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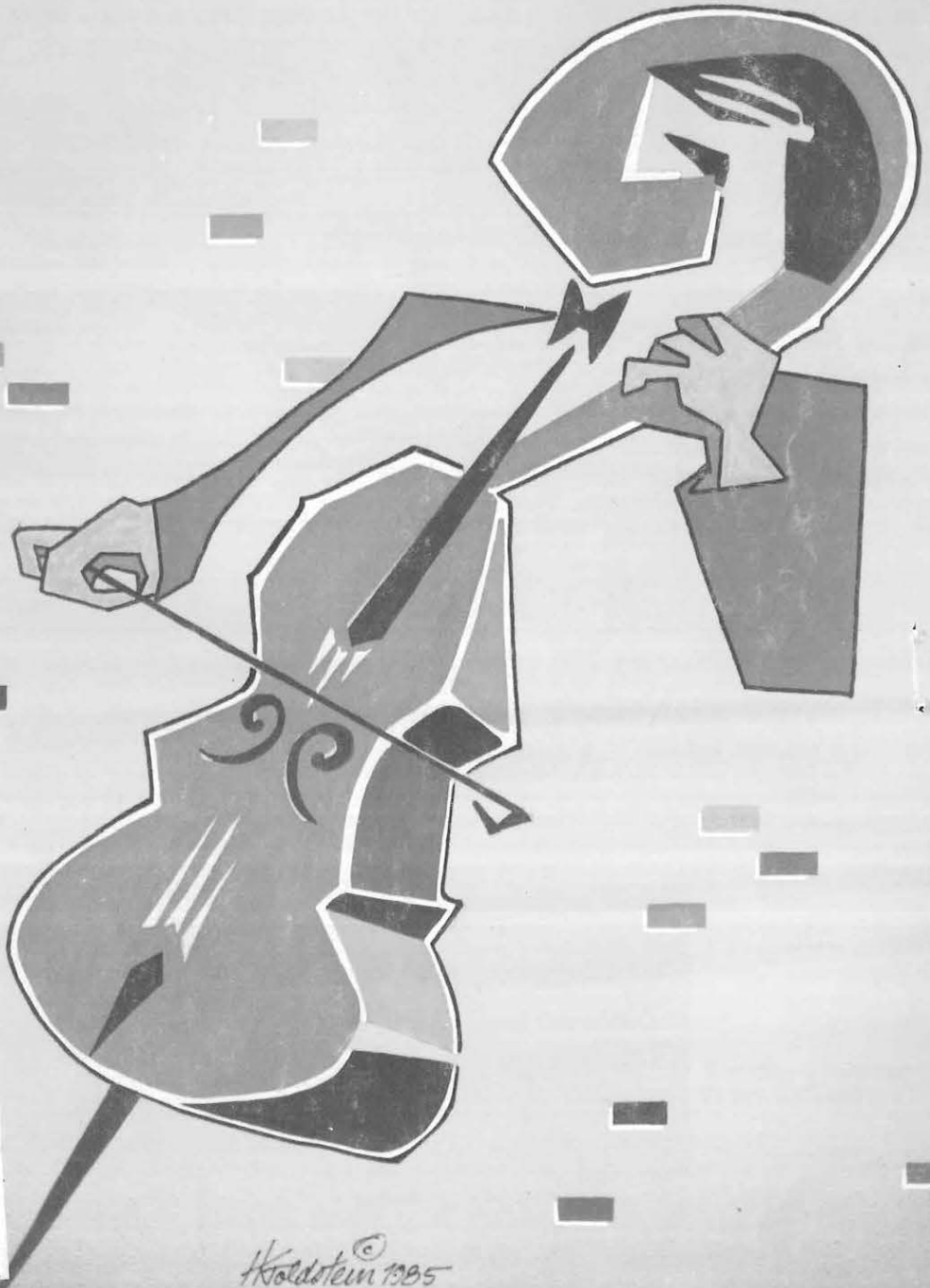
Nutritional Support Services

VOLUME 5, NUMBER 8, AUGUST 1985



NSS
The Journal of Practical Application in Clinical Nutrition

Nutritional Support Services

VOLUME 5, NUMBER 8, AUGUST 1985

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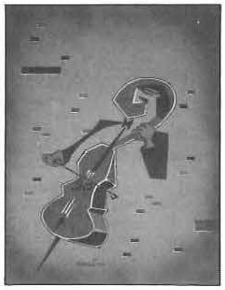

The cover by Los Angeles illustrator Howard Goldstein depicts a musician so immersed in his art that he has become fused with his instrument. Just as artists fully involve themselves in their crafts, so do physicians, nurses, and other health care professionals devote themselves to caring for patients, often to the point where the patients' concerns become their own concerns. This issue of *NSS* examines the unique nutritional needs of two groups of patients requiring special attention—those with liver disease or chronic renal failure. Also included is a feature new to *NSS*: a self-test (page 16) based on the article "Nutritional Support in Advanced Liver Disease" (beginning on page 8).

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clamp and a new cap. Turn off the tape recorder. When you have the heparin, syringe, alcohol and iodine wipe, clamp, and cap, turn the tape recorder back on and go to the next step."

All aspects of his care were presented to him as clearly and simply as possible. Oddly enough, at no time during the teaching sessions, including those before the tape was utilized, did Mr. F. have difficulty changing his catheter dressings. This procedure was facilitated by the use of a prepackaged TPN dressing kit instead of a combination of individual components.

It should be noted that throughout the training period Mr. F. sincerely wanted to go home, and he expressed this desire several times to doctors and nurses. And, with the shoe boxes and the new tape, he began to learn the procedures at a much faster rate. However, it became apparent that Mr. F. would never master the type of volumetric pump we were using. The doctors wanted to let him gravity infuse during the day, which would eliminate the need for any infusion device, but we asked permission to first try another simpler pump. The tape was remade, with instructions for a peristaltic infusion pump. Mr. F. was eventually able to master this new pump.

When the discharge date arrived the patient was calm, but the nurses, usually reassuring and at ease, were anxious. We met Mr. F. at his home that day, and spent the usual time organizing his supplies and reviewing paperwork and procedures. Then, offering sideline encouragement, we watched Mr. F. go through the steps that were to become his daily routine. With a little help from us, such as turning on and off the tape recorder and locating Box #1, he slowly but surely completed each step successfully.

We visited Mr. F. every day that first week, observing each procedure. Every day the steps went a little quicker and more smoothly. By the end of the week we were convinced that he was going to make it as a home TPN patient. In addition, it was arranged that a homemaker would come in each morning and keep track of his inventory of supplies.

What had started out as a frustrating situation turned out to be a very rewarding experience for all involved. The training also proves that the old adage, "Where there is a will, there is a way" still holds true. NSS

Physician Exchange

Feeding Tube Anchor

Presented at the Nutrition Practice Poster Session, Ninth Clinical Congress, American Society for Parenteral and Enteral Nutrition, Miami Beach, Florida, January 21–24, 1985.

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Introduction. Feeding tube dislodgment by disoriented or uncooperative patients frequently compromises nasoenteral alimentation. Repeated and/or prolonged interruptions of tube feeding infusions lead to suboptimal nutritional support. Frequent reinsertions of displaced feeding tubes are expensive, traumatic, and time-consuming. The use of a nasopharyngeal bridle[1] may decrease but not eliminate feeding tube dislodgment. We investigated the effectiveness of a feeding tube anchoring attachment, used along with a nasopharyngeal bridle, in decreasing the incidence of tube dislodgment and in prolonging the length of time that feeding tubes remained in place.

Methods. Patients requiring nasopharyngeal bridles in order to secure feeding tubes were randomized into two groups. Group I patients had an 0.5 cm segment of 14 French Silastic tubing bonded to an 8 French Entriflex* feeding tube using Silastic cement (*Figures 1* and 2). Nasopharyngeal bridles were inserted[1] using the following materials:

- Two 8 French polyethylene tubes,
- One pair Magill forceps,
- One tongue blade,
- Flashlight,
- 2-0 silk suture on a straight needle,
- Scissors.

The 8 French polyethylene tubes were inserted into each naris. These were grasped in the posterior nasopharynx with the Magill forceps and brought out through the mouth. The tips of these tubes were sutured, and the bridle was withdrawn from the nares in such a way as to leave one of the 8 French polyethylene tubes extending around the internasal septum with ends protruding through both nares. The external ends of the bridle were sutured and trimmed.

The "anchored" feeding tubes were then secured to the nasopharyngeal bridles within the patient's nares with 2-0 silk sutures tied on both sides of the anchors (*Figure 3*). Group II patients had 8 French Entriflex feeding tubes without anchors inserted. In these patients, the feeding tubes were attached to nasopharyngeal bridles within the patients' noses using 2-0 silk sutures.

Patients were followed for a minimum

*Biosearch Medical Products, Inc., Somerville, NJ.

Figure 1: **An 0.5 cm segment of 14 French Silastic tubing is bonded to an 8 French Entriflex feeding tube using Silastic cement and a blunt needle.**

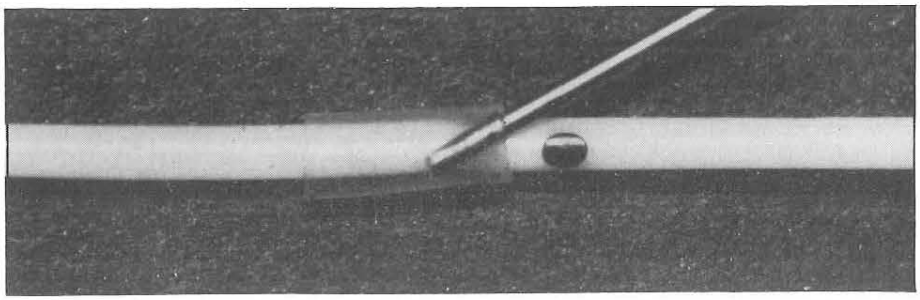
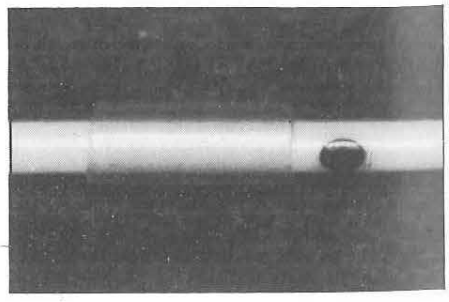


Figure 2: **An anchoring attachment bonded to a feeding tube.**



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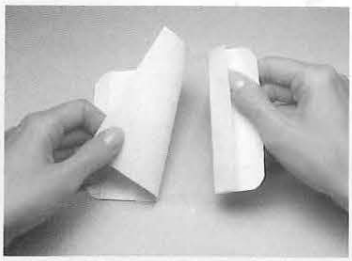

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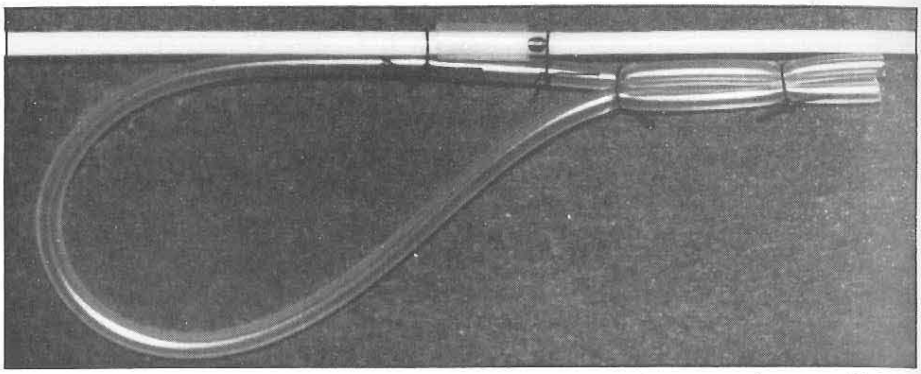

Figure 3: **A feeding tube with an anchoring attachment secured to a nasopharyngeal bridle (simulation).**

of seven days after feeding tube and bridle insertions, unless the feeding tubes were dislodged earlier. If a patient expired, was discharged from the hospital, or had the feeding tube voluntarily discontinued earlier than seven days following insertion, the patient was replaced in the study randomization using the same type of anchored or nonanchored tube originally inserted. If a feeding tube became unusable (occluded or ruptured), it was replaced with an anchored or nonanchored tube of the same type as originally inserted. Patients with functioning feeding tubes were followed for as long as they remained hospitalized.

The incidence of feeding tube dislodgment, the length of time to dislodgment, and any complications related to the anchor, the nasopharyngeal bridle, and the feeding tube were compared in the two study groups.

Results. Feeding tubes were inserted into 67 patients. Of these, 53 patients (79%) completed the study protocol. Patients ranged in age from 22–102 years. There were 37 males and 30 females—29 Group I patients and 24 Group II patients. Anchored feeding tubes (Group I) were dislodged in two patients (7%), while nonanchored feeding tubes (Group II) were dislodged in eight patients (33%). This difference was significant ($P=0.031$, Fischer's exact test). Anchored feeding tubes became dislodged an average of 15 days following insertions, while nonanchored tubes became dislodged an average of four days after insertions ($P=0.022$, Mann-Whitney U test).

There were no nasal erosions or instances of nasopharyngeal bleeding noted in any of the patients.

Summary. Enteral alimentation is a safe, economical, and physiological method of specialized nutritional support. Feeding tube dislodgment, especially in uncooperative patients, often precludes effective enteral alimentation. We report a safe and effective method of significantly improving long-term enteral access. The technique has important implications, including cost containment, improved nursing productivity, maintenance of adequate nutritional support, and improved patient comfort.

REFERENCE

☐ 1. Barrocas A. The bridle: Increasing the use of nasoenteric feedings. *Nutr Supp Serv* 2(8):8–10, 1982.

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