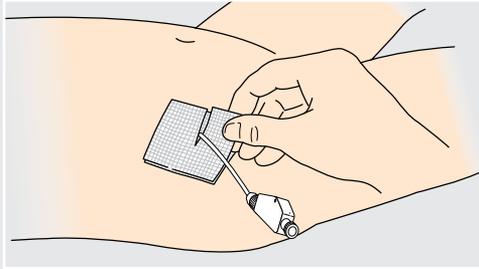


Figure 9

5. Apply adhesive dressing or bandaging tape over the gauze pads to secure them in place (*Figure 10*).

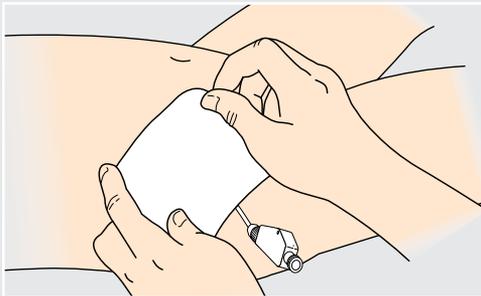


Figure 10

Catheter maintenance

Flushing the short-term catheter

Flushing the catheter with water helps keep it clear and open.

For the first two weeks after the short-term catheter has been inserted, flush the short-term catheter twice each day with 10 mL of saline. Flushing is no longer necessary once the enema routine has begun.

1. Gather supplies recommended by your physician, such as:
 - 10 mL syringe
 - Physician-recommended liquid
2. Wash your hands with soap and water before beginning.
3. Fill the syringe with 10 mL of physician-approved solution or liquid.
4. Remove the cap from the end of the short-term catheter.
5. Insert the tip of the syringe into the end of the short-term catheter and turn (*Figure 11*).

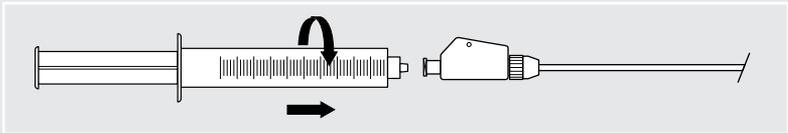


Figure 11

6. Slowly inject the liquid into the short-term catheter. The liquid should go in without any resistance.

▶ **Caution**

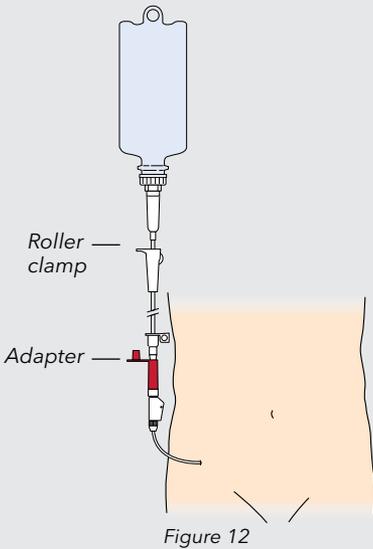
If you experience difficulty injecting liquid into the catheter, contact your nurse or physician.

7. Re-apply the cap for the short-term catheter.

Performing an enema routine through the short-term catheter

1. Gather the enema administration sets prescribed by your physician for your enema routine and any other supplies you may need.
2. Wash your hands with soap and water and dry thoroughly.
3. Add the prescribed amount of enema solution to the first hanging enema bag.
4. Mix 1 teaspoon of salt with 500 mL (2 cups) of warm tap water.
5. Add the saltwater solution to the second hanging enema bag.
6. Hang the enema bags on a shower curtain rod or wall hook.

7. While seated on the toilet, remove the cap from the short-term catheter and connect it to the tubing of the bag containing the enema solution. This connection may require the use of an adapter (Figure 12).



▶ Caution

If you experience excessive pressure or stool/fluid reflux when connecting the connecting tube to the catheter, try connecting the connecting tube while lying down. Keeping your abdomen in a relaxed position, as it is while lying down, will help alleviate pressure and reduce the likelihood of stool reflux. Similarly, bending over while connecting may increase pressure and have the opposite effect.

8. Open the clamp and allow the enema solution to flow in. If cramping occurs, decrease the flowrate by adjusting the roller clamp.
9. Once the entire first hanging enema bag is empty, close the clamp, disconnect the first bag and change to the second hanging enema bag containing the saltwater solution. Wait 15 minutes before using the second hanging enema bag.

10. After 15 minutes, open the clamp and allow the saltwater solution to flow through quickly. This usually takes about 5 minutes.
11. Once the second hanging enema bag containing the saltwater is empty, disconnect the bag from the catheter and reconnect the cap.
12. Wait 20-40 minutes for the enema results to occur. Stool will pass out of your body through the rectum. Massaging the abdomen firmly from right to left may help empty the bowel faster (*Figure 13*).
13. Rinse the hanging enema bags well with warm water, then wash them with soap and water. Allow them to air dry before storing.

This entire process should take 30-60 minutes the first few times. However, with more experience and familiarity, the procedure may take less time.

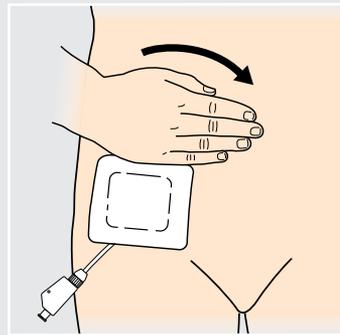


Figure 13

► **Important**

Do not discard the adapter, hanging enema bag or cap after use. They will be used every time an enema is given. Also, do not use any solvent, such as alcohol or acetone, to clean the short-term catheter.

Removing the sutures

When the physician inserted the short-term catheter into the cecum, he or she may have placed two or more sutures to hold the cecum to the wall of the abdomen. Typically, after the first two weeks the cecum will be adhered to the wall of the abdomen and the tract will have matured. This time may vary from patient to patient. Consult your physician to determine when the sutures should be removed.

If your physician feels it is appropriate, you may be able to remove the sutures. To complete this process, follow these instructions:

1. Remove the dressing over the short-term catheter in the usual way.
2. Unroll the gauze that is holding the sutures close to the skin.
3. With a pair of scissors, cut the string close to the skin and throw away the string (*Figure 14*).

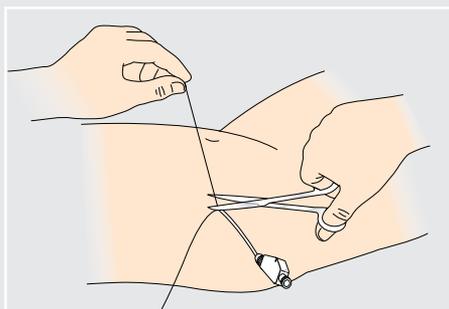


Figure 14

▶ **Caution**

Be careful not to inadvertently cut the catheter with the scissors.

4. The parts of the sutures that are inside the bowel will pass harmlessly through with stool.
5. Clean the exit site and put on a new dressing (see pages 27-29).

The Chait Cecostomy Catheter

Procedure #2: Placement of the Chait Cecostomy Catheter

About six weeks after the short-term catheter is inserted, the short-term catheter will be replaced with a long-term low profile Chait catheter via an outpatient procedure. The Chait catheter insertion is easier and quicker than the short-term catheter insertion procedure, and an overnight stay at the hospital may not be necessary.

The physician will check to see if the tract is healed and to ensure that no infection is present. If the condition of the tract and surrounding area is appropriate they will remove the short-term catheter and insert the Chait catheter. This procedure typically takes 10-15 minutes, if there are no complications.

The external part of the Chait catheter fits snugly against the abdomen. The internal part coils itself inside the bowel like a telephone cord (Figure 15).

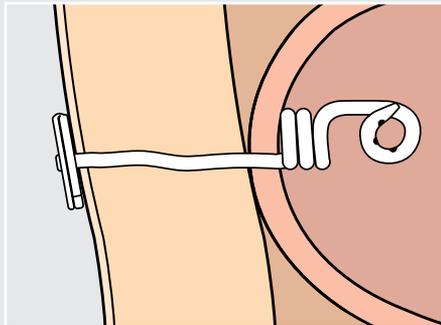


Figure 15

Possible complications with the Chait catheter

The Chait catheter insertion is usually free of complications, but the following complications are possible and should be discussed with a doctor.

- Discomfort around the tube site.
- Minor skin irritations.
- Infection around the tube or within the abdomen.
- Fever and nausea.
- Granulation tissue (a build-up of harmless, red, raised tissue where the tube enters the body).
- Dislodgment of the Chait catheter.

If any of these complications are observed, refer to the Troubleshooting chart on page 50 of this guide.

After the Chait catheter has been inserted, your enema routine can be performed as soon as needed.

Chait catheter care and use

The enemas for your enema routine will be given through the reusable Chait Access Adapter with Connecting Tube that is provided with the Chait catheter (*Figure 16*).

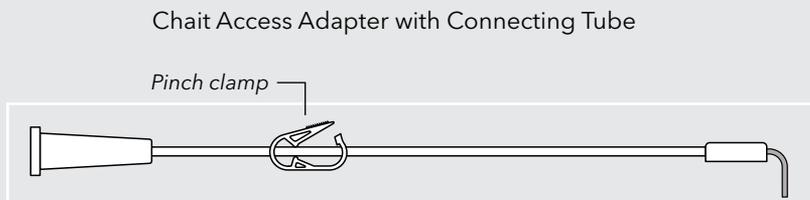


Figure 16

► Note

Should you need a replacement connecting tube, please contact your physician with the following part numbers:

Order Number	Reference Part Number
G11630	CTU10.0-18-CAA

Performing an enema routine through the Chait catheter

1. Gather the enema administration sets prescribed by your physician for your enema routine and any other supplies you may need.
2. Wash your hands with soap and water and dry thoroughly.

3. Add the prescribed amount of enema solution to the first hanging enema bag.
4. Mix 1 teaspoon of salt with 500 mL (2 cups) of warm tap water.
5. Add the saltwater solution to the second hanging enema bag.
6. Hang the enema bags on a shower curtain rod or wall hook.
7. While seated on the toilet, open the trapdoor lid of the Chait catheter and insert the metal pin of the connecting tube into the opening (*Figure 17*).

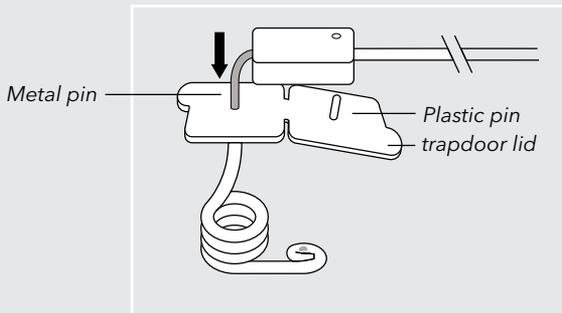


Figure 17

Align the plastic pin on the trapdoor lid into the small hole in the plastic block of the connecting tube to make a secure connection (*Figure 18*).

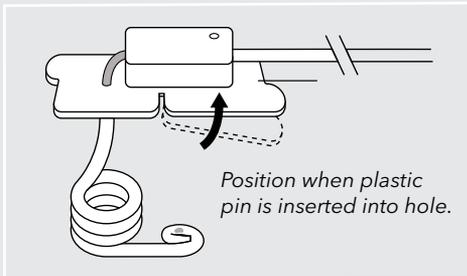
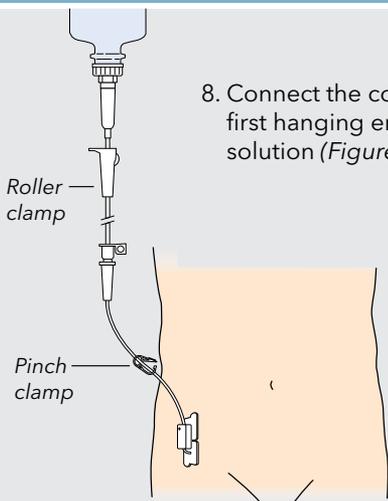


Figure 18

► **Note**

If you experience excessive pressure or stool/fluid reflux when connecting the connecting tube to the Chait catheter, try connecting the connecting tube while lying down. Keeping your abdomen in a relaxed position, as it is while lying down, will help alleviate pressure and reduce the likelihood of stool reflux. Similarly, bending over while connecting may increase pressure and have the opposite effect.



8. Connect the connecting tube to the fitting on the first hanging enema bag, which contains the enema solution (*Figure 19*).

Figure 19

9. Open the clamps on the connecting tube and administration set and allow the enema solution to flow in. If cramping occurs, decrease the flowrate by adjusting the roller clamp on the administration set.
10. Once the entire first hanging enema bag is empty, close the clamps, disconnect the first bag and change to the second hanging enema bag, which contains the saltwater solution. Wait 15 minutes before using the second hanging enema bag.
11. After 15 minutes, open the clamps and allow the saltwater solution to flow through quickly. This usually takes about 5 minutes.

12. Once the bag containing the saltwater is empty, disconnect the bag and connecting tube from the trapdoor and close the trapdoor.
13. Wait 20-40 minutes for the enema results to occur. Stool will pass through the rectum. Massaging the abdomen firmly from the right to left may help empty the bowel faster (*Figure 20*).

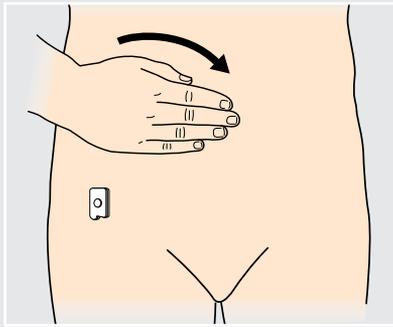


Figure 20

14. Rinse the hanging enema bags well with warm water, then wash them with soap and water. Allow them to air dry before storing.

Rinse the connecting tubes, with warm tap water. Then wash the tubes with soap and hot tap water (*Figure 21*).

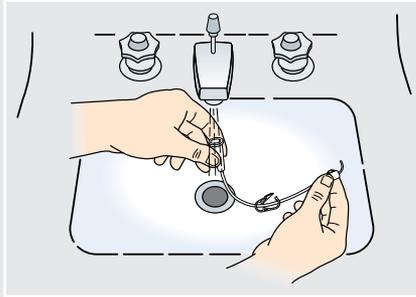


Figure 21

► **Note**

Do not discard the connecting tubes or hanging enema bags after use. These tubes will be used frequently. Also, do not use any solvents, such as alcohol or acetone, to clean the tubes.

The access tubes should be cleaned after each use. Allow the tubes to dry completely. Store the tubes at normal temperatures in a clean, dry place.

Maintaining the Chait catheter

After extended use, the Chait catheter may need to be replaced by a physician. If you notice any of the following signs of wear or failure of the Chait catheter, notify the physician immediately:

- A crack in the hinge, tube or cap.
- A loose, leaky fit between the connecting tube and Chait.
- Unusual discharge or irritation at the tube site.

If any additional problems occur with the Chait catheter, refer to the Troubleshooting chart on page 50.

Troubleshooting

Troubleshooting

You should not expect to have problems with the short-term or Chait cecostomy catheters. The troubleshooting chart below may help you recognize a problem if one occurs. If any of these problems occur, you should call your nurse or physician.

Problem	Symptom	Action
Damaged catheter	The catheter is cracked, cut or broken.	Clamp the catheter and contact your physician to have it replaced.
Catheter dislodgement	The catheter has visibly come out of the tract.	Within 3 weeks of placement, the tract may not be fully developed; call your physician. After 3 weeks (or when your physician confirms the tract has developed), insert a Foley-type catheter (see page 54 for instructions).
Granulation tissue around catheter	The skin around the catheter exit site is red, raised or bleeding.	Contact your nurse or physician.
Infection	You experience pain, redness, fever, swelling or a greenish discharge.	Call your nurse or physician immediately.
Leaking around Chait catheter during enemas	Water or enema fluid is on the skin or Chait surface.	Keep the catheter and exit site clean and dry. If the exit site doesn't heal and seal off within 3-5 days, call your nurse or physician.

How to Insert a Foley-Type Catheter

How to Insert a Foley-Type Catheter

1. Gather the supplies recommended by your physician, such as:
 - 10 French Foley-type catheter
 - Tape
2. Wash your hands with soap and water and dry thoroughly.
3. Examine the old tube while it is coiled and note the discolored portion that was inside the body. Measure the length of this discolored portion of tubing. Then, mark the Foley-type catheter with this same measurement in order to know how far to insert the catheter into the tract.
4. Very gently advance the Foley-type catheter into the hole in the abdomen to the same depth as the old catheter.
5. Securely tape the remaining exterior part of the Foley-type catheter to the abdomen. **Do not inflate the balloon.**
6. Contact your physician for immediate follow up.

Patient Information and Card

Patient Information and Card

A catheter identification card is provided below. Work with your physician to fill this card out completely, and carry it with you at all times in case of an emergency.

This patient has received a:

Chait Cecostomy Catheter



Please refer to your patient guide for more information.

Patient Name: _____

Catheter Lot #: _____

Tract Length: Short (0-6 cm) Medium (3-9 cm) Long (6-14 cm)

Catheter Length: Short (20 cm) Medium (24 cm) Long (28 cm)

Date of Insertion: _____

Nurse's Name: _____

Telephone #: _____

Physician's Name: _____

Telephone #: _____

PC_CHT_REV0

Glossary of Terms

ACE (Antegrade Continence Enema) Routine

A procedure that is used to help empty the bowel of stool in the normal direction of flow.

Anal Sphincter Muscles

A circular muscle that surrounds or encircles the opening to the rectum.

Antegrade Enema

Performed with the normal direction of stool flow.

Appendicostomy

An artificial opening from the abdomen into the appendix, similar to a cecostomy.

Catheter

A soft tube that is inserted into the body.

Cecostomy

An artificial opening from the abdomen into the cecum.

Cecum

The first portion of the large bowel.

Crohn's Disease

A chronic inflammatory bowel disease of the intestines that results in swelling and dysfunction.

Exit Site

The location where a device or catheter comes out of the body.

Enema Routine

The infusion of fluid into the colon to cleanse the bowels.

Fecal Incontinence

The inability to hold a bowel movement; the loss of regular control of the bowels.

Percutaneous

A medical term meaning “directly through the skin.”

Rectal Enema

The infusion of fluid into the anus to cleanse and evacuate the bowels.

Rectum

The rectum is the lower section of the large intestine.

Retrograde Enema

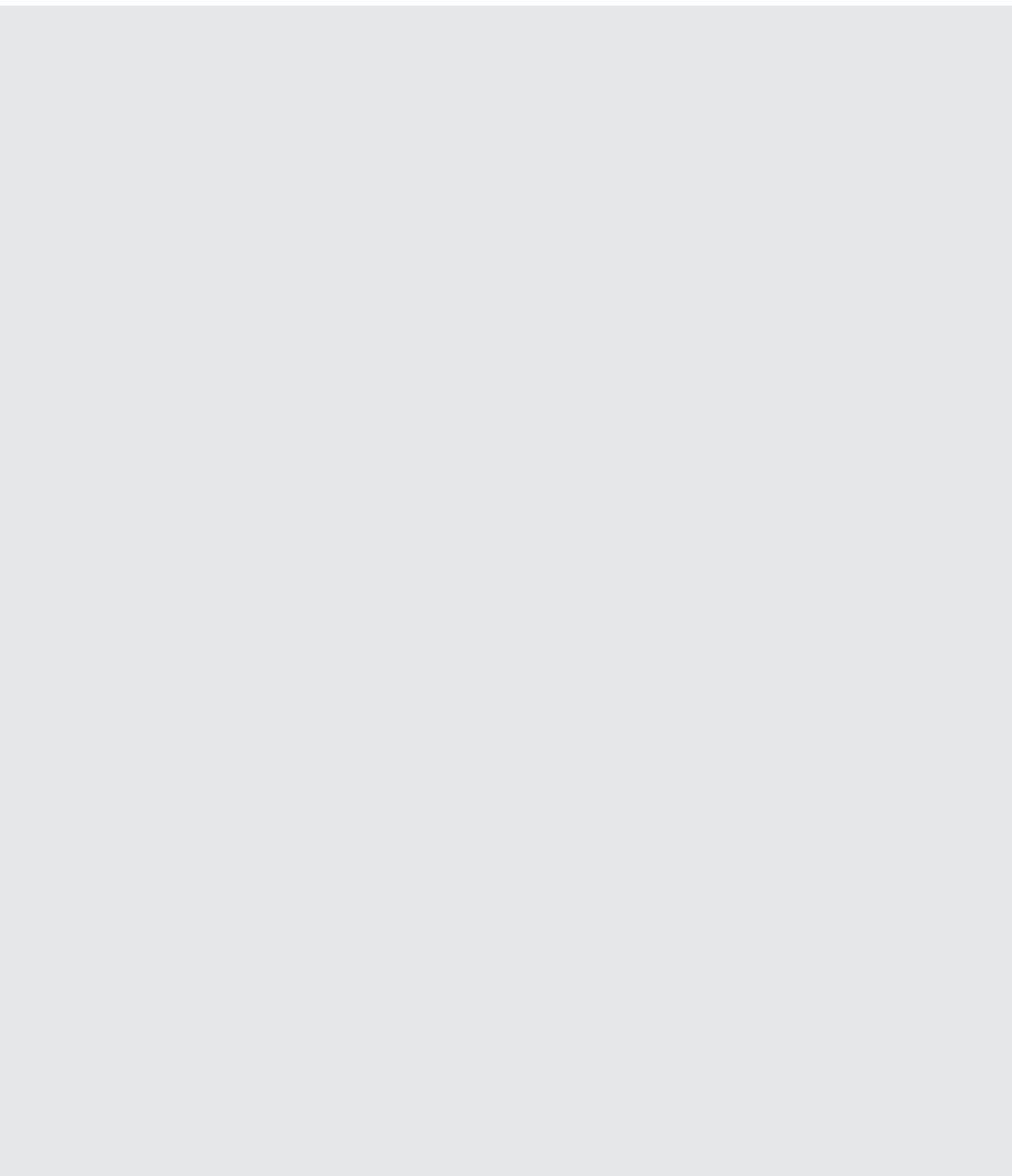
An enema performed against the normal direction of flow.

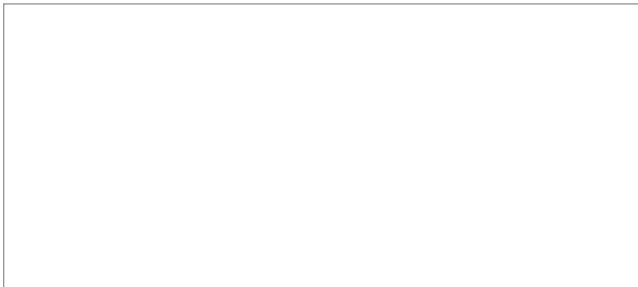
Stool

Solid or liquid waste discharged through the bowel, also known as excrement or feces.

Ulcerative Colitis

An inflammatory bowel disease that causes swelling and loss of function in the large intestine.





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