STAY-PUT™ Nasojejunal Feeding Tube

Instructions for Use
Endoscopic/Fluoroscopic Placement

Sterile unless package is damaged or opened.

Caution: Federal law restricts this device to use by or at the direction of a physician.

Important physician and assistant notice:

1. Inspect contents of kit. If damaged, do not use.
2. If using standard fluoroscopic placement technique, an 8 FR pediatric Levin tube is required to backload guidewire through nasal passage.
3. Single Patient Use Only
**Read Before Using**

Nursing Manual provided with kit should follow patient. Attach this instruction booklet to patient chart for future reference.

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**Endoscopic Placement Procedure**

- Prep the patient for endoscopy. It may be beneficial to lay the patient on left side.
- The 9 FR jejunal feeding line has a preassembled stylet to facilitate intubation. (Fig. A)
For additional stiffness, insert flexible tip guidewire into the red FEED port next to the guidewire. To promote movement of the guide-wire, apply commercially available cooking oil spray or medical grade lubricant liberally to the guidewire and the inner lumen of the 9 FR jejunal feeding line. Always insert the flexible end of the guidewire into the tube first.

- Using standard endoscopic technique insert endoscope into oral passageway and advance through the stomach into the 2nd or 3rd portion of the duodenum. Verify that there are no obstructions.

- Pull endoscope back into the stomach and inflate the stomach. Withdraw the endoscope 25 cm into the esophagus.
- Lubricate the tip of the 9 FR jejunal feeding line with water soluble lubricant. Insert the tube into the nasopharyngeal passage or the mouth depending on patient requirement. Advance the tube into the stomach with the endoscope using the friction created by the side-by-side position of the tube and endoscope. (Fig. B)

- Allow the tube to locate along the lesser curvature of the stomach. Use the endoscope to push the tube to the pylorus.
Advance 3-4 cm of the 9 FR portion of the tube into the duodenal bulb. Grasping forceps may be necessary to guide the tube. (Fig. C)
Advance the endoscope into the duodenum alongside the 9 FR feeding line. (Fig D) Use the endoscope to push the tube forward. Advance the endoscope no further than the second portion of the duodenum.

**NOTE:** Use suture string to grasp and guide tube should looping or kinking occur.

- Once bolus tip is in the distal duodenum/proximal jejunum, gently remove flexible tip guidewire from the tube, leaving stylet in place.
NOTE: Do not remove stylet until entire placement procedure is complete.

- While applying pressure to the stylet and aspirating air through the endoscope, retract endoscope from stomach using a rotating motion to minimize the risk of dragging the tube into the stomach. (Figure E)

- For the 9/18 FR tube, visually confirm that the gastric tip of the 18 FR tube is in the stomach and not in the duodenum. This permits gastric drainage.
• Remove stylet and guidewire. Flush 9 FR feeding line with 20-30cc water. If it is not possible to flush, the tube may be kinked. Reinsert guidewire and use endoscope to unkink line.

• Secure tube to nose with dressing provided. Record insertion depth using centimeter graduations on tube.

• Confirm proper gastric and/or jejunal positions using x-ray methods immediately.

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**Fluoroscopic Placement Procedure**

**Equipment:**

• #082301 or #082303 Nasojejunal Feeding Tube

• .035” x 350cm Flexible Tip Guidewire

• Standard or Pediatric Endoscope

• 8 FR Pediatric Levin Tube
- Prep patient for fluoroscopy and upper endoscopy.

- Following standard endoscopic technique, insert endoscope into the mouth. Advance it as far as possible into the duodenum. (Figure F)

- Insert flexible tip of the guidewire into one of the endoscope channels. Advance guidewire under fluoroscopy into the intestine until it is beyond the ligament of Treitz. (Figure G)
While slowly removing endoscope, advance guidewire as necessary under fluoroscopy in order to maintain its position in jejunum.

Use an 8 FR pediatric Levin tube to reposition the guidewire from the mouth to nose. Insert 8 FR pediatric Levin tube into nasal passage. When tube is in the back of the mouth, grasp tip and pull out through the mouth. (Figure H)
- Insert guidewire into the distal end of the Levin tube exiting the mouth. Then advance guidewire until it exits the proximal end of the Levin tube. (Figure I)

- Remove 8 FR Levin tube, while maintaining position of the guidewire in the jejunum. Straighten out guidewire in the throat. (Figure J)
- If desired, remove and discard optional stylet before placing 9 FR jejunal feeding line over guidewire. (The tube is designed to be placed with or without use of stylet.)

- To facilitate placement of the tube over the guidewire, apply commercially available cooking oil spray or medical grade lubricant liberally through the inner lumen of the 9 FR jejunal feeding line.

- Apply water soluble lubricant to the open flow-thru bolus tip tube of the 9 FR jejunal feeding line.

- Place open flow-thru tip over guidewire exiting the nose.
Under fluoroscopy, push tube along the guidewire until radiopaque bolus tip is in the jejunum beyond the ligament of Treitz. For the 9/18 FR Combination tube, the radiopaque gastric tip of the 18 FR tube should be in the stomach and not beyond the pylorus. (Figure K)
- Remove guidewire.
- Remove stylet (if used).
- Secure tube to nose using dressing provided.
- Confirm proper gastric and/or jejunal position using x-ray.

**Alternative Placement**

This tube can also be placed using the standard endoscopic technique of inserting a forceps through an endoscope, grasping the tube’s suture string, and advancing the tube into the intestine, or intraoperatively manually manipulating the tube beyond the ligament of Treitz.
Instructions for Use

Feeding and Decompression

9 FR Jejunal Feeding Line

- Upon fluoroscopic or x-ray confirmation of tube position, feeding can begin immediately through the tube’s jejunal FEED port.
- The 9 FR jejunal feeding line is marked every 10 cm starting at 80 cm from the jejunal tip. Use these markings to record placement depth and monitor tube position.
9/18 FR Jejunal/Gastric Tube

- Upon fluoroscopic or x-ray confirmation of jejunal/gastric placement of the combination tube, feeding can begin immediately through the tube’s jejunal FEED port.

- The 9/18 FR tube is marked at 10 cm intervals starting at the gastric tip. Use these markings to record placement depth and monitor tube position.

- When desired, gastric suctioning can be performed through the tube’s DRAIN port. Intermittent suction at 120mm of Hg should be used to suction the stomach. If continuous suction is used, a low setting of 60mm of Hg is recommended.

CAUTION: Use of continuous suction has the potential to damage the gastric lining.
CAUTION: For the 9/18FR tube, it may be necessary to reposition the tube after the use of suction. Decompression of the air in the stomach may cause the relative position of the tube to shift so that the gastric tip and suction outlets are in the duodenum. Duodenal position of the gastric suction outlets has the potential to damage the duodenal lining.

Poor gastric decompression or gastric distention may indicate that this situation exists. To correct positioning, x-ray the tube in the stomach and small bowel. Note position of the tube’s gastric tip. Gently pull the tube back until the gastric tip is in the stomach. X-ray to confirm position. This procedure can be performed using fluoroscopy.
Maintaining Tube Patency:
To keep the jejunal line open, irrigate with 20-30 cc of water every four to six hours during continuous administration of formula. It should also be irrigated before and after each intermittent feeding or administration of medications.

Administering Medication:
All medications should be finely crushed and dissolved in water and injected through the DRAIN or FEED port. Whenever available, liquid forms of medication are recommended.

Use of an Infusion Pump:
If an infusion pump is used, pressure should not exceed 40 psi.

Tube Modification:
Modification of the tube or any accessory part is inadvisable.

Monitoring Reflux:
Reflux of tube feeding should be monitored per facility protocol.
Tube Dislodgment:
If tube dislodgement is suspected because of severe coughing or emesis, a follow-up x-ray to verify tube placement is strongly recommended.

Removal

- When jejunal feeding is no longer necessary, the STAY-PUT Nasojejunal Feeding Tube can be replaced with a conventional nasogastric feeding tube.
- For the 9/18 FR tube, when gastric suctioning is no longer necessary, the STAY-PUT Nasojejunal/Gastric Feeding Tube can be replaced with a conventional jejunal or nasogastric feeding tube.
- If replacement with another STAY-PUT Nasojejunal Feeding Tube is desired, see section on alternative placement.
- To remove, close the cap, grasp tube near the red feeding adapter and gently pull.