

NHS Halton Clinical Commissioning Group
NHS Liverpool Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS South Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Warrington Clinical Commissioning Group

Policy for Transanal Irrigation

Transanal irrigation systems (Peristeen[®], IryPump[®], Aquaflush[®], Qufora[®]) are a highly specialist management option and should not be initiated by GPs in primary care, without specialist management. Comprehensive training for the individual plus on-going structured support is essential for safe and efficient long-term use of rectal irrigation¹.

Rectal irrigation should only be used after medication has been tried (oral drugs, suppositories and enemas), changes to the diet have been made and various physiotherapy and retraining sessions have taken place. Patients have to be motivated and determined to succeed with rectal irrigation.

The evidence is weak². The best evidence comes from a trial of 87 patients with neurogenic bowel dysfunction as a result of spinal cord injury³ but even this is limited as the outcome measures are reported by the patients. The NICE costing model is based on adults with neurogenic bowel dysfunction from the trial above and NICE admits there is considerable uncertainty in the costing. The estimated savings are £2,867 per patient over 37 years, based on it being used every other day. The savings are based on fewer hospital visits, fewer healthcare professional visits, less carer time, reduced faecal incontinence leading to fewer incontinence pads and fewer urinary tract infections.

Criteria from the current 2014/15 Cheshire and Merseyside commissioning policy	
Intervention	
Policy Statement	
Minimum eligibility criteria	Not Applicable as there is no current policy for Transanal Irrigation in place.

Proposed criteria for the revised, future policy		High level summary of changes
Intervention	Policy for Transanal Irrigation	
Policy Statement	Restricted	
Minimum eligibility criteria	<p>Transanal irrigation is commissioned for adults and children with neurogenic bowel dysfunction, post anterior resection syndrome, congenital bowel malformations, slow transit bowel, obstructive defaecation and a limited number of patients with faecal incontinence. All patients should meet the eligibility criteria below.</p> <p>ALL the following criteria must be met and apply to all patients whether referred to the specialist service by the GP or by another secondary care specialty:</p> <ul style="list-style-type: none"> • Only commissioned for adults and children who have already undergone an adequate trial of all other less invasive management options such as diet, lifestyle, defecation dynamics, pelvic floor re-education, bowel retraining, cognitive behavioural therapy and drug therapy have been maximised but proved unsuccessful. • All appropriate laxatives should have been tried at adequate doses and for several months at a time. See Pan Mersey Constipation Guidelines . • All appropriate investigations should have been carried out, including sigmoidoscopy, colonoscopy, defecating proctogram, biofeedback to strengthen the sphincter or transit studies. • The most cost-effective system should be used and prescribing should be initiated by a consultant-led multidisciplinary specialist service. • The patient should be established on alternate day use by the specialist service and the irrigation system should be stopped if the patient does not use it regularly or does not want to continue with it. • There should be a demonstrable improvement in validated measures of bowel function such as the Cleveland Clinic constipation scoring system, St Mark's faecal incontinence score or neurogenic bowel dysfunction score • It may take 4-12 weeks to establish a reliable and effective routine. If success has not been achieved by 8-12 weeks, a re-evaluation needs to be 	<p>Reason for proposed policy</p> <p>Transanal irrigation is a highly specialist procedure. The individual must be given in depth training and</p> <p>ongoing support to make sure that the condition is managed safely and efficiently.</p> <p>The policy has been aligned with NICE Medical Technology Guidance February 2018.</p> <p>EIA – The assessment identified that as this is a new policy and introducing criteria may potentially reduce the number of people currently receiving treatment that adverse impact was possible and therefore further engagement was recommended before carrying out a stage 2 assessment.</p>

			<p>undertaken. The specialist service should retain prescribing until the training and support criteria below have been met.</p> <ul style="list-style-type: none"> • The patient, carers and NHS staff supporting the patient should receive specialist training in the use of the irrigation system. • Ongoing structured patient support including written information, risk-awareness and action to take and contact telephone numbers must be established before the specialist requests a transfer of prescribing to primary care. • The patient's Primary Care Clinician must be supplied with sufficient written supporting material to monitor compliance and effectiveness and to be able to provide ongoing prescribing and supervision, plus a contact telephone number. GPs do not have to take over prescribing if they do not feel confident and competent to do so. • The specialist service should be available for advice and support for both patients and Primary Care Clinicians. <p>Electric pumps such as Iry Pump and Electric Wellspect should only be used for patients that meet <u>all</u> the other criteria but have very poor dexterity eg as a result of spinal injury, MS or CVA and are unable to use a balloon pump.</p>	
		<p>Evidence for inclusion and threshold</p>	<ul style="list-style-type: none"> • PrescQIPP Bulletin 171 February 2017. Rectal Irrigation (DROP-List) • NICE Medical Technology Guidance February 2018. Peristeen transanal irrigation system for managing bowel dysfunction. • Christenson P et al. A randomized, controlled trial of transanal irrigation versus conservative bowel management in spinal cord-injured patients. Gastroenterology 2006;131:738-747 	