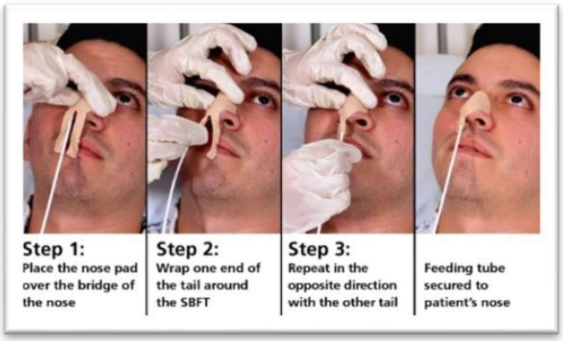
Gastric Tubes: Decompression and Nutrition

Gastric tubes can be classified as orogastric (entering through the mouth) or nasogastric (entering through the nose. These tubes dwell in the back of the throat and terminate in the stomach to provide decompression of the stomach or enteral nutrition. Gastric tubes may also be placed in the abdomen surgically, such as a percutaneous endoscopic gastrostomy (PEG) or a gastrostomy button.

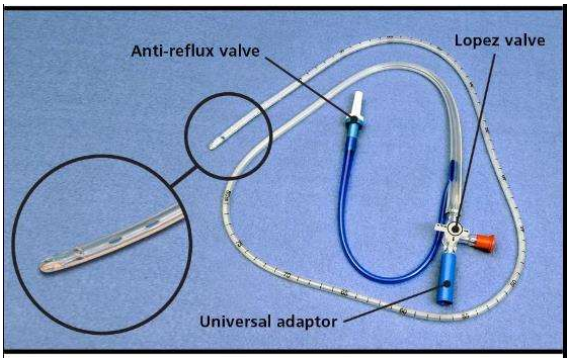
Placement

The length and diameter (French) of the tube will depend on the size of the patient. If placing a nasogastric (NG) tube, take into consideration the size of your patient's nostrils and if the patient has had any congestion or inflammation. To measure for placement, measure the distance from the tip of the nose or the mouth to the earlobe and then to the xiphoid process and add 7.5 – 10cm (or 10-15cm if post-pyloric placement is desired). Mark the depth on the tube with a marker or piece of tape. Abdominal x-ray or pH testing of aspirate are the recommended methods for placement verification.



Contraindications

- Basilar skull or facial fractures
- Recent nasal surgery
- Esophageal strictures
- Esophageal varices
- Post bariatric surgery - consult needed



Decompression

A Salem Sump tube, or Sump, is the most commonly used tube for gastric decompression. These are a dual-lumen tube, with one larger, clear lumen used for decompression or aspiration. The smaller, blue lumen is used as a vent to help prevent the distal holes from adhering to the walls of the stomach. The decompression lumen can be attached to low, intermittent suction or left open to gravity drainage. Typically, a larger sized tube (14 – 18 Fr) is used for decompression as they are less likely to clog. This type of tube is typically more rigid and may be uncomfortable for long-term use.

Enteral Nutrition

Flexible, small-bore feeding tubes are the preferred method for the delivery of enteral nutrition and medications. Tubes for enteral nutrition may terminate in the stomach or in the small intestines (post-pyloric), depending on patient condition and provider orders. These tubes are typically 8 – 12 Fr in diameter and usually contain a stylet or guidewire to aid with insertion. A Salem sump tube can be utilized for enteral feedings with an adaptor, but it is not the preferred tube type for this purpose due to the higher risk of complications.

Gastric Feeds

A Dobhoff tube is the most commonly used tube for enteral feeding in the adult population. This type of tube is a weighted, polyurethane tube that has a stylet to assist with placement. Gastric feeds can be administered as continuous infusions or as boluses.

Post-pyloric feeds

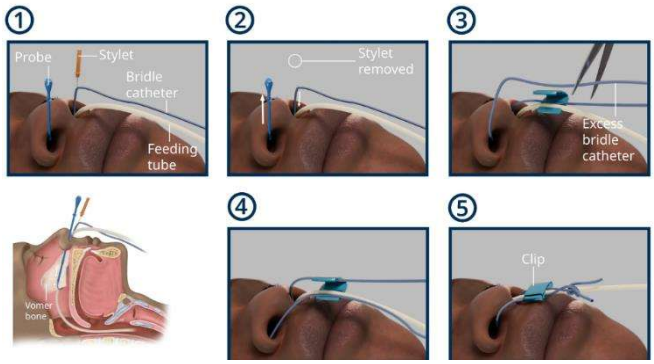
Post-pyloric feeds administered through a tube that has been passed beyond the pylorus, the opening between the stomach and the duodenum. This tube placement is typically achieved with an electromagnetic guidance system, such as a Cortrak. Post-pyloric feeds can only be administered as continuous infusions.

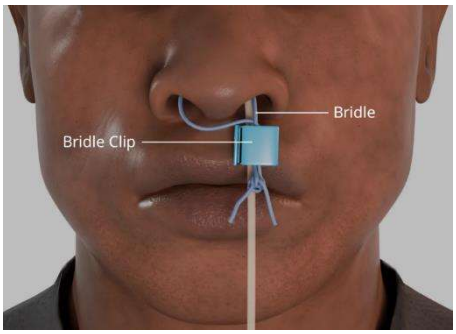
Indications for Post-Pyloric feeding include:

- Receiving paralytic agents
- Severe gastroesophageal reflux
- At high risk for pulmonary aspiration
- Post-surgery or trauma

Nasal bridle

A nasal bridle is an NG tube securement device that helps to prevent dislodgement, reduce skin irritation, and promote optimal nutrition. Nasal bridles are thin pieces of fabric or plastic which are placed around the nasal septum using magnetic stylets and secured to the NG tube with a clamp just below the nose. Bridles are contraindicated in patients with facial or skull fractures, nasal airway obstructions, recurrent or refractory epistaxis, or nasal ulceration.





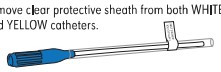
Reminder: Always follow hospital policy or protocol and provider orders when performing nursing interventions.

CORGRIP*
NG/NI Tube Retention System

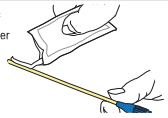
AVANOS

DIRECTIONS FOR INSERTION

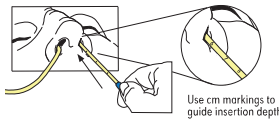
1. Remove clear protective sheath from both WHITE and YELLOW catheters.



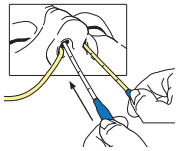
2. Lubricate the distal tip of BOTH catheters with water soluble lubricant. Take care to avoid lubricating the magnet tips.



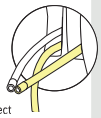
3. Insert the YELLOW retrieval catheter to the desired depth into the desired nostril. (Adjust appropriately for smaller patients). **Do not exert force when inserting the catheter. If over inserted, damage to sinus cavity may occur.**



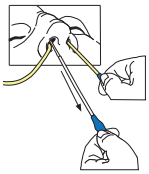
4. Insert the WHITE catheter into the OPPOSITE nostril to the same distance as the YELLOW catheter. Magnet tips should be the same point behind the vomer bone.



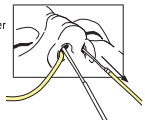
5. Some gentle manipulation of the catheters will encourage magnet engagement. When the magnets connect behind the vomer bone, you will hear the click and/or feel the connection.



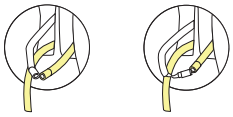
6. When magnet engagement has occurred, slowly/deliberately withdraw the WHITE catheter unti tape is visible and the catheter is completely out of the nostril (approximately 10 cm).

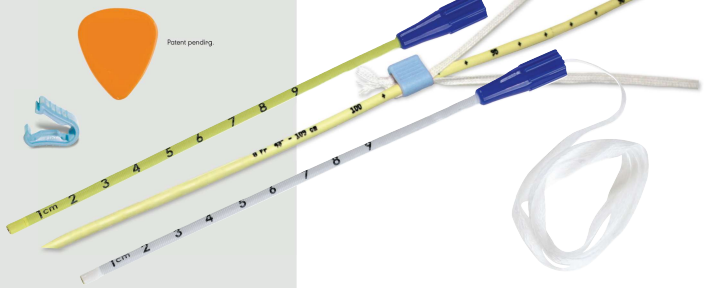


7. Then slowly/deliberately withdraw the YELLOW catheter until the tape is visible and the catheter is completely outside of nostril allowing the advancement of the umbilical tape behind the vomer bone and out the opposite nostril.

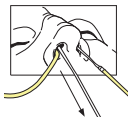


White catheter bends to fully engage magnet on tip of each catheter

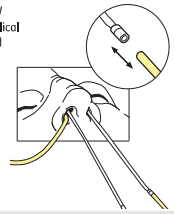




8. Pull the WHITE catheter until the umbilical tape is completely out of catheter.



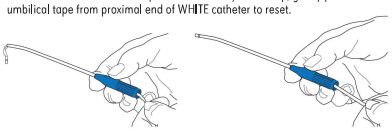
9. Disconnect the YELLOW catheter from the umbilical tape at the magnet and adjust the umbilical tape so that an equal length extends from each nostril.



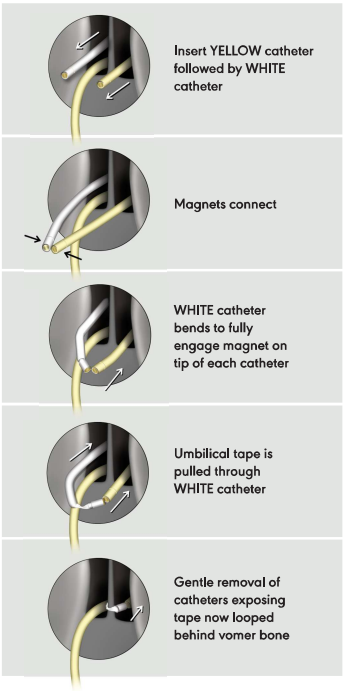
INSERTION TIPS AND ADDITIONAL RESOURCES

RESET UMBILICAL TAPE

If connection is not made and procedure needs to be repeated withdraw WHITE catheter. If umbilical tape is extended beyond the tip, gently pull umbilical tape from proximal end of WHITE catheter to reset.

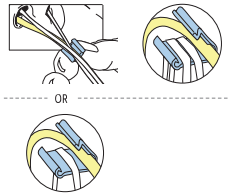


VISUAL OF MAGNET ENGAGEMENT BEHIND VOMER BONE

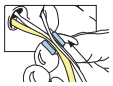


SECURING THE CORGRIP* TO THE NG/NI TUBE SSL* (SLOT-SLIDE-LOCK) CLAMP

1. SLOT the NG/NI tube into the groove of the SSL* Clamp. Place one or both sides of the umbilical tape onto the flat area of the clamp, in front of the feeding tube.

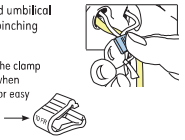


2. SLIDE the clamp up to approximately 1 cm from nostril.

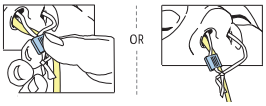


3. LOCK the clamp and umbilical tape into place by pinching the clamp closed.

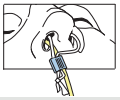
French size label on the clamp will be right side up when properly positioned for easy access to open.



4. Tie a double or triple knot with the extra umbilical tape **(Note: do not tie the knots around the NG/NI tube).**

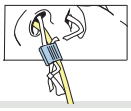


CAUTION:
Take care not to put tension on the umbilical tape or tube at the nare.

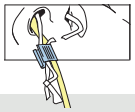


CORGRIP* AND NG/NI TUBE REMOVAL

1. Cut only ONE strand of the umbilical tape. Gently pull both the CORGRIP* and nasal tube out of the nose.



2. If removal of just the CORGRIP* is desired, open and remove clamp, cut one end of umbilical tape and remove (tube remains in place).



OPENING THE SSL CLAMP

1. Insert the Opening Device into slit of the SSL Clamp and pop clamp open with a slight twist of the Opening Device.

INDICATIONS FOR USE

The CORGRIP* Nasogastric/Nasointestinal (NG/NI) Tube Retention System is indicated for use with enteral feeding tubes of 8 FR and greater and NG decompression, suction and drainage tubes up to 18 FR to prevent inadvertent removal or displacement of the tubes for adult patients.

CONTRAINDICATIONS FOR USE

The CORGRIP* is contraindicated for patients with facial and/or cranial fractures, nasal airway abnormalities or obstructions. It should also not be used on patients that may pull on their feeding tube or the CORGRIP* Tube Retention System to such an extent as to cause serious self injury.

NOTE: The CORGRIP* may be placed before or after the NG/NI tube. For patients with small nares, it may be particularly beneficial to place the CORGRIP* prior to tube placement.

For more information please visit: avanosmedicaldevices.com
Call 800-448-3569 in the United States and Canada.

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