Guidelines for the use of Rectal Irrigation

(Healthcare Professionals)

St Mark's Hospital

King's College London
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The Burdett Institute of Gastrointestinal Nursing

Preface

Dear Colleague

It is always a little daunting introducing a new procedure into your clinical practice. There are always questions and some uncertainties. For this reason the bowel continence team at St Mark's Hospital have decided to share their guidelines on rectal irrigation with others. There is too much re-inventing of wheels in today's health service. We are not claiming that this is the last word on irrigation: there is always room for flexibility and adaptation. With experience, our practice may well change and develop over years to come. But for now, this is our clinical practice, which we are happy for you to use and adapt. Feedback or comments would be most welcome.

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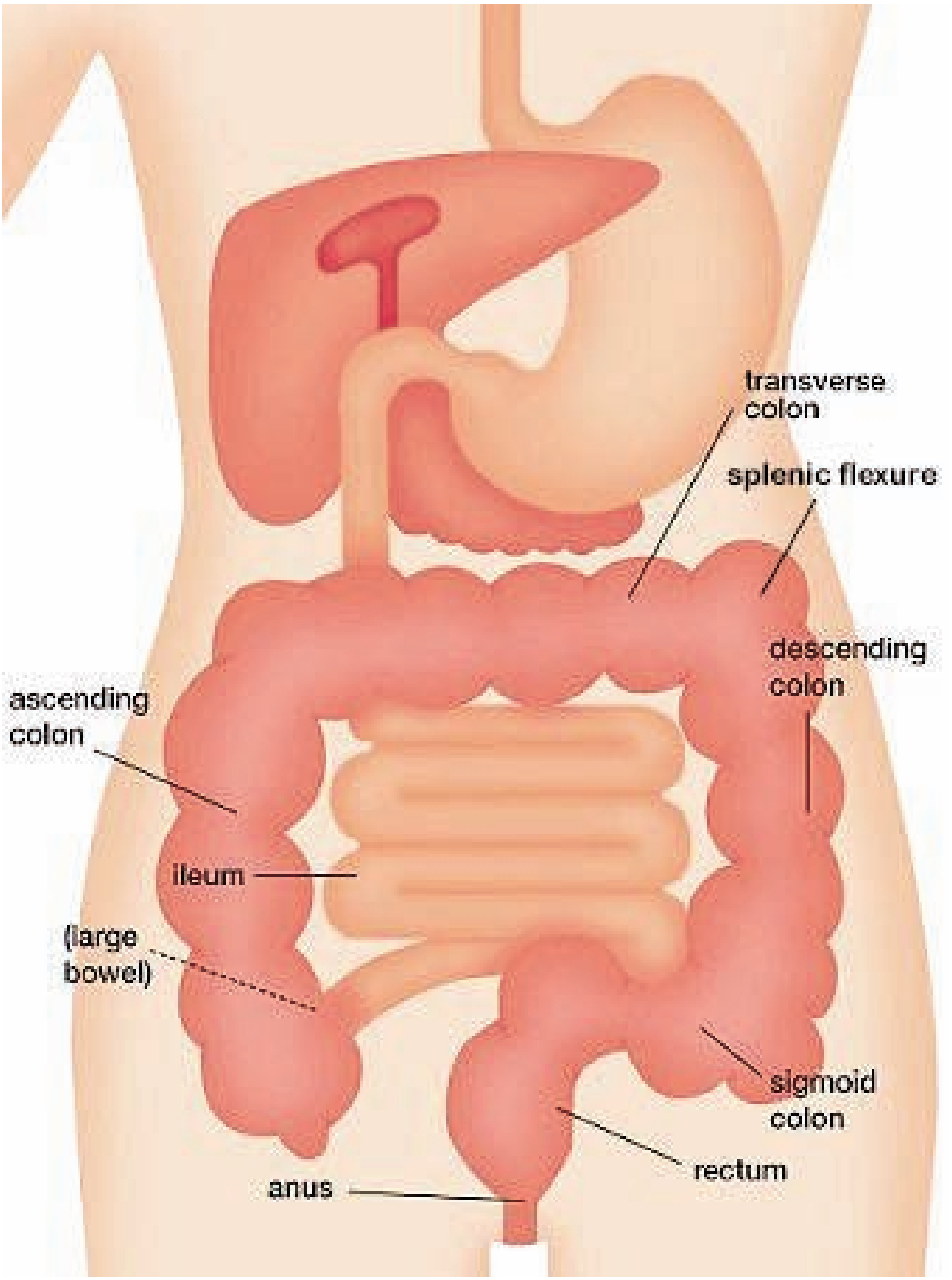
Background

Faecal incontinence is a common health problem, affecting over 1% of community-dwelling adults (1;2). Chronic constipation may affect 3-5% of the population depending on the definition used (3). Most patients will respond to lifestyle modifications (such as dietary modifications), medication (constipating or laxatives as appropriate) and behavioural methods such as pelvic floor muscle training or biofeedback (3;4). But for the minority who do not respond, symptoms may impose severe ongoing restrictions on quality of life.

Colostomy irrigation is a well-established technique for controlling stoma output. Trans-anal irrigation is reported to benefit some patients with faecal incontinence, rectocele and constipation (5;6). It is possibly more effective in patients with passive soiling than those with urge incontinence secondary to loose stool (7). It has been more widely reported in children with spina bifida than in adults (8-10).

Trans-anal irrigation has been found in a randomised controlled trial to be effective for both constipation and faecal incontinence in people with spinal cord injury (11). In scintigraphic studies anal irrigation has been found to empty stool as far up as the splenic flexure (12).

Trans-anal irrigation is widely used in Europe but until recently seldom in the United Kingdom (UK). More widespread implementation has been limited until recently because no purpose-designed equipment was easily available in the UK, necessitating the use of often unsuitable colostomy irrigation equipment. The advent of the first purpose-designed and CE marked rectal irrigation kit (Peristeen Anal Irrigation, Coloplast Limited) on prescription in the UK, means that this procedure can now be implemented much more widely in clinical practice.



Introduction

Rectal irrigation will usually only be tried if other less invasive methods of bowel management have failed to adequately control constipation and/or faecal incontinence. Depending on each individual's assessed symptoms and need (13), this will often include dietary measures, adjusting fluid intake, bowel habit, ensuring toilet access, evacuation techniques, medication and pelvic floor muscle training (14)(15). There is a relatively small evidence base for this procedure at present (5;7;11), and so much of the advice given here is based on expert opinion and practical experience.

Indications for use

- Neurogenic bowel dysfunction:
  e.g. spinal cord injury, spina bifida, multiple sclerosis
- Chronic constipation, including both evacuation difficulties and slow transit constipation
- Chronic faecal incontinence

Use with care and close monitoring

Some types of patient may require additional supervision or monitoring, at least until it is clear that irrigation is not producing any problems. This will depend on the judgement of the assessing professional, but may include:

- Spinal cord injury at or above T6, monitor for autonomic dysreflexia, until it is clear that the technique is well tolerated and does not provoke autonomic dysreflexia
- Unstable metabolic conditions (frail, known renal disease or liver disease: may need to monitor electrolytes and possibly use saline rather than water for irrigation)
- Under 18 years old (consult paediatric consultant and use saline for younger children)
- Inability to perform the procedure independently or comply with the protocol in the absence of close involvement of carers (e.g. due to physical disability, cognitive impairment, major mental/emotional disorder). Experience to date with irrigation by a carer suggests that it is no more problematic than self irrigation for physically disabled individuals
- Anorectal conditions that could cause pain or bleeding during the procedure (e.g. third degree haemorrhoids, anal fissure)

Relative contra-indications (use only after careful discussion with relevant medical practitioner)

- Pregnant or planning pregnancy (women)
- Active perianal sepsis
- Diarrhoea
- Anal fissure
- Large haemorrhoids that bleed easily
- Faecal impaction (clear, if possible before starting irrigation: digital rectal examination if unsure)
- Past pelvic radiotherapy which has caused bowel symptoms
- Known severe diverticular disease
- Use of rectal medications for other diseases
- Congestive cardiac failure
- Anal surgery within the past 6 months
- Children under 3 years old

Absolute contra-indications (irrigation should not be used)

- Acute active inflammatory bowel disease
- Known obstructing rectal or colonic mass
- Rectal or colonic surgical anastomosis within the last 6 months
- Severe cognitive impairment (unless carer available to supervise/administer)

Assessment

It is essential to carry out a full individual assessment of patient suitability prior to commencing irrigation. This will consider the above inclusion/exclusion criteria, assess patient motivation and acceptability of the procedure, and whether other possible alternatives have been considered or tried. This assessment should be in the format approved locally for bowel care, for an example see (13). Digital rectal examination should be performed before the first irrigation and documented in all cases to check that there is no obstruction, that the anus is not stenosed and that there are not any painful anorectal conditions (such as anal fissure).

Informed consent

Irrigation is an invasive procedure and as such informed consent must be obtained from the patient prior to commencing the procedure. This should follow local policy on whether this needs to be written or verbal consent. Either way, the discussion should be documented and the patient's consent recorded.

Equipment required

- Irrigation bag, control unit and single-use rectal catheter (Peristeen Anal Irrigation, Coloplast Ltd: available on prescription and via Charter Healthcare 0800 132 787).
- Most patients irrigate every other day and they will need a new catheter for each irrigation and a new water bag after every 15 irrigations (Accessory unit order number 29122, contains 15 catheters and replacement water bag). The irrigation system lasts for 90 uses so needs replacement every 6 months (order number 29121), if the patient irrigates every other day.

- Disposable gloves (optional for patient but required if healthcare professionals administer irrigation)
- Wipes for skin cleaning after procedure
- If healthcare professional or carer is to administer irrigation personal protective equipment is necessary (e.g. disposable gloves, apron)

Risks

- Worsened faecal incontinence (see troubleshooting on following pages)
- Minor discomfort or abdominal cramps (see troubleshooting on following pages)
- Minor rectal or anal bleeding
- Perforation of the bowel: likely to be very rare, but a possible complication as with any invasive procedure

Procedure

Wherever possible it is usual to teach the patient to perform his/her own irrigation independently. Most patients will be taught in the clinic or at home by using an actual irrigation procedure. Sometimes more than one teaching session is needed. The patient should be observed closely during the procedure for any signs of dizziness, fainting or feeling unwell.

All spinal cord injured patients with injury at or above T6 MUST be accompanied for their first procedure and observed for signs of autonomic dysreflexia. Patients known to experience dysreflexia should have medication to hand in case it is needed (16).

Occasionally it may be judged that verbal instruction and handling of the equipment is sufficient, with the patient then using the equipment independently and alone. If the patient has not had a digital rectal examination within the past 2 months, this should be performed to check that there is no obstruction to passing the catheter. An instructional DVD is available from Coloplast for patients for both initial teaching and to re-view at a later date.

See patient instructions for details of the procedure and troubleshooting common problems. Advice is to start with 500mls tepid tap water and if necessary increase until emptying is satisfactory, the average amount of water used is 750ml as this volume has proven successful, but volumes of 250-1500mls are reported (11).

Patients should be given clear instructions on how to contact the team for telephone or email advice while they are establishing the technique at home.

Use of laxatives or additives

If the patient is taking laxatives before starting irrigation, it is prudent to continue these in the usual dose until irrigation is established. Many patients find that they can gradually stop taking laxatives once bowel emptying with irrigation is routine.

If water alone does not promote rectal emptying, a prescribed phosphate enema may be added to the irrigation water. However, this should not be introduced until water alone has been tried for at least 1 month.

Tap water is suitable for most patients. However, young children (under 13 years) and any patient with electrolyte disturbances should use normal saline.

Record keeping

It is essential to keep accurate records, including:

- the reasons for selecting irrigation for this patient
- discussions held with the patients about risks and benefits
- informed consent to use irrigation
- information and instructions given to the patient and any carers
- communication with the primary care team
- any adverse events reported
- plans for follow up and monitoring (suggested to be at least 6 monthly clinical contact)

Problems - see also patient information

1. Bleeding

Minor bleeding on the catheter is not a concern. More major or regular bleeding should lead to referral for flexible sigmoidoscopy. Altered (dark red) bleeding should prompt urgent referral to colorectal services. If the patient experiences a haemorrhage with or without pain, emergency care is indicated as the rectum could theoretically be perforated. This might necessitate emergency surgery and the patient should know to gain emergency medical help in this VERY UNLIKELY event.

2. Difficulties with catheter insertion

Check for impaction, anorectal abnormalities. Check patient's insertion technique.

3. Other problems

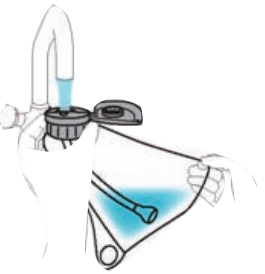
See patient information on following pages.

Information for Patients

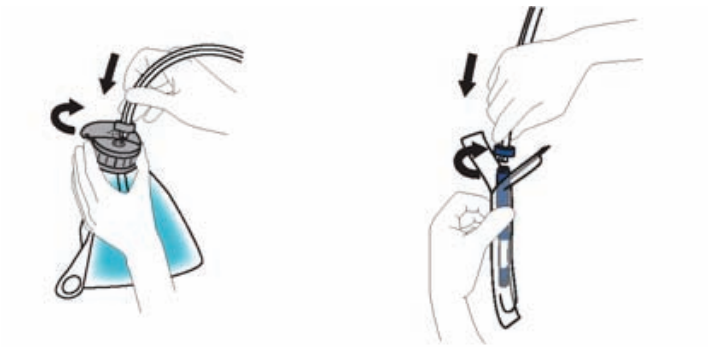
Rectal irrigation should only be started and carried out for the first time under the direction of a doctor, nurse or other qualified healthcare professional.

The procedure will normally take place while sitting on a toilet or commode.

- Fill water reservoir (it is important to fill the bag completely, even if the full volume will not be used: this makes it easy to control how much water is inserted and ensures the system works efficiently). Use lukewarm (not hot or cold to the touch) tap water. There is no need to measure the water temperature.

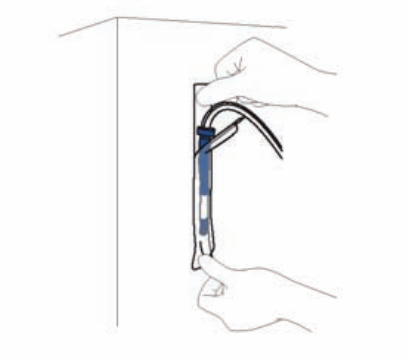


- Assemble the equipment: connect the irrigation bag, control unit and single-use rectal catheter, blue to blue and grey to grey.

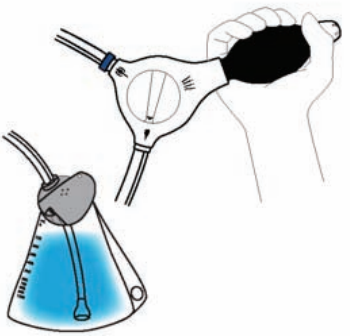


- Strap pump to the leg if this is most convenient.

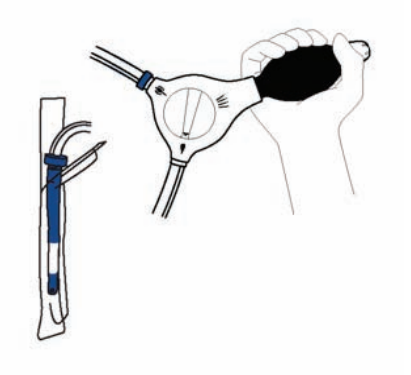
- Open the packaging of the rectal catheter 2-3cm (use the self-adhesive tab to fix the package to a vertical surface if convenient.)



- Turn the control unit dial to the water symbol.



- Pump the control unit 2-3 times to "prime" the tubing with water and activate the self-lubricating coating on the catheter.



- Turn the control dial to the Balloon symbol.  Do not pump yet.

- Transfer to the toilet if not on it already.

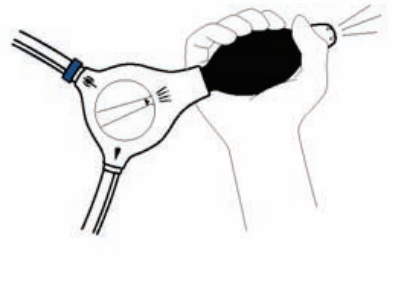
- Holding the catheter by the finger grip, gently insert into the anus as far as the finger grip will allow. If you feel any resistance while inserting the catheter NEVER use force, take the catheter out, check that there is not hard stool blocking the insertion, and gently try again.

- While still holding the catheter in place, pump the balloon (your healthcare professional will advise you how many times to pump but typically this is 3 to 4 times). This will inflate the balloon. Now let go of the catheter as the balloon will hold it in place.

- Turn the control unit dial to the water symbol and start to pump water into the rectum. About one pump each two seconds is the usual speed to avoid discomfort. People with a high spinal injury may need to pump more slowly than this.

- Continue pumping until the required volume has been instilled (your healthcare professional will advise you how much to use). It may take up to 10-15 minutes to pump in all the water.

- Turn the control unit dial to the air symbol to deflate the balloon. The catheter is likely to drop out under gravity. If not, a gentle pull will remove it.



- Use the catheter package to dispose of the catheter in a rubbish bin.

- Water and stool should start to pass into the toilet very soon after the catheter is removed. Gentle pushing, abdominal massage or pressure on the abdomen may help this process. AVOID THE TEMPTATION TO STRAIN. It is better to be patient and wait. It can take 10-20 minutes for the bowel to stop emptying. With practice, you will learn when you have "finished" and it is safe to leave the toilet.

- Clean and dry the anal area.

- Empty any remaining water from the bag and tubing.

- Turn the control unit dial to the finish position for storage.

- Store the equipment in a dry place away from direct heat sources.

How often should I irrigate?

Most people irrigate every 1 or 2 days, but more or less often is fine. It is probably best to get into a regular routine, rather than varying the interval a lot. It is only with time and practice that you will learn what works best for you and your bowel.

When should I irrigate?

Again, this is largely up to you. Irrigation seems to work best for most people if it is done at approximately the same time each day and we recommend that you start like this. Eating and drinking stimulate the bowel, so about 30 minutes after a meal will mean that you have the best chance of working with the natural activity of your bowel and achieving the best emptying. This will be morning or evening for most people. But once you have irrigation established, don't be afraid to try varying the routine a little to suit your needs and activities. The aim of irrigation is to free you up, not to tie you down.

How much water should I use?

Your healthcare professional will advise you on this but most people use 500-800mls for each irrigation. But it really is a case of trial and error to find what works best (complete emptying in the least time). It is usual for adults to start with 500mls and if necessary increase to 750ml. Stick to each volume you try for a few days rather than chopping and changing too often. A few people find that volumes as low as 200-300mls work; others need to use 1.5 litres for best effect. Some find that pumping in half the water, stopping removing the catheter and emptying, and then pumping in the other half and emptying again works best.

Can I travel with the irrigation equipment?

Yes! However, you should use bottled or cooled boiled water in places where the tap water is not safe to drink. Remember in different time zones your body may take a while to adjust to a new routine. Your diet may also be different and this can affect the bowel.

What happens if my medical condition changes or I have bowel or abdominal surgery?

You should stop irrigating and consult your healthcare professional before recommencing.

Are there any risks or complications?

Peristeen Anal Irrigation is licensed for patient use in many countries including the United Kingdom. Some people experience minor or temporary problems such as discomfort or a little bleeding (see troubleshooting below). There is a possible risk of a hole or tear in the bowel occurring if the catheter is not correctly inserted, but this risk is minimal if you follow the instructions given to you by your healthcare professional.

Troubleshooting

Pain

If pumping the water brings on pain, pause for a while and then continue. If the pain is acute or severe STOP IMMEDIATELY, DEFLATE THE BALLOON AND REMOVE THE CATHETER. If the pain persists for more than a few minutes or is accompanied by a lot of bleeding seek medical help immediately.

Bleeding

Occasional spots of bright red blood may be seen on the catheter, especially if you have haemorrhoids. This is not a cause for concern. If bleeding is occurring regularly, report this to your health professional. If you have a sudden major bleed, seek urgent medical attention.

Abdominal cramps

If you experience some abdominal cramps, try pumping more slowly, or stop for a minute and re-start when the cramps subside. Cramps may be a sign that the irrigation water may be too cool or is stimulating the gut to contract, so cramps can indicate that the irrigation is working well.

Feeling unwell during or after irrigation

Occasionally irrigating can make you feel unwell, either at the time or immediately afterwards. It is not uncommon to notice a little sweating or palpitations. You may even feel a little dizzy or light-headed until you get used to the procedure. If you are affected in this way, you should try to make sure that there is someone you can call for help if you feel faint.

If you have a spinal injury at or above T6 and are prone to autonomic dysreflexia: always make sure that you have your medication to hand when you irrigate and stop the procedure, deflate the balloon and remove the catheter if you notice any dysreflexic symptoms (this does not apply to anyone else).

Catheter expelled during pumping

If the balloon is deflated: check for a burst balloon. Practice inflation technique with a catheter outside the body to ensure the balloon symbol  is used and enough air is instilled. Check that you are not accidentally turning to the air symbol  when intending to use the water symbol  after inflating the balloon.

If the balloon is expelled immediately after inflation, the balloon is stimulating rectal contractions. Try inflating the balloon more slowly or inflate it a little less. If the balloon is expelled once you have begun to pump, check that the water is not too hot or cold, or try pumping more slowly. Expelling the balloon may be more likely to happen if you irrigate after a meal: try other times.

For women with impaired sensation or difficulty with your hands: make sure you have not mistakenly inserted the catheter into the vagina.

Nothing is passed from the rectum

Check that you are not dehydrated. Try drinking at least 1.5 litres per day, more if the weather is hot. You could be heavily constipated; this should be cleared as much as possible before you commence irrigation. Regular use of irrigation can be used to prevent constipation occurring in the future.

Water is passed but no stool

There may not be any stool if you had a good result last time you irrigated. You may need to irrigate less often if this is happening regularly. If you have not had any results for several days your stool may be very hard and impacted. You may need a laxative: consult your healthcare professional.

Water or stool leakage after irrigation

It may be necessary to wear a small pad when you first start irrigating, until you know from experience that this will not happen.

- Try sitting on the toilet longer to make sure that you are empty
- Try using more water
- Try using less water
- If you are losing a bowel motion between irrigations, you may need to irrigate more often
- An anal plug may help if the problem persists

How do I get the equipment?

Peristeen Anal Irrigation is available on drug tariff and can be delivered to you via Charter Healthcare 0800 132 787.

Who to call if there is a problem?

For St Mark's Hospital patients: St Marks Hospital Continence Service 020 8235 4164 (Monday- Friday 9am-5pm).

For other patients: contact the health professional who taught you irrigation.

In an emergency contact your local medical services.

Peristeen Anal Irrigation

Item	Contains	Product code	Usage
 System	Control unit, water bag, tubing, 2 rectal catheters, 2 straps, holdall	29121	Works 90 times (change every 6 months if irrigating every other day)
 Accessory unit	15 rectal catheters, water bag	29122	Order 1 box per month if irrigating every other day (catheter is single use, water bag needs changing every 15 times
 Straps	2 Straps	29124	Used if replacement straps are required
 Extra Tubing	2 tubes with blue connectors	29125	Used if tubing requires replacement

Useful contacts

For more information about Peristeen Anal Irrigation visit
www.coloplast.co.uk
or
Charter Healthcare (Home Delivery Service) 0800 132 787

Bladder and Bowel foundation
Tel 0870 770 3246
www.bladderandbowelfoundation.org

Patient Anal Irrigation Diary

Date	Time	Balloon Pumps	Water (ml)	Comments

References

(1) Perry S, Shaw C, McGrother C, Flynn RJ, Assassa RP, Dallosso H, et al. The prevalence of faecal incontinence in adults aged 40 years or more living in the community. Gut 2002;50:480-4.

(2) Macmillan AK, Merrie AEH, Marshall RJ, Parry BR. The prevalence of faecal incontinence in community-dwelling adults: a systematic review of the literature. Dis Colon Rectum 2004;47:1341-9.

(3) Muller-Lissner SA, Kamm MA, Scarpignato C, Wald A. Myths and misconceptions about chronic constipation. Am J Gastroenterol 2005;100(1):232-42.

(4) Norton C, Cody JD, Hosker G. Biofeedback and/or sphincter exercises for the treatment of faecal incontinence in adults. Cochrane Database of Systematic Reviews, Cochrane Library, John Wiley & Sons, Chichester UK 2006;(Issue 3. Art. No.: CD002111. DOI: 10.1002/14651858.CD002111.pub2.).

(5) Gardiner A, Marshall J, Duthie GS. Rectal irrigation for relief of functional bowel disorders. Nursing Standard 2004;19(9):39-42.

(6) Crawshaw A. How to establish a rectal irrigation service. Gastrointestinal Nursing 2004;2(2):29-31.

(7) Briel JW, Schouten WR, Vlot EA, Smits S, van Kessel I. Clinical value of colonic irrigation in patients with continence disturbances. Dis Colon Rectum 1997 Jul;40(7):802-5.

(8) Lipak GS, Revell GM. Management of bowel dysfunction in children with spinal cord disease or injury by means of the enema continence catheter. Journal of Paediatrics 1992;120:190-4.

(9) Scholler-Gyure M, Nesselaar CH, van Wieringen H, Van Gool JD. Treatment of defaecation disorders by colonic enemas in children with spina bifida. European Journal of Pediatric Surgery 1996;6(Suppl1):32-4.

(10) Shandling B, Gilmour RF. The enema continence catheter in spina bifida: successful bowel management. J Pediatr Surg 1987;22:271-3.

(11) Christensen P, Bazzocchi G, Coggrave M, Abel R, Hultling C, Krogh K, et al. A randomized, controlled trial of transanal irrigation versus conservative bowel managment in spinal cord-injured patients. Gastroenterology 2006;131:738-47.

(12) Christensen P, Olsen N, Krogh K, Bacher T, Laurberg S. Scintigraphic assessment of retrograde colonic washout in faecal incontinence and constipation. Dis Colon Rectum 2003;46(1):68-76.

(13) Norton C, Chelvanayagam S. A nursing assessment tool for adults with faecal incontinence. Journal of Wound, Ostomy, & Continence Nursing 2000;27:279-91.

(14) Norton C, Chelvanayagam S. Bowel Continence Nursing. Beaconsfield: Beaconsfield Publishers; 2004.

(15) National Institute of Clinical Excellence. Management of faecal incontinence in adults. London: NICE; 2007.

(16) Coggrave M. Effective bowel management for patients after spinal cord injury. Nursing Times 2004;100(20):48-51.

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