Digital rectal examination (DRE)

For further information refer to (RCN 2012) Management of lower bowel dysfunction, including DRE and DRF.

(NICE 2007) states that the procedure of DRE by a competent registered nurse is an essential component of bowel assessment.

**Definition of digital rectal examination**

Insertion of a lubricated, gloved finger into the patient's rectum to perform an examination.

**Indications**

- To assess anal/rectal sensation.
- To assess if faecal matter is present and its amount and consistency.
- To assess the need and outcome of using digital stimulation to trigger defecation by stimulating the recto-anal reflex.
- To assess the need for manual removal of faeces.
- To evaluate bowel emptiness (post-procedure).
- To assess content of the rectum in patients who are unable to communicate.
- To assess anal/rectal sensation in order to prescribe appropriate rectal medication.
- To assess effectiveness of enema or suppository.

**Exclusions and contra-indications**

Registered nurses should not undertake a DRE or manual evacuation of faeces when:

- no consent has been obtained (NHS Lothian 2014)
- the patient is under 16 years of age
- the patient’s doctor has given specific instructions that these procedures have not to take place
- the patient has recently undergone rectal/anal surgery or trauma (seek medical advice)
- the patient gains sexual satisfaction from this procedure (open discussion between doctor and patient is advised and chaperone facility offered)
- they do not feel competent to perform the procedure (NMC 2015)
### Precautions

- Active inflammation of the bowel for example Crohn’s disease, diverticulitis, ulcerative colitis.
- Radiotherapy to the pelvic area within the previous six weeks (seek medical advice).
- History of rectal/anal pain.
- History of rectal surgery or trauma to the anal/rectal area.
- Patients with tissue fragility and/or obvious rectal bleeding.
- Patient with a history of abuse.
- Spinal injured patients with known autonomic dysreflexia.
- Patients with known allergies.

### Requirements

- Disposable apron
- Non-sterile disposable gloves
- Procedure pad
- Paper tissue
- Lubricating jelly
- Disposable bag as per National Infection Prevention and Control Manual

### Observations while undertaking procedure

- Rectal prolapse
- Haemorrhoids (position, grade, number and prolapse)
- Anal skin tags
- Wounds, dressings, discharge
- Anal lesions
- Gaping anus
- Skin condition, broken areas, pressure sores of all grades
- Bleeding and colour of the blood
- Faecal matter
- Infestation
- Foreign bodies
### Procedure for digital rectal examination (DRE)

#### Prior to examination
- Explain the procedure to the patient and the potential risk factors.
- Obtain informed consent and document in nursing notes. (If the patient requests you to stop at any time during the procedure you must do so).
- Ask the patient if they wish to have a chaperone present.
- Give the patient the opportunity to empty their bladder.
- Ensure privacy, dignity and warmth are maintained at all times.

Please note that patients with a spinal cord injury (SCI) above T6 should be observed throughout the procedure for signs of autonomic dysreflexia.
- Ensure that baseline blood pressure has been recorded.
- Put a protective pad under the patient.
- Ask the patient to remove lower clothing. Offer assistance if required.
- Ask the patient to lie in the left lateral position with knees flexed (if possible) to enable easy visualisation of the perianal area. (The left side allows DRE to follow the natural anatomy of the bowel).
- Cover the legs/area not to be exposed.

#### Examination
- Explain to the patient that you will be looking and examining the outer and internal area.
- Examine the perianal area for lesions, such as skin tags, external haemorrhoids, fistula tumours, warts, infestation, foreign bodies, prolapsed mucosa, wounds, faecal matter, mucus or blood.
- Work with the anal reflex by putting your finger on the anus gently. Waiting a few seconds will allow the anus to contract and then relax. Sweep clockwise and then anticlockwise. Note the presence and consistency of faecal matter (refer to the Bristol stool form scale).
- Lubricate a gloved finger, part the buttocks and gently insert into the anus to avoid trauma to anal mucosa. (To prevent spasm or difficulty on insertion ask the patient to talk or breathe out). Note tone (slight resistance indicates good internal sphincter control) and any spasm or pain on insertion. If the patient experiences pain ask if they are happy for you to continue with the procedure.
Examination (continued)

- If you are competent to do advanced pelvic floor assessment this may also be performed.

- When examination has been completed remove finger, clean perianal area of any gel/faecal matter. Remove the gloves and apron disposing of them as per National Infection Prevention and Control Manual. Wash your hands (refer to hand hygiene).

- Allow the patient to dress in private, unless they require assistance.

- Explain your findings and discuss and agree plan.

- Document in nursing notes all observations, findings and action. Consider onward referral to another healthcare professional if appropriate.