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Summary

Paediatric gastrostomy insertion

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Endoscopy | Nurses | Small Intestine & Nutrition | Oesophagus | Surgery

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This presentation reviews common mistakes to avoid in paediatric gastrostomy insertion, emphasizing proper patient selection, timing, technique, and the importance of multidisciplinary discussion and parental education.

KEY POINTS

- Gastrostomy should be considered if a child requires nasogastric tube feeding for more than eight weeks, particularly in the first months of life, to prevent oral aversion and support growth in conditions such as neurodisability, prematurity, congenital heart disease, and short gut syndrome.
- Absolute contraindications include coagulopathy with INR above 1.5 and frank peritonitis; relative contraindications include VP shunt, severe scoliosis, peritoneal dialysis, and gastric varices, all requiring multidisciplinary team discussion.
- Routine fundoplication at the time of PEG placement is no longer recommended, though it may be indicated for recurrent aspiration, proven reflux, or progressive neurological disease.
- Antibiotic prophylaxis during the procedure is supported by meta-analyses and reduces infection risk; the speaker notes PEG is not a sterile procedure because the tube passes from mouth through the abdominal wound.
- The speaker recommends Mickey button changes always be performed endoscopically and teaches parents to rotate the tube daily to prevent buried bumper syndrome; a case of gastrocolic fistula after difficult button change underscores the need for lateral imaging and air contrast when resistance is encountered.
- Parents must understand that gastrostomy provides nutritional support but does not treat reflux or the underlying condition, and the speaker recommends waiting six months of non-use before tube removal, particularly in cardiac patients who may decompensate during winter infections.

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