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Summary

My patient is not thriving with PEG feeding

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Digestive Oncology | Education & Training | Small Intestine & Nutrition | Primary Care

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This educational presentation reviewed practical management of common PEG tube complications including diarrhea, leakage, buried bumper syndrome, and feeding intolerance through a case-based approach.

KEY POINTS

- The speaker emphasized a multidisciplinary approach requiring three elements for successful tube feeding: an experienced team (gastroenterologist, dietitian, nurse), appropriate tube and formula selection, and adequate caregiver education.
- For PEG site leakage, the speaker recommended keeping the area dry and applying zinc oxide ointment as a barrier, avoiding excessive cleaning, and using smaller (not larger) diameter tubes if the tract widens.
- Diarrhea in tube-fed patients may result from formula osmolarity and fiber content, delivery mode (bolus versus continuous), infections including C. difficile, malabsorption, medications, or rarely incorrect tube placement through adjacent organs.
- The speaker stated that gastric residual volume measurement should not be used as it leads to tube clogging and inappropriate cessation of feeding, with clinical measures preferred for evaluating tolerance.
- Buried bumper syndrome (occurring in 1 to 4 percent of cases as stated by the speaker) can be prevented by daily tube rotation and inward-outward movement starting one week after placement.
- For patients with persistent vomiting or aspiration on gastric feeding, the speaker recommended elevating the head of bed, switching to continuous low-rate feeding, using motility agents, and considering PEG-J placement if these measures fail.

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