Section: Division of Nursing

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PROCEDURE
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HACKETTSTOWN REGIONAL MEDICAL CENTER

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MINOR PROCEDURES
(Scope)

TITLE: PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG)
PERCUTANEOUS ENDOSCOPIC JEJUNOSTOMY (PEJ)

PURPOSE: To outline the steps for assisting with PEG & PEJ insertion

SUPPORTIVE DATA:
1. PEG/PEJ involves the non-surgical, percutaneous placement of a feeding gastrostomy/jejunostomy tube using an endoscope.
   Indications include:
2. Need for long-term nutritional support
3. Patients at high risk for surgical placement of a feeding tube.
4. In addition, for PEJ, consider all of the above, plus:
   a. Incompetent gag reflex or lower esophageal sphincter pressure which leaves the patient at risk for aspiration
   b. To provide jejunal feeding and gastric decompression

EQUIPMENT LIST:
1. Refer to EGD and safety procedures.
2. Snare or biopsy forceps
3. PEG kit and PEJ kit, if necessary. J tube placement requires a J-tube kit compatible with the size of the lumen of the G-tube.
4. Sterile gloves for surgeon
5. Scissors and Kelly clamp - located in package labeled "PEG instruments"
6. Foreign body forceps (rubber tipped or rubber-toothed grasping for use with PEJ placement).
7. Swabs and mouthwash

CONTENT:

PROCEDURE STEPS:

A. Pre-Procedure Assessment/Care

1. Verify signed informed consent.
2. Obtain baseline vital signs and attach to automatic vital signs, cardiac monitor and oximeter.
3. Obtain patient's medical history including allergies, current medications and information pertinent to the current complaint and document.
4. Obtain necessary lab results.
5. Notify physician if patient is currently on anticoagulant therapy, ASA or nonsteroidal anti-inflammatory products, or has abnormal laboratory values.
6. Verify length of NPO status, including tube feeding.
7. Remove dentures.
8. Establish patent IV line as ordered. Document according to IV policy.
9. Administer antibiotic prophylaxis as ordered and document.

KEY POINTS:

Contraindications:

1. Coagulopathy
2. Prior gastric or duodenal surgery
3. Compromised gastric wall from infection, ulcers or ischemia
4. History of malignancy and/or radiation therapy which could affect tube placement
5. Inadequate gastric emptying (relative)
6. Bowel obstruction
7. Sepsis
8. Ascites
9. Morbid obesity (relative)
10. Hiatal hernia w/stomach located in chest
11. Recent myocardial infarction
12. Patient has not remained NPO
13. Lack of operative consent

10. Swab the patient's mouth with mouthwash several times to reduce flora and incidence of infection.
11. Explain the purpose of the procedure, techniques to be used and sensations that the patient is likely to experience.
12. Explain the purpose of the tube, how it works, and the benefit it will provide to the patient/family.
13. Explain that sedation and local anesthetic will minimize the discomfort and that the actual insertion is simple and rapid.
14. Explain the need to prepare the skin.
15. Reassure the patient and/or significant others that the endoscope will not interfere with breathing.
16. On the patient's chart, document the teaching, stating who was informed and evaluate comprehension.

B. Responsibilities During Procedures:

1. Refer to EGD and Safety procedures.
2. Assist M.D. with administration of sedation medications and document amount of medication used and patient's response.
3. Position patient in a supine position, with head elevated, restraining limbs as necessary to protect the sterile field. Have oral suction immediately available.
4. Assist the surgeon with preparing the patient's abdomen for the surgical procedure.
5. Maintain sterility of the instruments and feeding tube.
6. Monitor the patient, suctioning the mouth as necessary.
7. The endoscopist transilluminates the stomach in a darkened room and the skin is marked at the selected site. Using sterile technique, the skin is anesthetized locally by the surgeon and a small incision is made. The gastrostomy tube is placed and snugged up against the gastric wall under the direct vision and instruction of the physician.
7. Document patient's tolerance to procedure and any signs of complications.

Complications:

1. Respiratory depression secondary to administration of medication
2. Aspiration
3. Bleeding
4. Infection
5. Perforation

Follow Moderate Sedation Policy Addendum

J-Tube Insertion: the J-tube is made to be inserted through the G-tube and guided by the endoscopist into the duodenum.

1. Insert J-tube through 28 FR. G-tube.
2. Pass biopsy forceps of choice through biopsy channel and grasp suture at tip of J-tube.
3. While holding J-tube securely, pass endoscope through pylorus into duodenum.
4. Release J-tube from biopsy forceps.
5. Remove biopsy forceps and scope from patient, leaving J-tube in duodenum.

The 9 FR. J-Line PEJ is designed for use with the 22 French Caluso or Nuport PEG. The 12 FR. J-Line PEJ is designed for use with the 28 FR. Super PEG. (The larger PEJ reduces the potential for clogging.)

6. An x-ray may be ordered to confirm placement.

C. Post Procedure Assessment/Care:

1. Refer to EGD.
2. Gently clean the skin and apply topical antibiotic ointment around insertion site.
3. Administer prophylactic antibiotics as per physician order and document.
4. Provide the nursing unit or care giver with written instructions regarding tube care and potential problems.

1. All care givers must be instructed to notify the physician immediately if the tube is removed, prior to the development of a well-formed tract, 10-14 days. The patient will be scheduled for a repeat PEG/PEJ procedure as soon as possible. If a well-established tract exists, reinsertion may be temporarily accomplished with a foley catheter or a replacement device.2. The G-tube and J-tube must be flushed thoroughly with 20-30 cc water or every shift following any instillation to prevent blockage.
3. All medications must be in liquid form.
4. It is helpful to permanently mark the G-tube at the exit site in order to monitor for continued proper placement.
5. The blue port of the feeding adapter is used to decompress the stomach and administer medications; the red port is used for feeding only.
6. The PEJ is designed to be replaced every 3 months.

REFERENCE:

1. MANUAL OF GASTROINTESTINAL PROCEDURES, FIFTH EDITION; 2004
2. Sandoz Nutrition, J-Line PEJ Procedure Video.