

Transanal irrigation

This is one of a number of bulletins providing further information on medicines contained in the [PrescQIPP PROP-List \(Products to Review for Optimised Prescribing\)](#). The PROP-List is an accumulation of medicines that are regarded as low priority, poor value for money or medicines for which there are safer alternatives. The PROP-List also includes products for which there are specific medicines optimisation issues to be addressed to ensure appropriate use and/or to minimise waste.

This bulletin focuses on transanal irrigation (also referred to as anal irrigation, rectal irrigation or retrograde irrigation) and provides the rationale for ensuring it is only considered as part of a supportive bowel care programme that incorporates a careful patient selection process. It also considers medicines optimisation issues to reduce waste.

Recommendation

- Be aware that transanal irrigation is a specialist management option for bowel dysfunction and should only be considered as part of a locally commissioned supportive bowel care programme.
 - » A clinical evaluation by an appropriate specialist is necessary before starting treatment.
 - » It is not recommended for initiation by GPs in primary care, without specialist management.
- Consider transanal irrigation only in those whose bowel dysfunction cannot be managed with more conservative options e.g. use of medication, changes to diet and physiotherapy.
- Commissioners should consider integrating transanal irrigation into care pathways that have been agreed across a locality and by the multidisciplinary team (specialists and primary care). Agreed pathways should:
 - » Ensure careful patient selection.
 - » Incorporate training and ongoing support for the patients from a specialist healthcare professional.
 - » Clearly state who is responsible for long-term support, monitoring and prescribing.
- Ensure that patients are made aware of the risk of bowel perforation (a rare complication), how to recognise the symptoms and actions to be taken.
- Consider using an appropriate, validated scoring system at baseline and at reviews to help identify if there has been a demonstrable improvement in symptoms.
- 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.
- If GP practices are responsible for ongoing prescribing:
 - » Have a robust communication process in place to ensure that the GP receives information from the specialist service about which products the person will need and the quantities required.
 - » Do not add items to the repeat prescribing systems until a consistent routine of irrigation has been established (often on alternate days). Consider only adding items that are required on a monthly basis as repeats.
- Monitor prescribing data and consider practice-level audits to identify issues such as initiation that is not in accordance with local guidance and overordering.

Background

Transanal irrigation systems

Transanal irrigation therapy is used as a treatment for bowel dysfunction. Warm tap water (36–38°C) is instilled into the rectum via the anus, using either a balloon catheter or cone shaped delivery system. Most systems use a hand-held manual pump to instil the water, although some can be used as a gravity-fed systems. A system with an electric pump is also available. On removal of the catheter or cone, water and faeces are evacuated into the toilet (or collection bag for one system).^{1,2}

The devices can be categorised as high-volume or low-volume according to how much irrigation water they deliver. In high-volume systems, the water is pumped from an irrigation bag which is attached to the rectal catheter or cone via plastic tubing. Low-volume systems with manual pumps that double up as the water reservoir are also available. Such systems do not require a separate irrigation bag and are more compact.¹ The amount of irrigation fluid required varies according to the individual's needs and the clinical condition.² High-volume systems empty the rectum, descending colon and part of the transverse colon.¹ Transanal irrigation has been shown to empty the rectosigmoid and the descending colon following in patients with spinal cord injury and in patients with idiopathic faecal incontinence.³ Low-volume systems usually empty the rectum only.¹

Irrigation should be performed daily initially, and then reduced to alternate days where possible after approximately 10-14 days.⁴ NICE guidance on the transanal irrigation system Peristeen Plus, assumes that the average frequency of use of this system, for most people with neurogenic bowel dysfunction, is every other day (as recommended by the company).⁵

For a summary of the different transanal irrigation systems available including details of their components and the number of times they can be used, see Attachment 1 - Summary of transanal irrigation systems listed in the Drug Tariff. Some of the systems included can also be used for colostomy irrigation, but use of this technique is beyond the scope of this bulletin.

Although a general discussion of indications and contraindications for transanal irrigation is included in this bulletin, specific indications and contraindications vary and should be checked for each product.

Potential indications

Transanal irrigation is used in the management of bowel dysfunction and should only be considered after less invasive advice and treatment options appropriate to the indication have been undertaken.² Bowel dysfunction can present with faecal incontinence or constipation. It can have neurogenic and non-neurogenic causes.⁵

Neurogenic causes of bowel dysfunction include:

- Spinal cord injury
- Spina bifida
- Multiple sclerosis
- Parkinson's Disease.⁵

Non-neurogenic causes of bowel dysfunction include:

- Injury to the rectum or bowel
- Slow transit constipation
- Obstructed defaecation symptoms.⁵

Transanal irrigation has also been used for low anterior resection syndrome (LARS) following rectal surgery for cancer (NICE have made a research recommendation for this indication, see 'National guidance' below). The symptoms of LARS include faecal incontinence or leakage, frequency or urgency of stools, loose stools, incomplete bowel movement, or tenesmus⁶ (feeling that you need to pass stools, even though your bowels are already empty).

National guidance

This section focuses primarily on guidance in relation to transanal irrigation. A wider consideration of the management of bowel dysfunction can be found in the CKS topics on [constipation](#), [constipation in children](#) and [faecal incontinence in adults](#). [PrescQIPP bulletin 272: Constipation](#) is also available.

NICE guidance

Current treatment options for bowel dysfunction include:

- Medication (oral drugs, suppositories and enemas)
- Changes to diet
- Physiotherapy
- Surgery.⁵

People with bowel dysfunction may also be offered training to help manage their symptoms at home, using biofeedback, bowel washouts and manual removal of faeces.⁵

In accordance with the **NICE Medical technologies guidance on the Peristeen Plus transanal irrigation system for managing bowel dysfunction [MTG36]**, transanal irrigation should be considered if bowel continence cannot be achieved by medication, changes to diet and/or physiotherapy.⁵ Note that the studies evaluated the original Peristeen system, which NICE assumed to be equivalent to Peristeen Plus with the balloon catheter.⁵

NICE [MTG36] makes the following recommendations:

- The case for adopting Peristeen Plus for transanal irrigation in people with bowel dysfunction is supported by the evidence. Peristeen Plus can reduce the severity of constipation and incontinence, improve quality of life and promote dignity and independence.
- Peristeen Plus may not be suitable for all people with bowel dysfunction. It may take several weeks before a person is comfortable with using Peristeen Plus, and some people may choose to stop using it. Peristeen Plus is therefore most effective when it is offered with specialist training for users, carers and NHS staff, and structured patient support.
- Cost modelling for Peristeen Plus is uncertain, but it is likely that Peristeen Plus provides additional clinical benefits without costing more than standard bowel care.⁵

MTG36 notes that the evidence for Peristeen in children is less robust than in adults (see 'Clinical effectiveness' section). However, the committee recognised that clinical studies are difficult in children with a wide range of underlying conditions, particularly because of challenges with communicating patient-reported outcome measures. Despite limitations in the published evidence, the committee concluded that Peristeen may offer significant benefits for children with bowel dysfunction.⁵

To date, only Peristeen Plus has been evaluated for clinical and cost effectiveness by the NICE MTG programme. NICE note that a number of different transanal irrigation systems are available. They state that clinicians and patients should discuss the options available and may try a number of devices before settling on a preferred system. Furthermore, some patients may need or prefer surgery, most often a colostomy, ileostomy or a procedure to allow treatment with antegrade continence enemas (ACE procedure).⁵

Peristeen Plus should be offered as part of a supportive bowel care programme. High initial drop-out rates may be reduced by ensuring good quality training and support for patients and staff. People using Peristeen Plus should have training from a specialist healthcare professional. The manufacturer has a team of nurses in the UK that provide training for patients and for bowel care specialists, with additional non-clinical resources including a patient support phone programme.⁵

The NICE committee noted that Peristeen Plus is usually first prescribed by specialist bowel care teams with ongoing prescription in primary care.⁵

The **NICE clinical guideline on the management of faecal incontinence in adults [CG49]** notes that faecal incontinence is a sign or a symptom, not a diagnosis, and often has multiple contributory factors. It is important to diagnose the cause or causes for each individual. It recommends that people who continue to have episodes of faecal incontinence after initial management (which covers diet, bowel habit, toilet access, medication and coping strategies) should be considered for specialised management. This may involve referral to a specialist continence service, which may include:

- Pelvic floor muscle training
- Bowel retraining
- Specialist dietary assessment and management
- Biofeedback
- Electrical stimulation
- Transanal irrigation.⁷

NICE [NG123] on the management of urinary incontinence and pelvic organ prolapse in women states that regional multidisciplinary teams that deal with complex pelvic floor dysfunction and mesh-related problems should include a healthcare professional trained in transanal irrigation.⁸

The **NICE guidance on the management of constipation in children (CG99)** does not make a recommendation on transanal irrigation. For idiopathic constipation, after treatment for faecal impaction (where present), maintenance treatment should include laxatives. It should also incorporate a combination of negotiated and non-punitive behavioural interventions and dietary modifications to ensure a balanced diet and sufficient fluids are consumed.⁹

Those who still have unresolved symptoms on optimum management should be referred to a paediatric surgical centre to assess their suitability for an antegrade colonic enema (ACE) procedure.⁹ Guideline surveillance has considered the evidence for transanal irrigation but decided that the evidence was insufficient to add a recommendation (see Clinical effectiveness below).^{10,11}

Other NICE guidelines which mention transanal irrigation but do not make recommendations on its use due to insufficient evidence include:

- **NICE [NG151] on colorectal cancer** makes a research recommendation on transanal irrigation compared to symptomatic treatment for people with major low anterior resection syndrome.¹²
- **NICE [NG210] on pelvic floor dysfunction** makes a research recommendation on the effectiveness of transanal irrigation for bowel symptoms in women with pelvic floor dysfunction.¹³

Commissioning recommendations

The Royal College of Surgeons and the Association of Coloproctology of Great Britain and Ireland have produced a commissioning guide for faecal incontinence. It suggests transanal irrigation should be accessible as part of a bowel care pathway for faecal incontinence. It states that specialist management should be considered for those with:¹⁴

- Refractory symptoms after initial management (including dietary modification, medication and advice on use of continence products).
- Gross sphincter pathology (congenital malformation).
- Relevant co-morbidity (neurological disease).¹⁴

A consensus expert review on best practice in transanal irrigation was published in 2013. It discusses the need for consultation with a specialist health care professional before treatment initiation, careful

patient selection, comprehensive patient training and sustained follow-up.⁴ This is a useful document covering many practical aspects of transanal irrigation, but it should be borne in mind that it is an older document that has not been updated. Some of the authors of this consensus review have published an updated and simplified treatment algorithm specifically for neurogenic bowel dysfunction in patients with spinal cord injury and multiple sclerosis, which discusses the evidence and role for transanal irrigation in this group of patients.¹⁵

In 2017 a consensus review was published on best practice of transanal irrigation in children. It has many parallels to the approach advocated in the 2013 consensus review for adults above, but with some differences due to the different patient population. The authors note that more preparatory work is required to provide the child and parents with detailed explanations and discussions, which may take several meetings. Based on a literature review and their personal experience, the authors state that transanal irrigation represents an effective and safe therapeutic approach for treating bowel dysfunction in children. They recognise the limited evidence base (consisting of cohort studies and case series) and the need for further research including RCTs.¹⁶

NICE and other experts agree that careful patient selection is required for transanal irrigation.^{4,16,17} It is most successfully adopted when integrated into care pathways that have been agreed across a locality and by the multidisciplinary team (specialists and primary care).¹⁷ Local pathways should outline conservative bowel management options such as toilet training, laxatives, dietary modifications, physiotherapy and lifestyle changes, that should be tried before considering transanal irrigation.¹⁷

Input from members of the multidisciplinary team can be used to assess a patient's suitability for transanal irrigation in partnership with the patient. This will involve consideration of their clinical condition including past and current treatments and whether there are any relevant contraindications.¹⁷

The role of the specialist healthcare professional(s) also involves:

- Helping to select the most appropriate transanal irrigation system for the individual.^{5,16,17}
- Advising on the volume of water to use initially and how to adjust it.^{4,16}
- Discussing and agreeing on laxative use on a case-by-case basis.^{4,16,17}
- Providing patient training, ongoing support^{4,5,16} and troubleshooting for any problems that arise.^{4,16}

Frequent reviews with a healthcare professional with appropriate knowledge and skills are required initially. The timing should be agreed as part of the integrated care pathway but an example might be every two weeks when starting treatment. Once a person is stable, regular reviews are still necessary to provide ongoing support and to ensure that transanal irrigation continues to be the most appropriate option for the person.¹⁷ The frequency of such reviews will vary according to the individual, but should happen at least annually.⁴

Clinical effectiveness

A prospective, multi-centre randomised controlled trial (RCT) by Christensen et al (2006) compared transanal irrigation with conservative bowel management.³ Eighty-seven adults with spinal cord injury with neurogenic bowel dysfunction were enrolled for the ten week trial period, using the Peristeen transanal irrigation system. Exclusion criteria included history of cerebral palsy or cerebral apoplexy, multiple sclerosis and diabetic polyneuropathy. For both of the primary endpoints below, a statistically significant difference in mean score (standard deviation, SD) favouring transanal irrigation compared with conservative management was demonstrated:

- Cleveland Clinic constipation scoring system (range, 0–30, 30=severe symptoms) – mean score 10.3 (SD 4.4) for transanal irrigation versus 13.2 (SD 3.4) (P=0.0016) for conservative management.
- St Mark's faecal incontinence grading system (range, 0–24, 24=severe symptoms) – mean score 5.0 (SD 4.6) for rectal irrigation versus 7.3 (SD 4.0) (P=0.015) for conservative management.

Statistically significant differences in favour of transanal irrigation were also observed for some secondary outcomes including neurogenic bowel function score, some aspects of a symptom-related quality of life score and total time for bowel care. Those in the transanal irrigation group were generally more satisfied with their treatment than those receiving conservative management. The authors also noted a statistically significant reduction in the number of urinary tract infections in the transanal irrigation group.³

The RCT by Christensen et al (2006) was included in the evidence assessment for MTG36 on Peristeen and was considered to be the best quality evidence to support the use of Peristeen. Other evidence came from observational studies consisting of a further 12 studies in adults, 11 studies in children plus two studies and one audit that were included specifically to provide information on adverse events. Note that the studies evaluated the original Peristeen system, which NICE assumed to be equivalent to Peristeen Plus with the balloon catheter.⁵ The company stated that changes to the technology improve its usability, but do not change its functionality. A clinical expert advised NICE that Peristeen and Peristeen Plus are likely to be largely equivalent, and that the evidence on Peristeen would be applicable to Peristeen Plus.¹⁸

A Peristeen Plus cone catheter system is also available but at the time of writing of MTG36 there was no published evidence for this version of the system so the guidance focused on Peristeen Plus with the balloon catheter.⁵

In regard to the studies in adults, despite the high risk of bias in the observational studies and the high initial drop-out rates in all studies, the evidence showed that adults who choose to continue using Peristeen report improved clinical outcomes.⁵

All the studies in children were non-comparative, observational case series. They showed improvements in some outcomes for children using Peristeen but the overall published evidence in children was considered to be of low quality. It was acknowledged that Peristeen is successfully used in children within the NHS and that there is anecdotal evidence describing its long-term use. Despite limitations in the published evidence, the committee concluded that Peristeen may offer significant benefits for children with bowel dysfunction.⁵

The position of MTG36 with respect to children appears to contrast with that of CG99 on constipation in children, which does not make a recommendation on transanal irrigation.⁹ Guideline surveillance of CG99 in 2017 and 2018 has considered the evidence for transanal irrigation,^{10,11} as it could be a potential non-surgical option for some patients who would otherwise have an ACE procedure.¹¹ On both occasions NICE decided not to add a recommendation on transanal irrigation to CG99.^{10,11}

NICE acknowledged that this is an area of research showing promising results for the treatment of constipation in this population. They point out that the evidence considered in MTG36 was not in scope for NICE guideline CG99.¹¹ For CG99, most of the evidence they reviewed was based on studies with small sample sizes and no comparator groups, which limited the impact on the guideline.¹⁰ In 2018 they concluded that there was still uncertainty around the safety and efficacy of transanal irrigation in this population, and so did not update the guideline.¹¹

Since the 2022 update of MTG36, some further small RCTs investigating transanal irrigation have been published. They include three RCTs in people with lower anterior resection syndrome^{19,20,21} and one in adults with spina bifida.²² Three of these studies used the Peristeen balloon catheter system,^{19,20,22} and one used the Peristeen cone catheter system.²¹ There remain broad groups in which RCT evidence is lacking, including children and most functional bowel dysfunction indications.

Much of the published evidence relates to the Peristeen system. There is insufficient evidence to suggest whether one system outperforms another.¹

Safety

Reported reasons for patients discontinuing transanal irrigation include technical difficulties such as expulsions of the catheter, bursting of rectal balloons, time consumption, dislike of treatment and adverse events. The types of adverse effects that occur more frequently include abdominal pain, sweating/hot flushes, general discomfort, headache and perianal/anorectal pain.²³

The potential for autonomic dysreflexia is of particular concern in those with spinal cord injury with lesions located at or above the T6 level. Possible symptoms include headache, flushing, sweating, bradycardia and piloerection.² Caution is required in those at risk and severe autonomic dysreflexia as it is a relative contraindication to the use of transanal irrigation (see Table 1 below).⁴

Inserting a catheter into the rectum, inflating a rectal balloon and administration of water under pressure carries the risk of potentially fatal bowel perforation. Bowel perforation is a rare complication (two per one million irrigations) according to a 2016 global audit of the Peristeen system, which compared the number of reported perforations with the sales data. Of the 46 bowel perforations evaluated in this audit, three were fatal. In two of these fatal cases, severe comorbidity and off-label use were contributing factors to both the incident and the fatal outcome. In the third fatal case, detailed medical history and hospital records were not available.²⁴

In 2011, the Medicines and Healthcare Products Regulatory Agency (MHRA) issued a Medical Device Alert to warn of the risk of bowel perforation (in relation to the Peristeen system). They highlight the need for comprehensive training and awareness of risk in those using the system. A medical evaluation by a doctor with appropriate expertise is also necessary before using the system. Patients (and carers where appropriate) should be made aware of the risk of bowel perforation, how to recognise the symptoms and actions to be taken.²⁵

The MHRA and the manufacturer of Peristeen issued further alerts in 2014 to draw attention to changes to the indications, contraindications, precautions and warning sections of the product information. More detailed instructions for patient examination before starting transanal irrigation was also added. This included the need for digital rectal examination and, in some cases, endoscopic investigation before transanal irrigation is commenced.^{26,27} The 2014 updates were prompted by the publication of a consensus review of best practice of transanal irrigation in adults.^{4,27} Note that the 2011 and 2014 Medical Device Alerts have now been archived, but are still available to view.

Warnings about the rare risk of bowel perforation are also included in the product information for other brands of transanal irrigation systems (Aquaflush, Navina and Irrisido).²⁸⁻³⁰

Table 1 outlines the absolute and relative contraindications for transanal irrigation, in accordance with the consensus review.⁴

Table 1. Absolute and relative contraindications for transanal irrigation⁴

Absolute contraindication	Relative contraindication
Anal or rectal stenosis	Severe diverticulosis: Diffuse disease Dense sigmoid disease Previous diverticulitis or diverticular abscess
Active inflammatory bowel disease	Long term steroid medication
Acute diverticulitis	Radiotherapy to the pelvis
Colorectal cancer	Prior rectal surgery
Within three months of rectal surgery	Faecal impaction

Absolute contraindication	Relative contraindication
Within four weeks after endoscopic polypectomy	Painful anal conditions
Ischaemic colitis	Current or planned pregnancy
	Bleeding diathesis or anticoagulant therapy (not including aspirin or clopidogrel)
	Severe autonomic dysreflexia
The list is not exhaustive, so healthcare professionals should always consider individual patient factors as well. In addition to considering the general contraindications listed above, healthcare professionals should ensure that they are familiar with the most up to date product information for the device(s) available in their area, and be aware of the absolute and relative contraindications listed for the product(s).	

The contraindications for the use of transanal irrigation in children are similar to those established for the adult patient population, except for the minimum age of the patient, which is dictated by the regulatory approvals in each region. As a guide, this is usually 3 years of age in Europe.¹⁶

Bladder & Bowel UK have published a [Children's Rectal Irrigation Pathway](#) which includes contraindications and cautions for rectal irrigation.³¹

Implementation

Alongside MTG36, NICE published [adoption support and shared learning examples](#). NHS contributors to this resource considered the following to be important:

- Representation from relevant members of the multidisciplinary team on the implementation group.
- Finding out if Peristeen Plus is already in use in other teams locally to identify learning or collaboration opportunities.
- Adopting Peristeen Plus as part of an integrated care pathway between specialists and primary care, including agreement about who takes responsibility for long-term ongoing support, monitoring and prescribing.
- Formalising funding through the integrated care pathways to allow coordinated funding and provision of transanal irrigation services.
- Approved training for staff in assessing, starting and supporting the use of Peristeen Plus.
- Support for patients and carers from suitably trained healthcare professionals.¹⁷

There are example implementation tools and resources shared by local trusts which include example patient pathways/care pathways, provided as part of the NICE implementation resources. Some more recent examples include the following:

- Bladder & Bowel UK [Children's Rectal Irrigation Pathway](#)
- Bristol, North Somerset and South Gloucestershire ICB [guideline on rectal and transanal irrigation](#).

A variety of patient resources are available from the manufacturers of the different transanal irrigation systems e.g. step-by-step guides, videos. These resources can be used alongside, and to reinforce training, from a specialist healthcare professional.

- Aquaflush systems - <https://www.clinisupplies.co.uk/category/bowel/transanal-irrigation/>
- Navina systems - <https://www.wellspect.co.uk/products/bowel-products/navina-irrigation-system/faq-navina/>

- Peristeen Plus systems - <https://www.coloplastcharter.co.uk/advice-and-support/life-with-bowel-problems/>
- IrriSedo systems - <https://www.qufora.co.uk/>. Qufora resources include a [Rectal Irrigation Decision Guide](#) for adults. This manufacturer sponsored resource was developed by consensus review of a working party of experts.³²

Those developing local pathways should consider what individual patient-level data should be collected to show if there has been a demonstrable improvement in symptoms. Patient-level data should be collected before and after starting transanal irrigation (at regular review points) using visual analogue scores (using the same validated measure across the locality supports a consistent approach).¹⁷

Examples of validated scoring systems include the Cleveland Clinic Constipation Score, the St Mark's Faecal Incontinence Grading System score and the Neurogenic Bowel Dysfunction score.²³ Qualitative data should also be collected from patients about how transanal irrigation affects their quality of life.¹⁷

Commissioners should ensure that a formal agreement regarding responsibility for ongoing prescribing is in place. NICE describe a number of approaches that can be used:

- Having an agreement with an area prescribing committee that specific transanal irrigation devices can be prescribed in primary care.
- Including specific transanal irrigation devices on a local formulary.
- Having a local agreement (e.g. a shared care agreement) that GPs will be responsible for prescribing formulary transanal irrigation devices for a person in whom it has been established. This approach would require training for primary care staff and clear communication with GPs (e.g. individualised letters stating the products and average quantities that the person will need).
- Commissioning a continence prescribing service which takes responsibility for the ongoing prescribing of continence products, including transanal irrigation systems, for all patients within an agreed area. Examples include: [Nottinghamshire Healthcare NHS Foundation Trust](#) and [Rotherham NHS Foundation Trust](#).
- The clinical commissioning group (which will now be an ICB) commissions the specialist service that has initiated transanal irrigation to provide long-term support and prescribing rather than the person being referred to primary care.¹⁷

Clinical responsibility for prescribing is held by the person signing the prescription, who must also ensure adequate monitoring.³³ It is therefore essential to ensure that the necessary agreements, processes and training are in place before requests for prescribing of transanal irrigation systems are received by primary care prescribers.

Transanal irrigation systems are classified as appliances. Only those listed in the appliances section of Drug Tariff can be prescribed on an NHS prescription. Prescriptions for appliances can be dispensed by pharmacies, dispensing appliance contractors and (in some circumstances) dispensing doctors.³⁴ If GP practices are responsible for ongoing prescribing they should:

- Have a robust communication process in place to ensure that the GP receives information from the specialist service about which products the person will need and the quantities required.
- Review how these appliances are managed within the practice's repeat prescribing system. Do not add items to the repeat prescribing systems until a consistent routine of irrigation has been established (often on alternate days). Consider only adding items that are required on a monthly basis as repeats.

Costs

For the estimated monthly costs of the different available transanal irrigation systems, see Attachment 1. For some systems the average monthly cost quoted is based on the system being used for a specific time period (from six months to two years for some systems). Cost-effectiveness of such systems will therefore be impacted if the initial drop-out rate is high, which is an issue that has been identified in transanal irrigation studies.⁵

The costs in attachment 1 are based on alternate day irrigation. In general, low-volume systems are cheaper than high-volume systems. However low-volume systems empty a smaller section of the bowel so it is possible that more frequent use may be required (e.g. daily).

[PrescQIPP cost comparison charts for transanal irrigation systems](#) are also available. They have the advantage of being updated regularly and can be used alongside Attachment 1 to ensure that pricing information is current.

Clinicians should select the system that best fits the individual's needs. Where more than one system is equally suitable, the least costly option should be selected.

Peristeen Plus has been evaluated for clinical and cost effectiveness by the NICE MTG programme. The cost model estimated savings associated with Peristeen Plus of £5,144 per person over a 37 year time horizon. Although the cost modelling is uncertain, the NICE committee felt that it is likely that using Peristeen Plus in people with bowel dysfunction does not cost any more than standard care. The committee was aware that the economic modelling only considered adults, but it judged that using Peristeen Plus in children is unlikely to cost any more than standard bowel care.⁵

Savings

In England, Wales, Northern Ireland, Isle of Man and Scotland in excess of £41.9 million is spent annually on transanal irrigation systems (NHSBSA England and Wales (July to September 2024), and Public Health Scotland (July to September 2024)). The spend per country is illustrated in table 2.

Table 2. Transanal irrigation 12 months spend country (NHSBSA England and Wales (NHSBSA July to September 2024 and Public Health Scotland July to September 2024)

	12 months spend on transanal irrigation
England	£36,214,105
Wales	£2,452,959
Northern Ireland	£405,120
Isle of Man	£47,251
Scotland	£2,815,396
Total	£41,934,830

Savings may be achieved by:

- Having clear patient care pathways that incorporate a careful patient selection process. Pathways should facilitate access to treatment where it is indicated and prevent inappropriate use.
- Incorporating a regular treatment review into patient care pathways with an appropriately skilled healthcare professional. This ensures that transanal irrigation continues to be the most appropriate option for the person.
- Minimising 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 times each consumable item can be used (see Attachment 1. Summary of transanal irrigation systems listed in the Drug Tariff).

- Monitoring prescribing data and practice-level audits to identify issues such as initiation that is not in accordance with local guidance and overordering (see Attachment 2. Transanal irrigation systems audit).

A 20% reduction in prescribing (by reducing wastage and inappropriate prescribing) would produce savings in the order of £8.3 million annually. This equates to £11,196 per 100,000 patients. The cost avoidance by country is illustrated in table 3.

Table 3. Transanal irrigation 12 months cost avoidance (assuming a 20% reduction in prescribing) by country (NHSBSA England and Wales (NHSBSA July to September 2024 and Public Health Scotland July to September 2024)

	12 months cost avoidance	Cost avoidance per 100,000 patients
England	£7,242,821	£11,409
Wales	£490,592	£14,945
Northern Ireland	£81,024	£3,936
Isle of Man	£9,450	£10,566
Scotland	£563,079	£9,384
Total	£8,386,966	£11,196

The strategies listed above which reduce prescribing of transanal irrigation systems and consumables can also support sustainability in healthcare by reducing the total carbon footprint of transanal irrigation devices prescribed. See [PrescQIPP bulletin 340. Sustainability in medicines optimisation](#) for a broader consideration of sustainability issues and reducing the carbon footprint of medicines.

Data for PrescQIPP subscribers

In addition to the bulletin visual datapack, PrescQIPP subscribers can access the PrescQIPP [Continence snapshot reports and visual analytics](#). The reports include organisational level data through to practice level data on transanal irrigation products (use the category filter 'anal irrigation system'), alongside other continence product prescribing data.

Summary

Transanal irrigation is a specialist treatment that should only be offered as part of a locally commissioned supportive bowel care programme. Its use should only be considered in those whose bowel dysfunction cannot be managed with more conservative options. Careful patient selection, training and ongoing support are essential.⁵

A number of transanal irrigation systems can be supplied on an NHS prescription, one of which (Peristeen Plus) has been reviewed by NICE. Clinicians and patients should discuss the options available to select a preferred system for the individual.⁵ A formal agreement about responsibility for ongoing prescribing should be established locally.¹⁷

A 20% reduction in prescribing (by reducing wastage and inappropriate prescribing) would produce savings in the order of £8.3 million annually. This equates to £11,196 per 100,000 patients.

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Additional PrescQIPP resources

Implementation tools and data:

<https://www.prescqipp.info/our-resources/bulletins/bulletin-355-transanal-irrigation/>

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