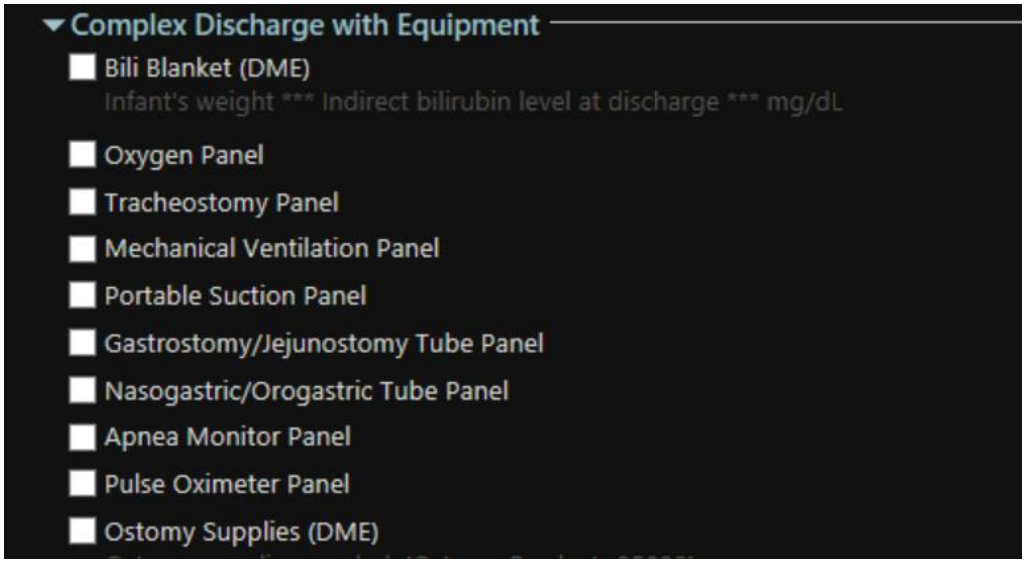
Newborn Critical Care Center (NCCC) Clinical Guidelines

Gastrostomy Tube Guidelines

A gastrostomy tube is a surgically placed tube, inserted through an opening in the stomach. A gastrostomy tube (GT) will benefit an infant unable to take in adequate nutrition for growth. Infants need GTs for various reasons but include the following: extreme prematurity, chronic lung disease, feeding aversion, neurological impairments, and congenital abnormalities. The gastrostomy tube can be temporary or permanent.

Guidelines for GT placement should include:

1. Family is ready to proceed with the plan for discharge with a feeding tube.
2. Trial of full oral/nasogastric (NG) feeds (unless contraindicated) has been conducted. If the patient is close to full oral feeds or the need for tube feedings is felt to be less than 3 to 6 months consider discharge with home NG feeding.
3. Identify the GT medical home. This is the team that will have primary responsibility for the GT and the home nutrition plan. This can be the primary pediatrician if they agree, the UNC feeding team, or complex care team. The provider must assure that there is a medical home for the patient with a GT. Pediatric surgery will continue to follow the patient over time assuring that the infant has the right size tube. Generally, Pediatric Surgery will see infants every 3 to 6 months after post- operative visits are completed.
4. Consult Pediatric Surgery. An upper GI study should be considered for those with long-term feeding problems, previous GI surgery or midline congenital anomaly. Discuss possible need for the UGI with the surgical team at the time of the referral. Pre-op education should begin prior to the OR and pre-op education should be as complete as possible. This will facilitate readiness for discharge following GT placement surgery. Parents and providers have access to the UNC Pediatric Surgery Gastrostomy Tube video.
5. Care Manager should begin simultaneously with the surgical consult. The care manager (CM) will assist with ordering the home equipment. These orders should be placed using the Gastrostomy/Jejunostomy Tube Panel in the NCCC Discharge orders.



PRE-OPERATIVE CARE

1. Communicate with the surgery team regarding the date of surgery and family contact numbers for surgical consent.
2. Fluid management plans should be discussed between the NCCC primary team and Pediatric Surgery the day prior to surgery. Most patients should be NPO from midnight with IV fluids at 100 – 120 mL/kg/day.
3. The patient may require a pre-op CBC and/or Chem 10. Coagulation studies are not routinely warranted.
4. ***Antibiotics will need to be ordered on a "sign and hold" basis*** (to be released by the bedside RN when patient is called by the OR) and should be available as the patient goes to the OR. Please consult with Pediatric Surgery about the timing and choice of antibiotics.

POST-OPERATIVE CARE

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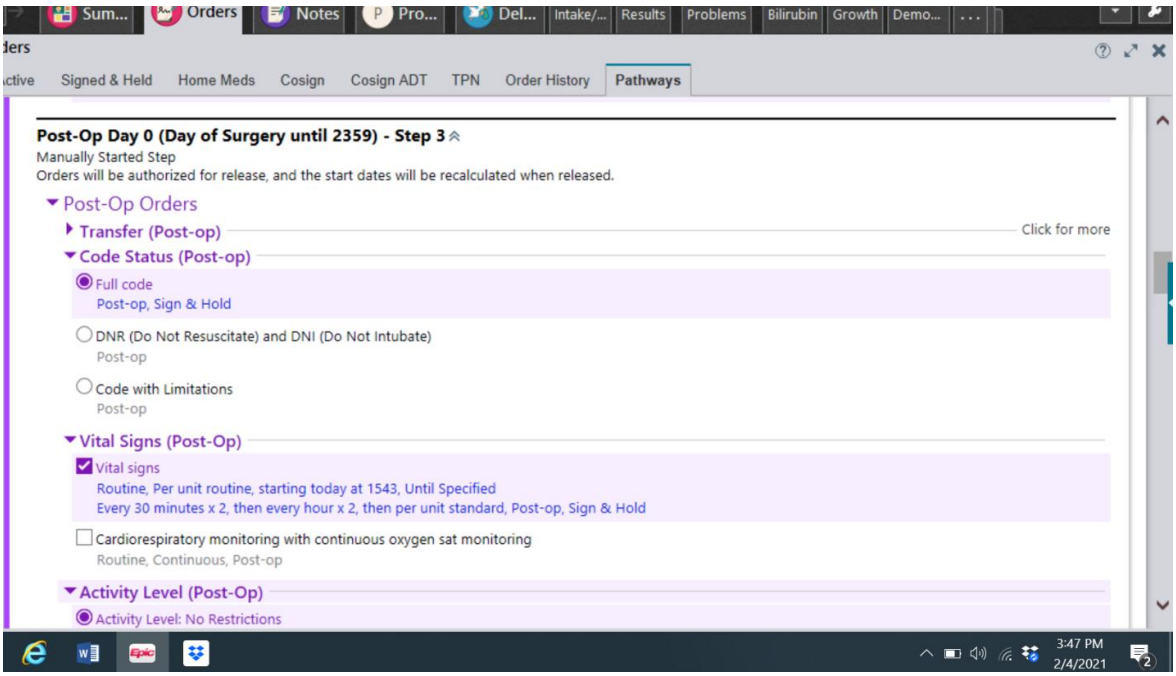
After return from the OR, most patients will follow the post-op pediatric GT order set which can be found under the **Pathways** tab in the **Orders** activity. Scroll down to see the post-op orders:



MEDICATIONS

- ***PAIN***
  - Unless contraindicated the infant should receive IV Tylenol for the first 24 hours
- ***OTHER***
  - Resuming pre-op medications must be considered on an individual basis. Medications can obstruct GT and care must be taken to avoid this complication. All medications should have a flush of water after they are given. Depending on the size of the infant a 3 to 5 mL flush is recommended.

FEEDING ORDERS

1. May use the GT immediately for medications, unless otherwise indicated by surgical team.
2. NPO with GT to straight drainage for the first 6 hours post-op. If stable at 6 hours post-op with normal vital signs for age, start feeds at 50% of goal.
3. May begin feeds with bolus feeding with advance to 75% to 100% at the 3rd bolus feed.
4. If the infant was receiving continuous feeding prior to the GT placement resume continuous feeding. After 6 hours of GT drainage, may start at 50% of goal and advance by 25% every 2 hours to be at full feeds at approximately 12 hours after return from the OR.
5. If there is abdominal distension, discomfort, discuss with the primary team and consider holding feeds for additional 12 hours. Discontinue IV fluids once full feeds have been achieved.

DISCHARGE PLAN

1. Complete GT teaching, which is largely done by nursing. Nursing will secure a "GT emergency bag" for the family to keep with their infant at all times.
2. Family should be encouraged to stay for an extended period of time in the care-by-parent room to practice with the GT and home equipment. Parents must demonstrate proficiency with the equipment prior to discharge.
3. Family should be aware of the accidental dislodgement policy for the GT, feel comfortable with the exact steps to take if they have concerns, and know how to contact Pediatric Surgery if dislodgement occurs.
4. GT stay sutures are generally removed on POD #5. If the patient is ready to go home prior to POD #5, check to see if the pediatrician is comfortable removing the sutures, or secure a pediatric surgery appointment for suture removal.
5. Routine follow-up appointment with Pediatric Surgery is scheduled for about 2 weeks post-op for a new GT. If the family returns for GT suture removal on POD# 5 then they do not need to return at 2 weeks post-discharge.
6. Provide the family with the contact numbers for Pediatric Surgery Department, and review indications for contacting Pediatric Surgery.
7. At the time of discharge an appointment will also be made with the GT medical home.

Reviewed March 2021 – Hubbard PNP / Wood MD / Phillips MD (Pediatric Surgery)