

Oley Webinar Practical Management of Home Tube Feeding Q&A not covered on the video

1. We have had patients in hospital for a short period of time (weeks) and the tube already appears blackened?

Cynthia Reddick: It is possible for the tube to become discolored by reflux of gastric contents which may include bile and medication. It is recommended that consumers flush their tube regularly for the purposes of hydration, to keep the tube clean, and to help prevent clogging. Use of a tube clamp will limit the gastric contents from refluxing into the tube and may decrease the incidence of tube staining. Not all tubes have clamps attached, so an external clamp may help in these instances. Tubes that are black or have black spots from mold colonization should be proactively replaced before they dry out and crack as a result of the mold.

2. Can you share more about your experience with patients using home blenderized tube feed at home. Have they experienced more complications, for example blockages? We would love a talk on this subject!

Cynthia Reddick: I don't have a great deal of experience with consumers who use home blends exclusively through their feeding tube. Keep in mind, there are many ways to incorporate home blends: 1) 100% home blend, 2) partial home blend + partial commercially prepared blend, and 3) partial home blend + standard tube feeding formula. Regardless of the home plan, I recommend the feeding regimen be reviewed by a Registered Dietitian (RD or RDN) for adequacy, especially when it is used as a sole source of nutrition. Blended formulations are thicker, so careful attention to flushing

and blending quality is mandatory. The higher quality the blender that is used, the fewer incidences of clogging one will likely experience. Reference the October/November 2017 issue of Oley's Lifeline for a comprehensive article on the subject authored by a group of experienced homecare dietitians, including myself: https://c.ymcdn.com/sites/oley.site-ym.com/resource/resmgr/2017_solll_images/2017_SOLLL.pdf

3. Is there a technique to use to relieve movement of a low profile tube during bolus feeding of blended foods?

Cynthia Reddick: Excessive movement of a low profile tube should be limited as much as possible during feeding of any kind. The first step would be to ensure the button is properly sized for the patient's stoma site. When using a bolus or straight extension set with a low profile device, you may find that it can cause the button to move around more than a right angle extension set. I recommend stabilizing the low profile device with your (or the patient's) forefinger and thumb as much as possible during the feeding and flushing administration. It can take a little longer to administer a blended formulation through a tube due to the viscosity, so plan to take your time and stabilize the tube during the entire feeding.

4. I replace my husband's feeding tube on average of every three months due to balloon failure. Does that sound reasonable to you?

Cynthia Reddick: I have seen balloon gastrostomy tubes last longer than three months, but I have also seen them last less than that over the years. There are a variety of things that could impact the life of a balloon. One manufacturer (Avanos) recommends filling the balloon with sterile or distilled water as opposed to tap water due to potential variations in water quality and contaminants (such as lead or sodium) in your area's water source. This practice can remove some variables that could impact the life of the balloon. It is also recommended to check the balloon fill volume on a weekly basis to ensure it is properly inflated. Each tube has a prescribed or recommended balloon fill volume, so check with the manufacturer's recommendation and verify that with your physician who placed the

feeding tube. Lastly, never fill the balloon with air! These practices could improve the life span of your husband's feeding tube balloon.

<https://www.mic-key.com/newsletter/your-questions-answered-balloon-water-part-2/>

5. Do you have any representation in Puerto Rico to teach all this useful and important information?

Cynthia Reddick: My employer, Coram/CVS Specialty Infusion, does not have a presence in Puerto Rico. I am available as a speaker and educator, however, in any location on the subject of home tube feeding.

6. How far off the abdomen should the bolster sit? I have read that it is important not to have it too tight which could cause Buried Bumper Syndrome. I read to have it about 1 cm off abdomen right after placement (since there will be swelling of skin after placement) and then after healing (2 weeks) tighten it to 1-2 cm off the abdomen.

Cynthia Reddick: There is a range of recommendations between the literature and manufacturers. One study suggests that placement of an external bolster 0 (zero) cm off of the abdomen leads to more complications. (DeLegge M, DeLegge R, Brady C. External bolster placement after percutaneous endoscopic gastrostomy tube insertion: is looser better? JPEN J Parenter Enteral Nutr. 2006 Jan-Feb;30(1):16-20.) The remaining recommendations mostly range between 1-3 cm. The use of traction during PEG placement may also contribute to the incidence of buried bumper syndrome as identified by Chung, et al. (Chung RS, Schertzer M. Pathogenesis of complications of percutaneous endoscopic gastrostomy. A lesson in surgical principles. Am Surg. 1990;56:134-137.) When there is excessive pressure between the internal and external fixation device (bolster), it can cause ulceration and migration of the internal bolster into the layers of the stomach wall. Buried bumper syndrome is more common with rigid or semi rigid internal bolsters when compared to balloon style tubes as reported by Kim, et al. (Kim YS, Oh YL,

Shon YW, Yang HD, Lee SI, Cho EY, Choi CS, Seo GS, Choi SC, Na YH. A case of buried bumper syndrome in a patient with a balloon-tipped percutaneous endoscopic gastrostomy tube. *Endoscopy*. 2006;38 Suppl 2:E41–E42.) I would suggest 2-3 cm as a target range for the external bolster placement away from the abdomen. I also recommend daily assessment and adjustment if needed so that it is neither too loose, which would allow for undesirable movement in and out of the stoma, nor too tight, which could cause ulceration or tissue necrosis.

7. Is there any fix to the tube degradation related to yeast as you described? We have a patient that this happens to every few months.

Cynthia Reddick: My suggestion is to focus on prevention with frequent flushes especially before and after anything infused through the tube. Additionally, if the patient is having the tube placed via endoscopy, it is possible that the patient's tube is colonizing yeast from the patient's mouth during the procedure. If the prior tubes have been replaced via endoscopy, I would suggest a balloon gastrostomy be placed via interventional radiology in lieu of a PEG. (Gottlieb K, Iber FL, Livak A, Leya J, Mobarhan S. Oral Candida Colonizes the Stomach and Gastrostomy Feeding Tubes. *JPEN J Parenter Enteral Nutr*. 1994; 18:264–267.)

8. I work for a home care company. We have been discussing our best, realistic protocol options for declogging tubes in the home setting (assuming warm water protocol does not work). Any experience with Clog zapper? Or other easy, inexpensive options?

Cynthia Reddick: I do have personal experience with Clog Zapper and I found it effective when I used it. I employed the use of Clog Zapper when other basic measures did not work: massaging tube, warm water with a gentle “push/pull” of the 60 ml syringe, time and patience. I also used a smaller medication syringe (6 ml syringe) through the medication port

which provided enough pressure to clear the clog, but not damage the tube.

9. I have read to clean with saline for the first 7-10 days and then switch to mild soap and water after that. What do you think?

Cynthia Reddick: I am not surprised by that nor am I opposed to that protocol. At Coram/CVS Specialty Infusion, we recommend and teach to clean a stoma site with soap and water daily, unless the patient has received instruction on a different protocol from their healthcare provider. I have encountered many instances where patients were instructed to clean with saline. I am not aware of any contraindication to using saline to care for a new wound. It is isotonic, does not interfere with the wound healing process, is cost effective, and available for purchase OTC. The intention of cleansing a wound is to remove debris and surface, free floating bacteria while promoting an optimal environment for healing.

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