Rectal irrigation

Rectal irrigation (also known as anal irrigation or trans-anal irrigation) has been used in the management of chronic constipation and/or chronic faecal incontinence due to neurogenic bowel dysfunction and functional bowel disorders.[1] Although a number of rectal irrigation systems can be prescribed on FP10, it is a highly specialist management option with a limited evidence base supporting its use.[2,3] A number of considerations are necessary to ensure its use is safe and appropriate.[3]

Key recommendations

- Rectal irrigation is a highly specialist management option and should only be considered as part of an appropriate locally commissioned bowel care pathway. It is not recommended for initiation by GPs in primary care, without specialist management.[3,4]
- It should only be considered where initial treatment with other less invasive options has proved unsuccessful. Initial management may include diet, bowel habit, toilet access, medication and coping strategies.[1,3,4] This is in line with NICE guidance on managing faecal incontinence in adults (CG49).[2]
- NICE guidance on the diagnosis and management of idiopathic constipation in children and young people (CG99) does not include rectal irrigation as a treatment option prior to surgical intervention.[5]
- A medical evaluation by an appropriate specialist is necessary before starting rectal irrigation. In some people endoscopic investigation is needed before rectal irrigation can be commenced.[6]
- Mild and transient symptoms, such as abdominal pain, chills, nausea and minor rectal bleeding, are seen frequently during or after rectal irrigation. There is also potential for autonomic dysreflexia, which is of particular concern in those with spinal cord injury with lesions located at or above T6.[7]
- Although extremely rare, rectal irrigation carries a risk of bowel perforation, which can be fatal. Patients should be taught to recognise the symptoms of colonic perforation and what actions to take.[3]
- Comprehensive training for the individual, plus on-going support are essential to the safe and efficient long-term use of rectal irrigation.[3]
- Minimise waste by ensuring the correct type and quantity of consumables are ordered. This should take into account the frequency of irrigation and the number of uses appropriate for the product. A summary of the different rectal irrigation systems available (including components, number of times they can be used and estimated monthly costs) is included in attachment 1 of the full PrescQIPP bulletin on rectal irrigation.
- Products should not be added to GPs repeat prescribing systems at initiation. Once a consistent routine of irrigation has been established (often on alternate days[1]) it may be appropriate to add only items that need to be ordered on a monthly basis to the repeat prescribing system. Treatment should be reviewed regularly.
- For those taking laxatives before starting irrigation, it is prudent to continue these in the usual dose until irrigation is established. They may subsequently be able to gradually stop taking laxatives, but many continue to need them.[1]

Supporting evidence

The only indication for which there is randomised controlled trial evidence (from one study, n=87) supporting rectal irrigation is spinal cord injury with neurogenic bowel dysfunction in adults.[8]

For other indications, data are largely derived from uncontrolled case series.

Savings

In England and Wales, Over £14.8 million was spent on rectal irrigation systems over the course of a year (ePACT June to August 2016).

A 20% reduction in prescribing (by reducing wastage and any inappropriate prescribing) **would produce savings in the order of £2.4 million annually. This equates to £4,879 per 100,000 patients.**

Additional resources available: https://www.prescqipp.info/resources/category/348-rectal-irrigation-drop-list

Bulletin

Data pack

Summary of systems

References

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Contact help@prescqipp.info with any queries or comments related to the content of this document.

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