Transanal irrigation as a treatment for bowel dysfunction

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Transanal irrigation (TAI), also known as rectal irrigation, is used throughout the UK as a treatment for bowel dysfunction, and it has recently received National Institute for Health and Care Excellence (NICE) approval for treating both constipation and faecal incontinence (NICE, 2018). Following adequate training by a specialist, TAI is self-administered by the patient (or by their carer or other health professional), at home, usually sitting on the toilet or commode chair.

Warm tap water (36–38°C) is instilled into the rectum and sigmoid colon via the anus, using either a rectal catheter or a cone. When the catheter or cone is removed, the water is expelled, along with the contents of the rectum, sigmoid colon and possibly descending colon. TAI can re-establish controlled bowel evacuation, enabling the user to choose the time and place of evacuation (Emmanuel, 2010).

Frequency of irrigation and volume of water used (typically 70–1000 ml) varies depending on the patient’s response and tolerance. Where there is electrolyte imbalance, Norton and Coggrave (2016) anecdotally advised the use of normal saline and monitoring of electrolyte balance. If the tap water available is not drinkable, bottled water is advised (Emmanuel et al, 2013).

**Mechanism of action**

Proposed mechanisms of action include simple mechanical washout in the recto-sigmoid colon, increased colonic peristalsis stimulated by the washout or a combination of these (Christensen and Krogh, 2010). A scintograpic study (Figure 1) has shown that, on average (mean), the irrigation fluid reaches just beyond the right colonic flexure, and antegrade colonic propulsions are induced through the colon. This occurred especially in those with spinal cord lesions and faecal incontinence, where most of the recto-sigmoid and descending colon was emptied. In patients with idiopathic constipation, only 59% of the recto-sigmoid colon emptied; however, this was sufficient for patients to feel benefit from TAI. For all 19 patients in this study, bowel function and quality of life improved, reinstating predictability and control over defaecation (Christensen et al, 2003).

Christensen et al (2003) suggested that, for patients with faecal incontinence, efficient emptying of the colon and rectum means that new faeces does not reach the rectum for around 2 days, reducing leakage between irrigations. In patients with constipation, regular evacuation of the recto-sigmoid area can promote transport through the entire colon, preventing impaction (Emmanuel, 2010).

**Key words**

- Constipation
- Efficacy
- Equipment
- Faecal incontinence
- Safety

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Patient benefits

TAI was first used in patients with neurogenic bowel dysfunction, a significant number of whom develop constipation and/or faecal incontinence. Levinthal et al (2013) studied gastrointestinal symptoms in 218 people with multiple sclerosis. Constipation and faecal incontinence were common, reported by 36.6% and 15.1% of the study population respectively. Previously, Christensen et al (2006) had definitively established the benefit of TAI for patients with spinal cord injuries. They undertook a large (n=87), randomised controlled, multi-centre trial of TAI (using Peristeen) and conservative bowel management strategies in patients with spinal cord injury. TAI significantly reduced constipation and faecal incontinence when compared with conservative strategies. Subsequent observational studies have shown TAI to be effective in patients with other neurogenic bowel conditions, including multiple sclerosis and Parkinson’s disease (Emmanuel, 2010).

TAI is an effective treatment for chronic constipation that has proven refractory to medical management (Emmett et al, 2015). Chronic constipation is a common condition, occurring in 14% of the community, particularly in women, and increasing in prevalence as the population ages (Suáres and Ford, 2011). Patients with obstructed defaecation syndrome, functional defaecation disorder, chronic idiopathic constipation or constipation-predominant irritable bowel syndrome can benefit from TAI (Emmett et al, 2015). Recent NICE guidance (2018)—focussing on the Coloplast Peristeen system—recognised that TAI can reduce constipation and faecal incontinence in patients with bowel dysfunction, supporting earlier findings.

Table 1. Indications for transanal irrigation

<table>
<thead>
<tr>
<th>Chronic constipation</th>
<th>Chronic faecal incontinence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idiopathic, IBS-C, opioid-induced, neurological or result of obstructive defaecation syndrome, in which symptoms are present for over 6 months and there is inadequate response to:</td>
<td>Idiopathic, IBS-D, neurological or result of obstructive defaecation syndrome, in which symptoms are present for over 6 months and there is inadequate response to:</td>
</tr>
<tr>
<td>• At least two types of laxatives used at maximum tolerated dose</td>
<td>• Biofeedback therapy</td>
</tr>
<tr>
<td>• Biofeedback therapy</td>
<td>• Lifestyle changes</td>
</tr>
<tr>
<td>• Lifestyle changes</td>
<td>• Constipating medication</td>
</tr>
<tr>
<td>Specialist initiated drugs if indicated and available locally, such as Prucalopride, Lubiprostone, Linaclootide, Naloxegol</td>
<td>Note: IBS=irritable bowel syndrome, either constipation-dominant (-C) or diarrhoea-dominant (-D)</td>
</tr>
</tbody>
</table>

Applicability

TAI is indicated as a treatment for constipation and/or faecal incontinence and should only be initiated when conservative approaches have proven inadequate (Table 1).

A full patient assessment should be undertaken prior to initiating TAI, during which red flags should be excluded. These include blood in faeces, weight loss, abdominal pain, new or continuing changes in bowel habits and family history of colorectal cancer or inflammatory bowel disease (IBD) (Emmanuel et al, 2013). If present, TAI is contraindicated until malignant disease is excluded or IBD becomes quiescent. Patient assessment should include an assessment of the patient’s motivation for undertaking this treatment, as well as the presence of any conditions affecting dexterity, mobility or cognition. Medical and surgical history should be ascertained to identify any contraindications or circumstances requiring extra care (Table 2). All patients should undergo digital rectal examination to exclude anorectal obstruction (that is, the rectum could be loaded with faeces), anal stenosis, anal stenosis or painful conditions, such as anal fissure. Results and patient consent to proceed with TAI should be documented according to local policy (Norton and Coggrave, 2016).

Efficacy

Several studies document the success of TAI in patients with spinal cord injury and cauda equina syndrome. The most robust of these was...
a randomised controlled trial that compared TAI with conservative bowel management over a 10-week period. TAI was more effective, significantly reducing the severity of constipation and faecal incontinence. Additional benefits included greater general satisfaction, reduced time spent on bowel management (from 74 to 47 minutes per day) and fewer urinary tract infections (Christensen et al, 2006). In the author’s experience, the time taken for TAI can be as little as 15 minutes. Subsequent prospective studies confirmed improvement in symptoms and quality of life (Christensen et al, 2008; Del Popolo et al, 2008). Importantly, success is maintained in the long term (Christensen et al, 2006; Christensen et al, 2009; Faaborg et al, 2009).

There is limited data on the efficacy of TAI in adults with specific neurogenic bowel conditions, such as spina bifida or multiple sclerosis. These patients are often included in studies with mixed populations, so results for specific neurogenic conditions should be interpreted with caution. These include Del Popolo et al (2008), whose prospective non-randomised study included 12 patients with spina bifida and two with multiple sclerosis in a population of 33 with neurogenic bowel dysfunction. This short, 3-week study reported significant improvement with TAI, with similar success rates for both constipation and faecal incontinence (63% and 68% respectively), reducing reliance on laxatives, time spent on evacuation and reliance on caregivers.

Faaborg et al (2009), in a mixed population of spinal cord injury, multiple sclerosis and spina bifida, reported a successful outcome for 46% of users of TAI, with 35% ongoing success at 3 years. Christensen et al (2009) reported effectiveness in the long term (at 10 years) for 50% of users. In a small study of 10 patients with mixed neurogenic bowel dysfunction, Storrie et al (2009) suggested TAI is beneficial where rectal compliance is reduced. Rectal compliance is the ability of the rectum to stretch and therefore store faeces prior to defaecation. When this is reduced, patients are unable to ‘hold on’ and typically make frequent visits to the toilet to pass small amounts of stool.

TAI has also proven beneficial in patients with Parkinson’s disease, stroke, cerebral palsy and cerebral thrombosis (Christensen et al, 2009).

In addition to patients with neurogenic conditions, TAI has been reported as successful for other types of bowel dysfunction (Figure 2).

### Table 2. Circumstances when transanal irrigation is contraindicated or should be discontinued or used with caution

<table>
<thead>
<tr>
<th>Contraindicated or discontinued</th>
<th>Used with caution</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Active inflammatory bowel disease</td>
<td>• Cognitive impairment</td>
</tr>
<tr>
<td>• Acute diverticulitis</td>
<td>• Congestive cardiac failure</td>
</tr>
<tr>
<td>• Anal or colorectal stenosis</td>
<td>• Faecal impaction</td>
</tr>
<tr>
<td>• Change in bowel habit, until cancer is excluded</td>
<td>• Inactive inflammatory bowel disease</td>
</tr>
<tr>
<td>• Colorectal cancer</td>
<td>• Low blood sodium</td>
</tr>
<tr>
<td>• During chemotherapy</td>
<td>• Long-term steroid therapy</td>
</tr>
<tr>
<td>• Ischaemic colitis</td>
<td>• Painful anal conditions, including fissure, fistula, haemorrhoids, solitary rectal ulcer syndrome</td>
</tr>
<tr>
<td>• Pregnancy (even for established users)</td>
<td>• Pelvic radiotherapy</td>
</tr>
<tr>
<td>• Within 12 months after radical prostatectomy</td>
<td>• Pregnancy (planned)</td>
</tr>
<tr>
<td>• Within 3 months of rectal or colorectal surgery</td>
<td>• Previous anal, colorectal or pelvic surgery</td>
</tr>
<tr>
<td>• Within 4 weeks of polypectomy</td>
<td>• Previous diverticulitis or diverticular abscess</td>
</tr>
<tr>
<td>• When rectal medications are used for other conditions</td>
<td>• Prone to rectal bleeding or on anticoagulant therapy, not including aspirin or clopidogrel</td>
</tr>
<tr>
<td>• Within 3 months of colonic biopsy</td>
<td>• Renal disease</td>
</tr>
<tr>
<td>• Within 6 months of rectal or colorectal surgery</td>
<td>• Severe autonomic dysreflexia</td>
</tr>
<tr>
<td>• Severe diverticulosis (diffuse disease or dense sigmoid disease)</td>
<td>• Severe diverticulitis (diffuse disease or dense sigmoid disease)</td>
</tr>
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<td>• Previous anal, colorectal or pelvic surgery</td>
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<td>• Severe autonomic dysreflexia</td>
<td>• Severe diverticulosis (diffuse disease or dense sigmoid disease)</td>
</tr>
<tr>
<td>• Severe diverticulitis (diffuse disease or dense sigmoid disease)</td>
<td>• When rectal medications are used for other conditions</td>
</tr>
</tbody>
</table>

Christensen et al (2009) identified factors correlating to success as:

- Low rectal volume at urge to defaecate
- Reduced rectal capacity
- Low anal squeeze pressure
- Anal insufficiency in neurogenic bowel dysfunction.

In a systematic review of TAI as a treatment for chronic functional constipation, Emmett et al (2015) identified seven small studies using high-volume irrigation with patient reported satisfaction (subjective or visual-analogue scale) as the outcome measure. With an aggregate success rate of 50%, similar to that for neurogenic conditions, this may be considered adequate in the treatment of a chronic, refractory condition, especially given the simple and reversible nature of the treatment (Christensen et al, 2010; Etherson et al, 2017).

A subsequent large retrospective report by Etherson et al (2017) examined outcome questionnaires from 102 of 148 consecutive patients with chronic idiopathic constipation. Patients reported 21,476 irrigations over 119 patient years; mean duration of therapy was 60.5 weeks. Figure 3 shows the proportion of patients in whom symptoms improved.
Overall 67% of patients were ‘moderately’ or ‘very much’ better. Baseline characteristics—age, duration of constipation, proctographic findings of obstructive defaecation and colonic transit time—did not predict the response to TAI.

Unpublished observations by Emmett recorded impressions from patients recently commenced on TAI:

‘I thought it [TAI] would have been hard; I’d never done anything like that before, but

I tried it ... really, really good; I felt great with it.’

One patient who had stopped socialising, was missing out on family holidays and was unable to take his dog out on long walks found that TAI significantly improved his quality of life:

‘So I use the water solution and I, it’s there, you just do it straight away, use it; you go outside, walk around, clear; if you don’t use it, you’re stuck indoors all day.’

TAI is performed routinely, often on alternate days (Norton and Coggrave, 2016), although, in the author’s experience, patients with refractory constipation will undertake daily TAI. It is generally regarded as a safe treatment, although mild and transient side-effects may occur and be tolerated by patients. For example, Gosselink et al (2005) reported a 43% incidence of ‘technical issues’, and up to 74% of long-term users reported expected adverse events. The most commonly reported were abdominal discomfort, anorectal pain, anal-canal bleeding, leakage of irrigation fluid and expulsion of rectal catheter (where used) (Christensen et al, 2009), although only 28% of users discontinued irrigation for these reasons.

Patients with neurogenic bowel dysfunction experienced different side effects in the Christensen et al (2006) study, the most common being abdominal pain (15.7%).
sweating (10.5%), chills (7%) and pronounced general discomfort (5.9%). However, these symptoms occurred in patients using conservative bowel management too, except for sweating, which was significantly less common in TAI.

It is well recognised that inserting a rectal catheter into the rectum, inflating a balloon and instilling water under pressure carries the risk of a potentially lethal perforation. Christensen et al (2016) examined 49 reported cases of perforation and calculated an average risk of perforation of six per million irrigations. More recent data indicates a risk of only two perforations per million irrigations. In 67% of cases, perforations occurred within the first 8 weeks of treatment; the risk did not increase with long-term use. This is highly relevant, as most indications for irrigation require prolonged treatment.

For comparison purposes, the standard quoted risk for perforation during flexible sigmoidoscopy is 1 per 40 000 (Atkins et al, 2002). For many patients undertaking TAI, the alternative is a colostomy, which carries a 30-day mortality risk of 2% (Iversen et al, 2014).

Patients may have increased risk of perforation if they have had previous rectal surgery (transanal rectal resection, ventral mesh rectopexy or rectal prolapse repair), irradiation or diverticular disease (Christensen et al, 2016). Following resection for rectal cancer, more than 80% reported a change in bowel habits, and 45% had bowel problems that severely impact on quality of life, termed low anterior resection syndrome (LARS). TAI is an effective treatment for this (Rosen et al, 2011). Emmanuel et al (2013) recommended endoscopy prior to initiating TAI in this patient group. Christensen et al (2016) noted 15 cases of perforation in patients with non-neurogenic dysfunction, 11 (67%) of whom had previous pelvic organ surgery. Patients should be informed of this increased risk. If rectal catheters are used, the balloon should be inflated to the minimum size that allows the rectal catheter to be held in situ, thus preventing unnecessary pressure against the rectum wall.

### Equipment

There is a growing range of equipment available for use in the delivery of TAI (Figure 4). All should be used according to the manufacturer’s instructions. There is potential for health professionals to feel overwhelmed by the choice.

![Figure 4. Examples of equipment for transanal irrigation](Images supplied to the authors by MacGregor Healthcare)

- Qufora IrriSedo Mini
- Qufora IrriSedo Cone System
- Qufora IrriSedo Balloon system
- Qufora IrriSedo Bed System

There are several factors to consider when selecting equipment. A decision as to whether a high or low volume of water is likely to be required is a pertinent first step. In the author’s experience, patients with neurogenic dysfunction, constipation-predominant irritable bowel syndrome, idiopathic constipation, obstructive defaecation syndrome or faecal incontinence do well with high-volume irrigation. Several systems can deliver this.

The patient should choose whether they prefer using either a rectal catheter or a cone. In the author’s experience, most patients can use any system. There are some factors that require special consideration. If the patient has reduced dexterity and/or mobility, they may find it difficult to hold a cone in position while the water is instilled, a rectal catheter may be more appropriate in these circumstances. Patients who experience anal pain due to anismus may find rectal catheters more comfortable, as they clear the anal canal and sit within the lumen of the rectum. For those who are dependent on carers delivering TAI, a catheter-based system may be more convenient. All rectal catheters and some cones have a hydrophilic coating activated by water. The balloon is inflated.
with air or water. The author has found water filled balloons useful in circumstances where the water leaks during instillation or the balloon is expelled while inflated.

For high-volume irrigation, the patient can choose either a pump system (manual or electric) or a gravity-fed system to instil the water. This will determine where the water container sits, either on the floor or hung up (manufacturers supply a wall hook). Patient dexterity and mobility may again influence this choice. Although there is no recent comparison data between equipment, it seems likely that efficacy is similar, as demonstrated by Crawshaw et al’s (2009) comparison of a gravity-fed system with an electric pump (the forerunner of B Braun IryPump). They concluded similar results and patient satisfaction with both systems, although 75% of respondents preferred the electric pump as a mode of delivery.

Low-volume irrigation (up to 250ml) can be used successfully in patients who experience passive faecal incontinence or post-defaecation soiling (Collins and Norton, 2013). Small volumes of water can also wash out rectoceles. Irrigation should be used with caution in patients following surgery. Clinicians can seek advice from the surgeon, as well as refer to Table 2. For patients with urgency and faecal incontinence resulting from LARS, the author starts with low-volume irrigation, usually with effective clearance and significant improvement in quality of life. Some patients are very nervous about starting TAI, therefore low-volume irrigation can be a gentle introduction to this treatment. Figure 5 offers an algorithm for equipment selection.

Despite these considerations, sometimes the patient cannot use or tolerate the equipment of choice. In the author’s experience, it is very important to ascertain what patients mean if they state TAI is not working, as technical issues with equipment can usually be overcome. Health professionals can be reassured that it is simple for patients to change to an alternative system. Recent guidance from NICE (2018) recommended that clinicians and patients should discuss the options available and that different systems may be tried.

**Note:** Systems delivering high-volume irrigation can also be used to deliver low-volume irrigation

**Qufora Irrisedo Bed** is a system that allows a bed-bound patient to receive irrigation. Water is pumped from a suspended water bag into the rectum through a non-balooned rectal catheter, with three sizes available. It is a closed system, and waste is collected in a drainage bag. It is recommended for use in those who are receiving terminal care or are bed-bound for other reasons, including neurogenic bowel dysfunction (Wilson, 2017).

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**Figure 5. Equipment selection for transanal irrigation**

<table>
<thead>
<tr>
<th>Low volume (&lt;250ml)</th>
<th>High volume (&gt;250ml)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Passive faecal incontinence</td>
<td>• Obstructive defaecation syndrome</td>
</tr>
<tr>
<td>• Post-defaecation soiling</td>
<td>• Constipation-dominant irritable bowel syndrome</td>
</tr>
<tr>
<td>• Low anterior resection syndrome</td>
<td>• Idiopathic constipation</td>
</tr>
<tr>
<td>• High anxiety regarding transanal irrigation</td>
<td>• Neurogenic bowel</td>
</tr>
<tr>
<td>• Faecal incontinence</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cone</th>
<th>Cone</th>
<th>Rectal catheter</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Qufora Irrisedo Mini</td>
<td>• Qufora Irrisedo Cone (gravity-fed or pump, hydrophilic cone and 1.5l bag)</td>
<td>• Qufora Irrisedo Balloon (gravity-fed or pump, water-filled balloon and 1.5l bag)</td>
</tr>
<tr>
<td>• Aquaflush Compact</td>
<td>• Aquaflush Quick (gravity-fed, finger support to hold cone and 1.5l bag)</td>
<td>• Peristeen (manual pump, air-filled balloon and 1.5l bag)</td>
</tr>
<tr>
<td>Both can be used with extension tube for easier water instillation, also allows delivery of full amount (100ml)</td>
<td>• Aquaflush Lite (gravity-fed and 1.2l bag)</td>
<td>• Navina Classic (manual pump, air-filled balloon and 1.5l bag finger grip for holding catheter)</td>
</tr>
<tr>
<td></td>
<td>• IryPump (electric pump, reusable cone and integral temperature indicator)</td>
<td>• Navina Smart with app (electronic touch-sensitive control unit, air filled balloon, 1.51 bag and finger grip for holding catheter)</td>
</tr>
</tbody>
</table>

Consider in patients with:
• Reduced dexterity or mobility
• Reliance on carer support
• Anorectal pain

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before deciding which is most suitable. It takes 6–8 weeks for the patient to become familiar with TAI (Emmanuel et al, 2013). It is most effective when offered with specialist training and structured support (NICE, 2018), particularly in the initial phase to adjust the regimen and address safety concerns. Gallo et al (2018) reported a case of TAI-induced enterovaginal perforation in a female patient who had self-initiated TAI. Competencies of the specialist required to initiate, monitor and evaluate TAI developed from a TAI pathway developed by the Northern Regional Irrigation Specialist Group are outlined in Box 1.

**Box 1. Competencies for health-care professionals teaching transanal irrigation**

- Demonstrate competency in using the equipment
- Demonstrate knowledge of the range of commercially available systems
- Evaluate progress and adjust regimes accordingly
- Show understanding of benefits and risks associated with transanal irrigation
- Teach patients how to use chosen equipment
- Undertake and interpret findings of digital rectal examination
- Identify suitable equipment, considering:
  - High-volume versus low-volume
  - Cone systems versus rectal catheter systems, as well as bed systems
  - Gravity systems versus manual or electric pumps
  - Patient dexterity and mobility
  - Availability of carer support if available
  - Toilet access and provision of suitable aids, such as a commode
- Undertake holistic assessment of patient, including:
  - In-depth assessment of bowel symptoms, including onset, duration, triggers, previous treatment and effect on quality of life
  - Medical and surgical history
  - Medications
  - Ascertain patient expectations in relation to treatment
  - Assessment of mobility and dexterity
  - Availability of carer or other support to assist with irrigation if appropriate
  - Consider home environment, such as access to toilet, and provision of required mobility equipment, such as a shower chair or commode

**Conclusion**

TAI has been shown to be an effective treatment for constipation and faecal incontinence in selected patient groups. It is safe and well tolerated by patients, with a very small risk of perforation. Recent reports of safety and efficacy demonstrate the benefit-to-risk ratio in support of the use of TAI. Careful patient selection and consideration of contraindications and cautions improves the safety of TAI. It is most effective when initiated by specialist health professionals and where patients have access to structured ongoing support. For those patients with refractory bowel dysfunction whose symptoms improve with TAI, it can be considered as a long-term management solution. The following quote, recorded in Emmett’s unpublished observations, summarises one patient’s response to TAI:

“It’s not unpleasant; it’s nothing to be embarrassed about. You fit it into your daily routine easily; it’s quick to use; it’s discreet—the packaging comes nobody knows what you’re getting delivered—and if it works just try it, and if it is working, keep going.”

**Declaration of interest** The authors have no conflicts of interest to declare


**CPD reflective questions**

- Reflect on the ways in which transanal irrigation can be a useful therapy for patients
- Consider how to advise patients on finding the right irrigation system for their needs
- In what situations should transanal irrigation be used with particular caution or discontinued entirely?


Suares NC, Ford AC. Prevalence of, and risk factors for, chronic idiopathic constipation in the community: systematic review and meta-analysis. Am J Gastroenterol. 2011; 106(9):1582–91; quiz 1581, 1592. https://doi.org/10.1038/ajg.2011.164

Qufora® IrriSedo Mini system is the easy and convenient way to instil a small amount of water into the rectum.

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“It is great, it’s made my life better. It’s freed me, I’m no longer tied to the toilet, no longer sore. I’m now very confident”

“Made my bowel super easy to control. I can feel confident all day after I’ve used it. I like that it is small and discreet too”

“It has turned my life around and not having to use drugs, just warm water is very good. Whoever invented it deserves a knighthood”

“A relatively simple solution to a very embarrassing problem”

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