PEG, RIG or Surgical Gastrostomy? A why, where, when & how guide to gastric tube placement

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Aims of this session

- Brief overview of decision making
- Via the safest route.
- With minimal risk and complications.
- Achieving effective outcome
Why a Gastrostomy Tube?

- Diagnosis - if they have one
- Reason for enteral nutrition
- Assessments and/or imaging studies
- Can the patient swallow their own saliva?
- Dietetic input, what’s been tried/failed?
- Screening for contraindications.
- What is the patients’ long term prognosis?
- Ethical guidelines. Is a case conference required?
What is the device being used for?

- Feed, fluids and/or medication
- Venting
- Type or size of the device
- Who is going to manage the device?
- Implications on lifestyle?
- Replacement and repair
Gastrostomy Tubes

• Which one do you choose?
• Placement techniques
• Risk, benefit and alternative
• Clear management/post placement guidelines
• Trouble shooting
Options

• PEG
  Percutaneous endoscopic gastrostomy
  – Quick – good tubes

• RIG
  Radiologically inserted gastrostomy
  – No endoscope – avoids mouth

• Surgical placement
  - No endoscope – avoids mouth
  – But which tubes can we use
How do you decide on placement techniques?

• Depends on why they need the tube
• Is it safe to do a pull through PEG
• Is it safer to do a direct puncture
• Is endoscopy safe, sedation or GA
• Is there capacity in radiology?
• Do theatres have the correct equipment?
Pull-Through PEG
Advantages

• Simple technique
• Range of devices available
  • Size
  • Material
  • Internal fixator
  • External fixation
Disadvantages

- Requires endoscopy
  - Difficult in advanced tumours
  - Mouthguard
  - Airway management
- PEG bumper pulled through mouth
  - Site infection
  - Tumour seeding
- PEG removal / retrieval
Russell Introducer Method
(aka Direct Puncture or Push PEG)

- Balloon-retained tube
- Inserted directly through abdo wall
- Seldinger technique – dilators
- Large “cutting” trocar needle
- Split introducer – peel away
- Gastropexy
PEXACT (Endoscopic “Direct Puncture” PEG)
MIC Introducer

Where we all make a difference
Kimberly-Clark MIC - Endoscopic Placement

Where we all make a difference
Advantages

- Aseptic technique
- Well tolerated
- Direct placement of “Button”
- Endoscope provides view only
- Ultrathin (nasal) endoscope
Disadvantages

- Less familiar technique
- More complicated procedure
- Still needs endoscopy
- Difficult if “target” restricted
- Balloon-retained device
AMT Mini ONE® Balloon Button  
Kimberly-Clark Mic-Key® Balloon Button
Feeding Port
Safety Plug
External Bolster
One Way Valve
Internal Retention Bolster

AMT Button
Bard® Equivalent
Low Profile G-Tube

Bard is a registered trademark of C. R. Bard, Inc.

Where we all make a difference
Radiologically Inserted Gastrostomy (RIG)

- Have you got a dedicated and skilled interventional radiologist available?
- Timing and ease of access to this service provision?
- Types of devices available
- Who do they contact if problems?
Wills-Oglesby Percutaneous Gastrostomy Set

Used for percutaneous catheter placement for gastrostentropic feeding.
- Locking loop prevents inadvertent removal from the stomach.
- Locking loop and distal end contain 12 sideports to facilitate gastric feeding.
**Small-bore RIG: Problems**

- (Gastropexy)
- Re-intervention rate ~30%
  - Blockage
  - Displacement
- No replacement
- (No jejunal extension)

Seeding to PEG site
Gastro-Colo-Cutaneous Fistula

Incorrectly placed PEG tube

Summary

• Why we doing it?
• Who is going to look after it?
• What does the patient think?
• Can the patient get replacement devices locally?
• What capacity do we have?
• Planning and effective safe care

Where we all make a difference
Thank you.

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