

CHAMP: Bedside Teaching

FOLEY CATHETERS: CARE & DISCONTINUATION

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I. Teaching Trigger:

Leakage around Foley Catheter

Clinical Question:

How do you trouble shoot leakage around Foley Catheters?

Teaching Point:

1. Such leakage is usually caused by irritation by Foley balloon and/or detrusor spasm.
 - a. Trial using SMALLER catheter and/or smaller inflation of catheter ballon (ie, < 10 ml)
 - b. Trial pyridium 100 mg tid
 - c. Trial bladder antispasmodic, eg Ditropan XL 5 mg qd or shorter acting oxybutynin 2.5-5mg up to tid; must be d/c'd 24 hr before catheter removal if foley inserted for inability to void. Monitor for cognitive side effects.

II. Teaching Trigger:

Patient pulls out catheter.

Clinical Question:

How do you manage a Foley catheter pulled out by a patient?

Teaching Points:

1. Re-insert catheter and flush until clear *unless* indication no longer present *and* there is no significant traumatic bleeding. If there is significant bleeding, re-insert 3-way catheter and use continuous bladder irrigation until clear.
2. If catheter is reinserted and there is no urine return, remove catheter and call urology (especially in men, catheter could have been in a “false passage”).
3. If catheter not reinserted, monitor urine output in case of clot retention.
4. If there is profuse hematuria that does not clear, insert 3-way catheter for continuous irrigation until clear.
- 5.

6. Sitter (preferred choice) or hand restraint (mitt preferable)

III. Teaching Trigger:

Discontinuing a catheter

Clinical Question:

How do you discontinue a Foley Catheter?

Teaching Points:

1. Remove catheter (DO NOT CLAMP); best to do first thing in the morning.
2. Ensure adequate fluid intake (PO or IV).
3. Monitor for voiding and incontinence over next 8 hours; check PVR after the first void.
4. If PVR is: < 300 ml (women), <150 – 200 ml (men), then continue without catheter, and monitor the PVR over the next day *at a minimum* (these numbers are empirical; there are no evidence-based guidelines).
5. If PVR is higher, continue catheter decompression with treatment of underlying cause of inability to void.

IV. Teaching Trigger:

Indication to place a catheter

Clinical Questions:

How do you insert a Foley Catheter?

What are some problems you may encounter?

Teaching Points:

1. Sterile technique: sterile gloves, field, cleanse meatal area with betadine swabs; lubricate catheter tip well.
2. Women: in older women, urethral meatus usually easily seen in introitus; may have violaceous nodule (urethral caruncle, benign, associated with mucosal atrophy; usually not obstructing). If not easily seen, palpate along anterior vaginal wall to help locate the meatus.
3. Men: best results if can pre-medicate with Lubijet with lidocaine gel: insert while holding penis upright.
4. Inability to pass catheter most often due to sphincter tightening, and not obstruction; have patient relax, take a deep breath, then as they exhale, push catheter in with gentle but firm “torque” turn. Mistake often made with men:

using too small a catheter (will turn back on itself); start with at least 14F or 16F, or Coudé.

5. Once catheter in with urine return, inflate balloon **ONLY** after advancing catheter all of the way into the bladder (catheter ports just distal to the meatus) to avoid intra-urethral inflation. If no urine return, trial irrigation; if still no return, removal catheter and repeat trial.