Introduction A replacement button-gastrostomy has been developed, retained by a mechanical internal fixator formed by loops of the tube shaft. When stretched by the introducer/extractor tool it returns to a completely flat tube profile, avoiding the need for oversizing the stoma, reducing pain on exchange and potentially increasing the tube dwell time beyond the recommended 3 month intervals of balloon tubes. We assessed whether the prototype is applicable to clinical practice.

Methods Suitable patients referred for replacement of a conventional gastrostomy were invited to receive a 14Fr prototype instead of a 12Fr balloon gastrostomy requiring a 16Fr track. Gastrostomies were inserted without local anaesthesia, unless required for removal of the existing PEG/RIG. Regular follow-up at increasing periods was performed and difficulties and complications recorded. Informed consent and approval by the institutional review board was given, the device is CE marked.

Results All tubes were sited and subsequently exchanged without difficulty and essentially pain-free. Two patients had PEGs removed fluoroscopically under sedation prior to siting the tubes, 14 patients with an existing balloon tube found the exchange from much less painful. Initially the prototypes were changed routinely after 6 months. At present they are left until the patient indicates a need for review. No complications occurred during the insertion of the feeding tubes. No accidental displacements occurred. Seven feeding tubes (47%) are still in situ after a median of 250 days. Of the remaining tubes five were removed due to end of treatment, 4 were changed back to a balloon tube (two patient preference, two for infection and leakage). 14/16 patients indicated a clear preference for the prototype because of lack of balloon-maintenance, reduced number of tube changes and painfree tube removal and insertion.

Conclusion The feasibility study proved the mechanical retainer to have sufficient internal fixation with much reduced need for maintenance and applicable to clinical practice. Dwell time can easily exceed 1 year and patient acceptability was much higher than expected. The reduced number of tube changes and lack of pain of these would be particularly important in children.

Competing interests J Cain: None declared, T Westwood: None declared, L Wilbraham: None declared, D Edwards consultant for: Vygon, H U Laasch consultant for: Vygon, Kimberley-Clarke.

REFERENCE


**PMO-080** HOME ENTERAL TUBE FEEDING VIA PERCUTANEOUS JEJUNOSTOMY: A 5-YEAR UK REGIONAL STUDY OF TRENDS AND OUTCOMES
doi:10.1136/gutjnl-2012-302514b.80

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**Introduction**
NHS Lothian home enteral tube feeding (HETF) point prevalence figures reveal that of the 325 adults on HETF in the Lothian region, 18 (5.4%) are being fed via jejunostomy. The aims of this study were to establish the trends in jejunostomy feeding over a 5-year period and to identify the associated complications.

**Methods**
A retrospective review of the regional HETF database was carried out to identify all adults discharged home to the Lothian region on jejunal feeding between 01 January 2007 and 31 December 2011.

**Results**
Ninety adults were discharged on jejunal feeding within the study period. The number of adults receiving jejunostomy feeding at home had increased with an average of 11 per year from 2007 to 2009 rising to an average of 28 per year from 2010 to 2011. Patient age at start of feeding ranged from 17 years old to 79 years old with a median age of 61.6. The most common reason for home jejunal feeding was post-oesophagectomy for oesophageal cancer (65%), followed by gastrectomy (8%) and oesophageal rupture (6%). Length of time on home jejunal feeding ranged from 7 days to 999 days with an average of 165 days, equivalent to 23.6 weeks. The most common clinical outcome was discontinuation of HETF and a return to normal oral diet (64%), 16% died due to underlying disease, and 14% continued on jejunostomy feeding. A review of the complications associated with use of a jejunostomy feeding tube revealed that 55% had documented complications and of this number, 56% had more than one complication documented. In practice, this incidence may be higher as not all patient records had the results of the survey which was concerned with the practical issues, the nursing process, and enteral nutrition complications. A cluster sample recruited intensive care nurses (n=253) from different health care sectors in Jordan.

**Conclusion**
Clinical nutrition is perceived by 79.7% of nurses as a secondary role. Nurses showed greater levels of knowledge and responsibility for “preventing complications” and “evaluation” than “assessment” and “identifying goals”. Tube position is still confirmed via unreliable measures such as air bubbling technique (mean 4.00, SD 1.14). The mean for measuring Gastric Residual Volume was above the mid-point (3.70, SD 1.53). However, there was inconsistency in recognising the limit, threshold and frequency of measuring this volume. Diarrhoea is the most frequent complication of enteral nutrition (mean 3.36, SD 1.34) followed by abdominal pain, tube dislodgement, weight loss and uncontrolled blood sugar. Nurses perceived that the incidences of complications are less likely to occur in the presence of evidence-based guidelines than absence (rho=0.73, df=251, p<0.001).

**Competing interests**
None declared.

**REFERENCES**

**PMO-081** ENTERAL NUTRITION IN THE CRITICALLY ILL: THE IMPACT OF NURSING ADHERENCE TO FEEDING PROTOCOLS ON THE EFFECTIVENESS OF TREATMENT IN JORDANIANS INTENSIVE CARE UNITS
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**Introduction**
The aim of the study is to assess nurses’ adherence to enteral nutrition evidence-based guidelines in intensive care.

**Methods**
Mixed-methods design was employed. This abstract will show the results of the survey which was concerned with the practical issues, the nursing process, and enteral nutrition complications.

**Results**
Clinical nutrition is perceived by 79.7% of nurses as a secondary role. Nurses showed greater levels of knowledge and responsibility for “preventing complications” and “evaluation” than “assessment” and “identifying goals”. Tube position is still confirmed via unreliable measures such as air bubbling technique (mean 4.00, SD 1.14). The mean for measuring Gastric Residual Volume was above the mid-point (3.70, SD 1.53). However, there was inconsistency in recognising the limit, threshold and frequency of measuring this volume. Diarrhoea is the most frequent complication of enteral nutrition (mean 3.36, SD 1.34) followed by abdominal pain, tube dislodgement, weight loss and uncontrolled blood sugar. Nurses perceived that the incidences of complications are less likely to occur in the presence of evidence-based guidelines than absence (rho=0.73, df=251, p<0.001).

**Conclusion**
Nurses show more concerns about the outcomes of enteral feeding instead of the preliminary assessment. Measuring gastric residual volume and confirming tube placement are still deficient and require further evidence. Evidence-based practice is acknowledged by nurses where undertaking such protocols is emphasised.

**Competing interests**
None declared.

**REFERENCES**

**PMO-082** OUTCOMES AFTER “THROUGH THE PEG” PLACEMENT OF JEJUNAL EXTENSIONS
doi:10.1136/gutjnl-2012-302514b.82

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**Introduction**
Percutaneous endoscopic gastrojejunostomy (PEG-J) placement by conventional techniques is technically demanding,