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Management of Tubes and Ostomies

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Disclosures

Mary Ciechoski MS ANP-C

Speakers Bureau: Allergan – Clinical Area – IBS-C, IBS-D

Speakers Bureau: AbbVie – Clinical Area – IBD, EPI, HCV

Speakers Bureau: Gilead – Clinical Area – HCV

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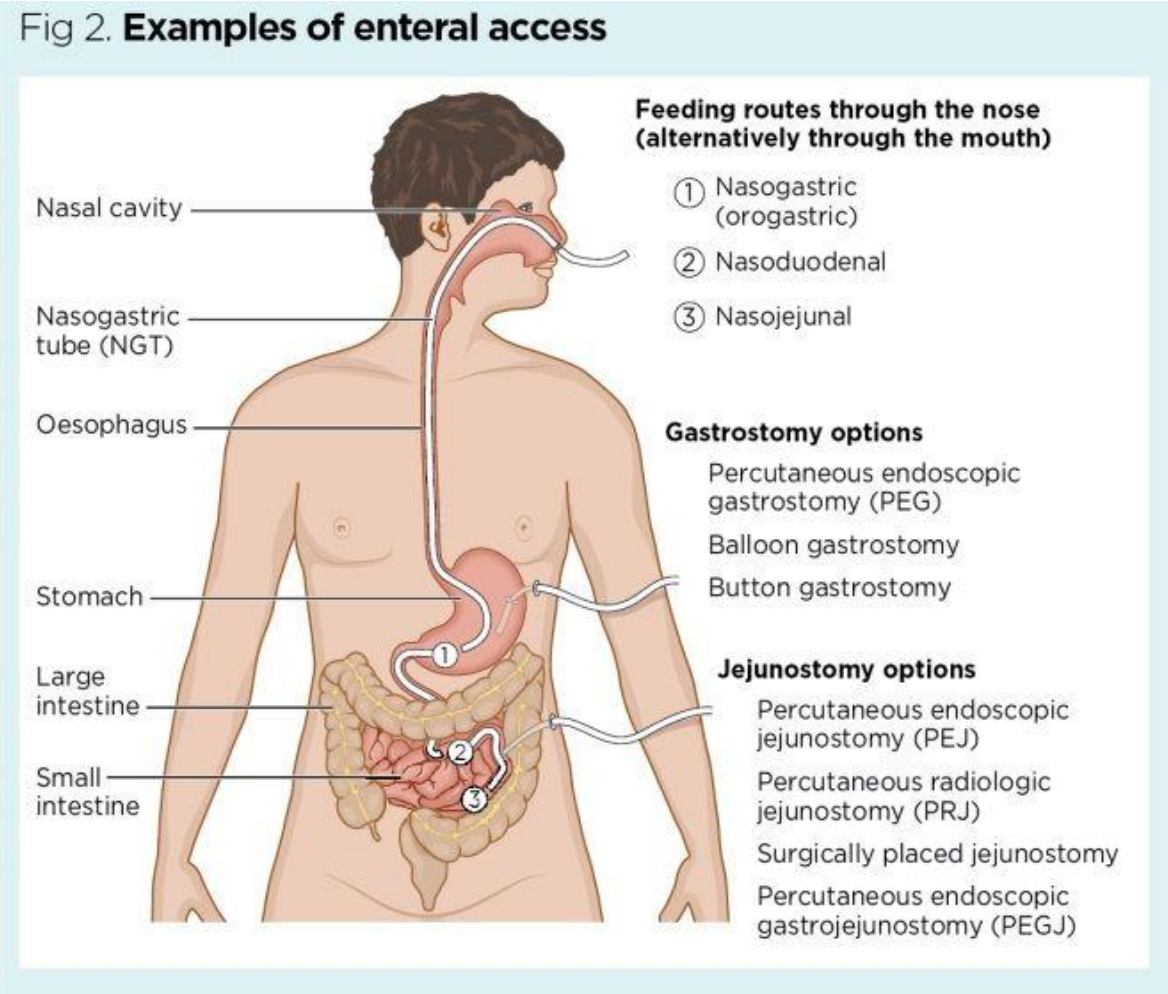
Examples of Enteral Access



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Indications for Placement

- Critical illness, mechanical ventilation
- Severe infection of the throat, Possible strictures/tumors of the esophagus
- Decompression
- Anticipate alternate means of nutrition – Chemo/radiation therapy, Progressive neurological diseases, Inability to maintain adequate nutrition/hydration
- Risk of aspiration

Contraindications to Nasogastric Placement

- Extensive naso-facial trauma
- Basilar skull fracture
- Esophageal trauma – burns, perforation
- Esophageal obstruction – tumor, foreign object
- Severe Coagulopathy
- Patient with abnormal anatomy, gastric bypass or Nissen fundoplication's should be placed under fluoroscopy

Proper Placement With/Without Guidewires

- Size Matters
- Nasogastric tubes come in various sizes (8, 10, 12, 14, 16 and 18 Fr). Stiff tubes are easier to insert
- Some fine-bore tubes may come with a guide wire to aid placement. Most with a radio-opaque marker at the tip to check its position on X-ray

NGT/Small Bore Tube Placement Pearls

- Know the anatomy and aim the tube down the nasal cavity into the nasopharynx
- Once the tube enters the nasopharynx – apply a small amount of pressure on the tube allowing the tube to move to the back of the throat
- Ask the patient to look down and swallow (once)
- Advance the tube – never force the tube
- Confirm placement

Nasogastric, Oral Gastric/Duodenal Tubes

- Determine proper placement

  Ultrasound guidance

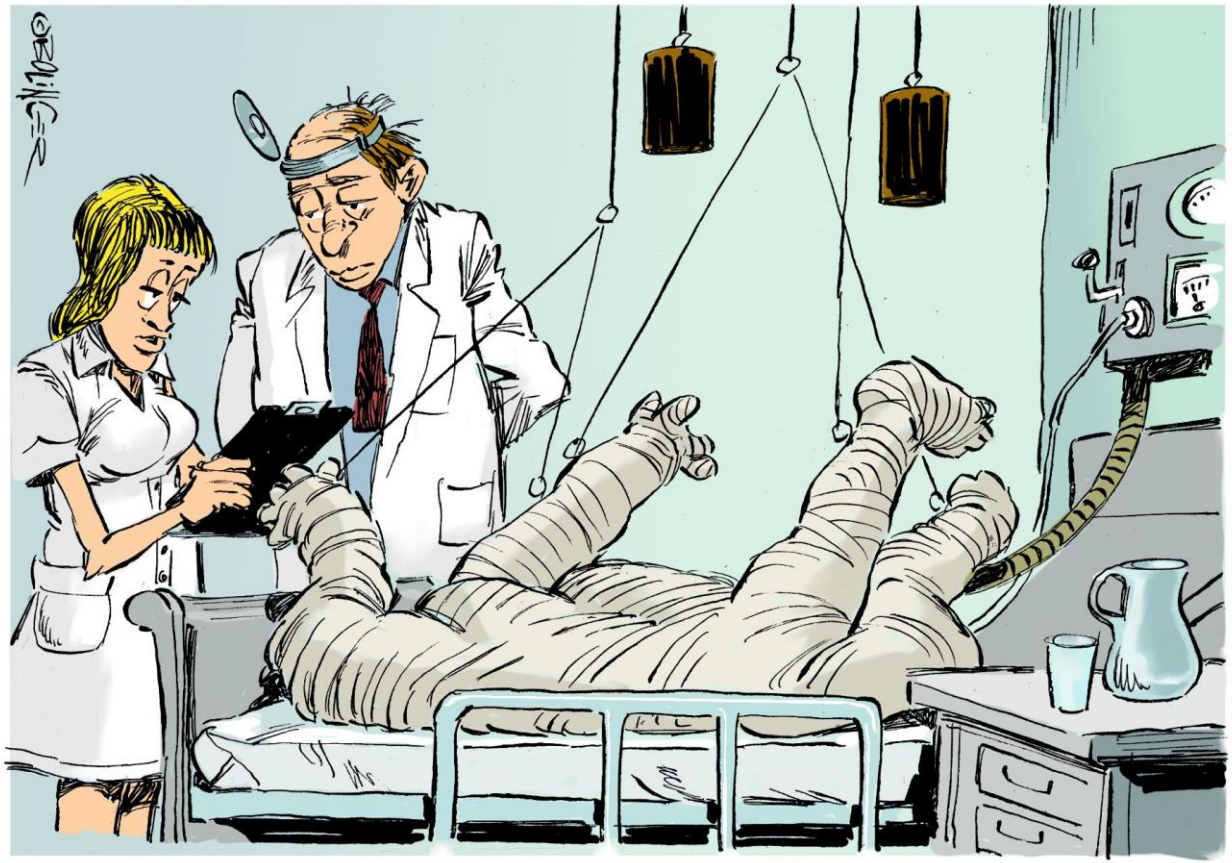
  X-ray confirmation prior to starting nutrition – not all patients cough if the tube is in the wrong position

- Secure the nasogastric/duodenal tubes

  Tape and devices

  Bridals?

Confirm Placement



"Doctor, I'm fairly certain we've been feeding the wrong end for a week."

Risks Associated With Nasogastric/Duodenal Placement

- Nasal ala & Columella ulceration
- Sinusitis
- Misplacement in the lung – pneumothorax
- Aspiration
- Mucosal trauma if suction is used
- Inadequate nutritional support

Trouble Shooting

- Abrasions of the nares and Columella
- Malposition of the tube
- Clogged tubes – methods to unclog
- Tube kinking and knotting
- High residuals – related to tube position, gastric obstruction, ileus

Do’s and Dont’s of NG/Small Bore Tubes

- Always check position prior to administering feeds, medications
- Drugs that shouldn’t be crushed: Extended release, tablets with coating
- Avoid crushing medications if a liquid or slurry can be prescribed
- Always flush the tube before and after administering medications/enteral feeds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HOSPITAL
FEEDING TUBES REMOVED $50.
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G-Tubes, PEG Tubes and PEJ Tubes

- Indication for placement
  Long term need for nutrition support
  In preparation for chemotherapy/radiation therapy
- Tube Care and maintenance
  Tube position length and bumper placement
  Skin Care

Trouble Shooting PEG/G-Tubes

- Malposition – tube migrating into the stomach
- Leaking from stoma
- Skin excoriation and infection
- Buried Bumper
- Tube inadvertently removed
- Tube Clogging

Gastroduodenal and Jejunostomy Tubes

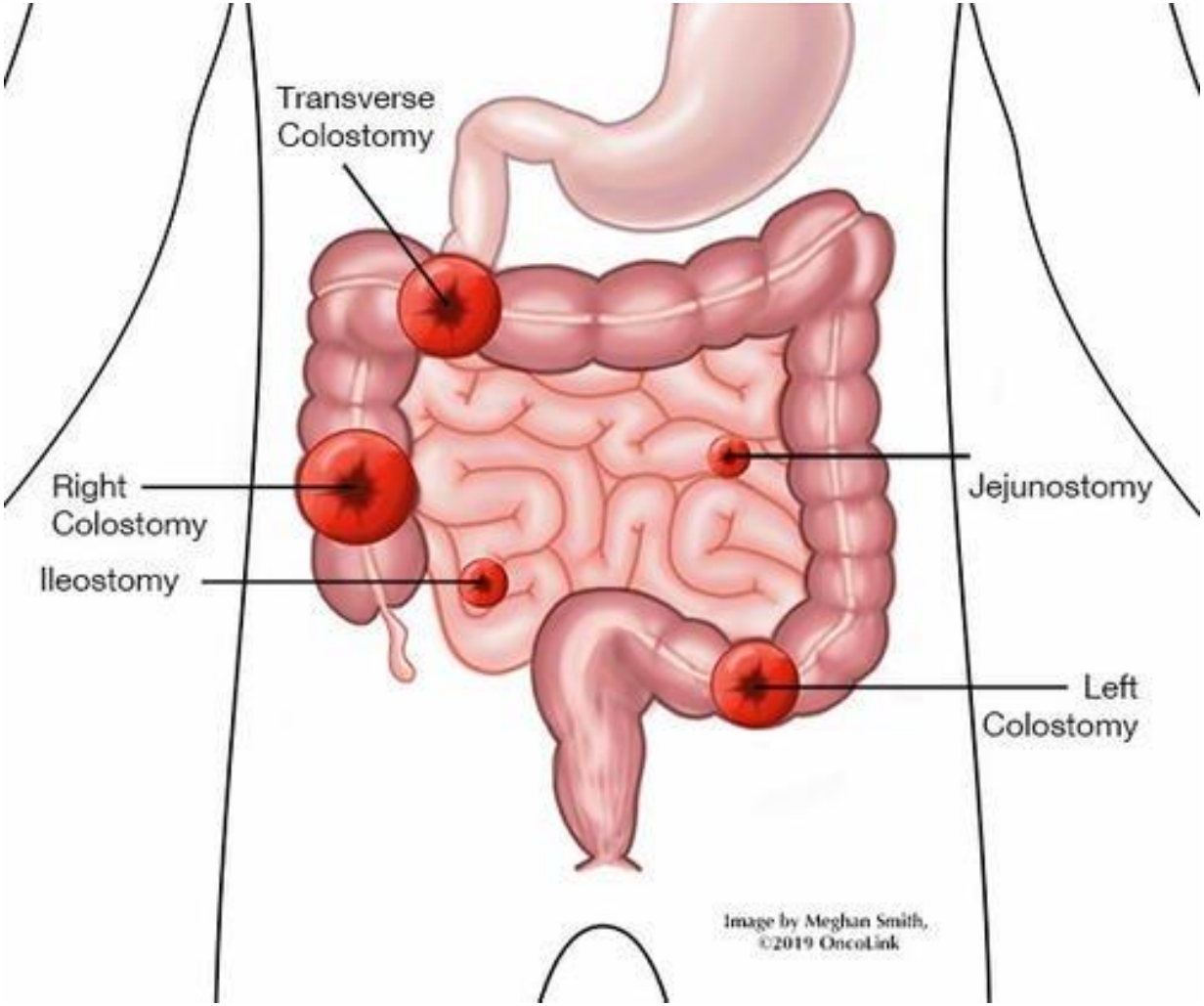
Indications:

- Inability to tolerate gastric feeds
- Need to decompress the stomach while administering enteral feeds
- Gastric dysmotility/obstruction
- Pancreatitis

Gastroduodenal and Jejunostomy Tube

- Placed endoscopically, Surgically or with interventional radiology
- Allows for enteral feeds via the J-port and decompression via G-Tube
- Prone to clogging
- Gastroduodenal tube easily become dislodged

Examples of Ostomies



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Indications for Ostomies

- Small or large bowel obstruction
- Obstructing Lesions
- Strictures or fistulas
- Intestinal injury – trauma, necrotizing enterocolitis
- Genetic conditions – Hirschsprungs
- Severe constipation or colonic inertia

Stoma Sites

- Patient should be able to see the ostomy
- Skin should be flat without creases or scars. Belt line should be avoided

Ileostomy – usually Right lower quadrant

Sigmoid colostomy – usually left lower quadrant

Ileostomy

- Indications – To rest the bowel in order to heal distal mucosa or protect anastomosis

  Evacuate stool following a total colectomy - severe Ulcerative Colitis, Crohn’s Disease, Neoplasm

  Relieve bowel obstruction

Complication of Ileostomy

- Complications:
  - Skin excoriation
  - Dehydration and depletion of electrolytes (K,Na, Mg) – Instruct pt on signs and symptoms
  - Malnutrition of nutrients – B12
  - Retraction or Prolapse
  - Parastomal Hernia
  - Stricture or fistula formation
  - Risk of nephrolithiasis

High Output Ileostomy

- Monitor for dehydration – dry mouth, decreased urinary output, abdominal pain, fatigue
- Consider trial of Loperamide or Lomotil
- May need to consider codiene, Octreotide, Gattex
- If the output is greater than 1500ml per day – may need IV hydration. Encourage patient not to increase PO fluid when experiencing dehydration

Colostomy

- Indication:
  - Severe refractory Ulcerative Colitis, Crohn's Disease
  - Severe diverticulitis – recurrent episodes, diverticular abscess
  - Genetic syndromes and colonic inertia
  - Neoplasm

Complications of Colostomy

- Skin excoriation – ulcers, dermatitis, local skin infections – topical antibiotics, antifungal cream barrier creams and skin prep under the wafer
- Obstruction or ischemia
- Necrosis, Retraction and prolapse – need surgical intervention
- Stenosis
- Bleeding

"THAT WOULD BE A WHOLE LOT FUNNIER IF IT WEREN'T HOOKED UP TO YOUR COLOSTOMY BAG."

Risk Factors Associated With Complications

- Tobacco use
- Obesity
- Chronic steroid use
- Malnutrition
- Crohn’s Disease, UC, cancer
- Advanced Age

Care of Ostomies

- Size of the wafer and particular bag should be determined by a Stoma specialist
- Closed ostomy bag – needs to be replaced often
- Open ostomy bag – can be emptied and resealed
- Many bags have a gas release valve
- Empty bag when 1/3 to ½ full
- Make sure the bag is odor proof

Patient Concerns

- Gas:
  - Gas release valve on the bag
  - Deodorant can be added to the bag
  - Simethicone 125 mg – 1 – 2 before meals
  - Avoid gassy food – beans, broccoli
- Obstruction: Chew nuts well. Avoid skin from fruit and corn

Patient Concerns

- No restrictions on exercise
- Ostomy is not affected by sexual intercourse
- Bathing can be done – with or without the pouch
- Covering the Ostomy – Cummerbuns are available and cover the ostomy and the bag

Summary

- Know the purpose of the tube, type of tube, locations of the tube and assess for complications
- Know the location of the Ostomy and the potential complication
- Patient education is essential
- Know when to refer to a specialist

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