Device Fact Sheet
Feeding Tubes

This Device Fact Sheet was compiled by the BCM Transition Medicine Clinic for primary care providers to have important information regarding patients with the above device. Our clinic wants to partner with you to provide the best care for patients. Please call 713-798-6333 if you have questions.

Feeding Tube Basics/Types

- Gastrostomy — conduit from skin to stomach, traditionally with wall of stomach sutured to abdominal wall
- PEG tube — percutaneous endoscopically guided, held in place with balloon in stomach and bolted against skin
- Malecot tube — a primary tube, longer term in less active patients
- Balloon foley — placed as a place holder in an emergency
- Mic-Key Button — less bulky, flat against skin, often replaces initial G tube for convenience, Mickey with side port to inflate balloon, Bard inserted using trochar
- J tube — skin to jejunum, for severe reflux/aspiration, slow motility issues
- GJ tube — through stomach into jejunum, separate ports to infuse in stomach and jejunum
- Bard g-tubes should be changed by a health professional every 1-3 years depending on their appearance. A foley catheter that is smaller than the Bard caliber (i.e. 18 FR Bard/ 14 FR foley) should be given to the family to have available for emergency need. Families/caregivers can be trained to replace Mic-key at home.

Care and Use

- Cleaning — keep site clean, patients may bathe and swim 1 week after placement
- Changing — parents often taught to change buttons at home but some require procedural replacement (GJ tubes, J tubes, Bard buttons, Malecot tubes). External tubes and adapters can be changed at home, traditional gastrostomy tubes (sutured) change 2-4 weeks after initial placement, PEG tubes in 8-12 weeks,
- Feeding — continuous (G or J tubes) or bolus type (typically G tubes only)
- Medication — most through G tube, some ok through J tube depending on absorption (refer to pharmacist)
- Flushing — with water, flush after any feed or medication to keep prevent clogs
- Venting or burping — permit air to escape through stoma tube, can relieve abdominal pain and distention
- Look for signs of outgrown tube — tube digging into skin, external tabs curled up, red pressure marks on surrounding skin, button or tube not spinning easily.

Troubleshooting

- Tube clogged — slowly push syringe with 10 ml warm water without forcing as tube may be internally displaced, repeat again in 10-15 minutes. Pineapple juice or cola soda may be advised as decloggers.
- Tube displaced or pulled out — It is important to know the length of tubing usually from skin to end of Malecot or GJ, noting significant changes in length.
  - Fresh tube (placed in last 4 weeks or 12 weeks for PEG tube) cover with gauze and refer immediately to surgery clinic or hospital
  - Well healed — replace in 4-6 hours (hole will start to close). If unable to replace, place Foley and refer to surgeon
  - Confirm placement by aspiration of gastric content, auscultation of injected air over stomach area
- Drainage — If tube without balloon, small amount is ok. If tube with balloon, check if balloon snug and inflated by gently pull back and check for proper amount of saline in balloon (typically 5 ml) - if balloon leaking, may need replaced. To protect skin — use barrier cream (zinc oxide, desitin, etc.) or may be covered with a small gauze pad.
- Irritation/ granulation tissue — Check if leaking or too tight (i.e. due to weight gain). Red or pink redundant flesh around site can be common. Treat with EMLA/silver nitrate or triamcinolone if persistent. May have thick yellow drainage without other signs of cellulitis.
- Yeast infection — erythema, rash, itching, treat with topical antifungals
- Cellulitis — caused by typical skin bacteria, will not typically have drainage at site
- Refer to Pediatric Surgeon with any doubts or concerns