

Consensus

Consensus Statements Regarding Optimal Management of Home Enteral Nutrition (HEN) Access

Mark H. DeLegge, MD, FACP and the HPEN Working Group

From Coram Healthcare, Denver, Colorado and Section of Nutrition, Digestive Disease Center, Medical University of South Carolina, South Carolina

Choice of Enteral Access Device

- A full understanding of a patient's current disease status, duration of enteral access needs, activity level, gastric and small bowel anatomy, gastrointestinal function, patient preference, and the available institutional enteral access expertise will determine the appropriate enteral access device (EAD).
- EADs can be placed endoscopically, radiologically, or surgically. An expert in EAD placement and maintenance should be identified at each institution. This expert is usually a gastroenterologist, a radiologist, or a surgeon. Some centers may have more than 1 expert.
- Because of early and frequent naso- or oroenteric feeding-tube failure, patients requiring enteral feeding for 30 days or more should receive a percutaneous enteral feeding tube.

Gastric Enteral Access

- Elevated gastric residuals are the most common reason that gastric feedings are held or terminated. Gastric feedings should not be held for gastric residuals of 300 mL or less unless there are clinical signs of intolerance such as significant abdominal distention, nausea, or vomiting. Gastric residuals should be monitored at home 2–3 times a day in the neurologically impaired patient who cannot communicate symptoms of nausea, abdominal pain, or fullness. If there is no change clinically in the patient's status, decrease monitoring to once daily for 5–7 days and then stop.
- Gastric access should always be considered first as it is easier to obtain than jejunal access and provides more enteral-feeding delivery options.
- Patients with advanced head and neck cancer receiving radiation or chemotherapy should generally receive pretherapy PEG tube placement.

Jejunal Enteral Access

- Jejunal access is appropriate for patients with the diagnosis of gastroparesis, gastric feeding intolerance, a documented gastric aspiration event, severe gastroesophageal regurgitation, inability to obtain gastric access, gastric outlet or duodenal obstruction, gastric or duodenal fistula, esophageal resection, gastric resection, or pancreatitis.
- Jejunal feeding is contraindicated in patients with a symptomatic small bowel ileus, small bowel obstruction, symptomatic adynamic colon, or colonic obstruction.
- For maximal drug absorption or drug efficacy, a pharmacist should be consulted to understand what, if any, requirement for gastric digestion or gastric activation is necessary when enteral nutrition is delivered directly into the small intestine.

EAD Tip Location

- If there is any question of the location of the tip of an EAD, a water-soluble contrast radiographic study through the tube should be obtained to identify the tube tip location before EAD use.

Enteral Access Care and Maintenance

- All clinicians inserting or providing maintenance care for EAD should be familiar with the spectrum of commercially available products including oro/nasoenteric tubes, percutaneous gastrostomy tubes, percutaneous jejunostomy tubes, percutaneous gastro/jejunostomy tubes, surgical gastrostomy tubes, surgical jejunostomy tubes, surgical gastro/jejunostomy tubes, replacement gastrostomy tubes, replacement jejunostomy tubes, and low-profile devices.
- All clinicians inserting and providing maintenance care for EAD should be familiar with the associated complications, including peristomal infection, sinusitis and nasopharyngitis, mucosal ulceration, peristomal leakage, hypertrophied or herniated peristomal tissue, enteral access tract tissue breakdown, colcutaneous fistula, buried bumper syndrome, inappropriate feeding-tube-tip location (eg, bronchial, intraperitoneal, esophageal), tube occlusion, tube migration, tube material degradation, and tube leakage.

Received for publication April 25, 2005.
Accepted for publication October 3, 2005.
Correspondence: Mark H. DeLegge, MD, FACP, Medical University of South Carolina, 96 Jonathan Lucas Street, Ste 210, Charleston, SC 29425. Electronic mail may be sent to deleggem@musc.edu.

- All physicians replacing percutaneous gastrostomy and jejunostomy EAD should be familiar with the recognition and treatment of associated complications, including tube-tract disruption, tube-tract bleeding, tube-tract infection, intraperitoneal tube placement, and early tube-tract closure.
- Any patient receiving an EAD for HEN should receive regular clinical monitoring to assess the effi-

cacy of the prescribed enteral therapy, maintenance of the EAD, and monitoring for complications related to the enteral feeding regimen, enteral feeding formula, or EAD.

ACKNOWLEDGMENTS

These statements were developed as a consensus of the HPEN Working Group, January 2005.