AVANOS*

CORFLO* PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) KITS

PULL Technique

Instructions for Use

AVANOS*CORFLO* Percutaneous Endoscopic Gastrostomy (PEG) Kits
Pull Technique

Rx Only: Federal Law (USA) restricts this device to sale by or on the order of a physician.

All contents included are sterile unless otherwise specified on component labeling.

Indications

CORFLO* PEG tubes are intended for the delivery of enteral nutrition, water and medications into the stomach and to allow gastric decompression or drainage.

Note: *It is recommended that patients undergoing the PEG procedure receive prophylatic intravenous antibiotics. It is also recommended that intragastric antibiotics be administered to those patients who have received antacids, M_2 receptor antagonists, or who are achlorhydric.*

Patient Preparation

Move patient to supine position, prep and drape.

Tube Site Selection

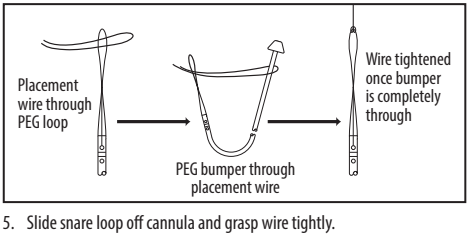
1. Place endoscope and examine stomach and duodenum. Tensely inflate stomach with air.
2. Dim room lights and transilluminate stomach and abdominal wall.
3. Depress a finger at the site of transillumination and endoscopically visualize finger impression.
4. Place snare loop at site of finger impression.
5. Infiltrate the site with local anesthetic.
6. Make approximately 1 cm incision in the abdominal wall.

⚠ **Caution:** The stomach should be kept inflated throughout the procedure to ensure contact of the gastric and abdominal walls.

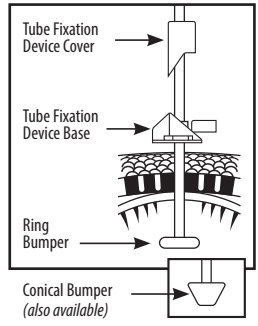
Tube Placement

⚠ **Warning: For kits that contain a plastic cannula, do not reinsert the needle or any other sharp object into the cannula while the cannula is in the patient.**

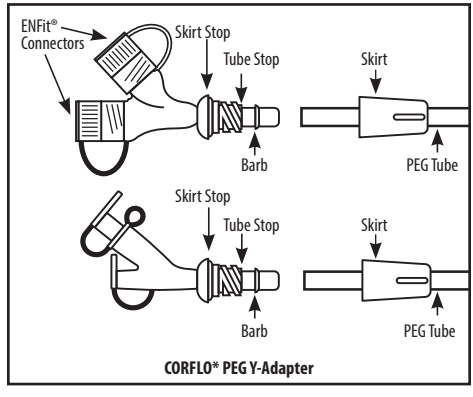
1. Pass the Seldinger needle through the incision and into the stomach so it can be visualized by the endoscope.
2. Loosely tighten snare loop around cannula.
3. Remove trocar from cannula and immediately insert looped placement wire into the cannula.
4. Quickly feed 10 – 15 cm of wire into stomach.



5. Slide snare loop off cannula and grasp wire tightly.
6. Retract snare sheath tightly into scope.
7. Remove scope and snare as a unit.
8. Interlock the loops of the PEG tube and the placement wire as shown.
9. Lubricate the PEG tube.
10. Apply gentle steady traction to abdominal end of placement wire while guiding PEG tube into patient's mouth.
11. Continue traction until end of PEG tube is pulled through abdomen.
12. Continue pulling the PEG tube through the abdominal wall until the 15 cm mark on the tube is visible.
13. Reinsert the endoscope.
14. Visualize that the bumper has completely re-expanded within stomach.
15. Cut placement wire to remove from wire loop on tube.
16. Slide Tube Fixation Device Base and then Tube Fixation Cover over entire tube. Base portion goes first.



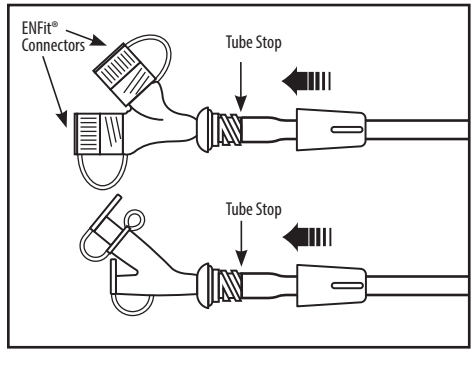
17. Cut the PEG tube to desired length at least 2 inches below the dilator portion.
18. Close Y-Adapter caps.
19. Untwist skirt from Y-Adapter.
20. Put PEG tube through narrow end of skirt.



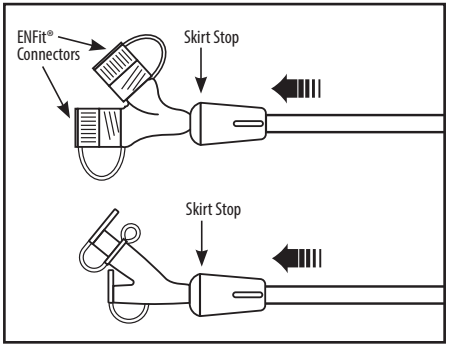
CORFLO* PEG Y-Adapter

Note: *The use of the skirt is VITAL – it occludes the air lumen which prevents air from escaping the internal retention bumper to minimize inadvertent removal of the PEG tube.*

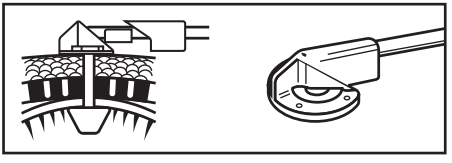
21. Push PEG tube onto barbed end of Y-Adapter.
IMPORTANT: PUSH OVER BARB UNTIL TUBE STOP IS REACHED.



22. Twist and push skirt on until skirt stop is reached.



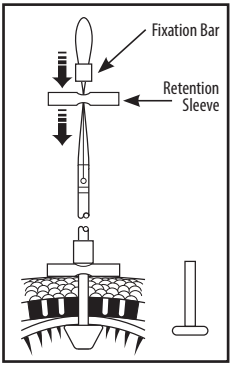
23. Slide base of Tube Fixation Device down the tube (flat surface first) to the abdominal wall.
24. Under endoscopic visualization, position the internal bumper loosely against the gastric mucosa. There should be no blanching of the gastric mucosa.
25. Secure tube in groove of Tube Fixation Device Base and slide Tube Fixation Device Cover (pointed end first) down the tube to engage with base until a click is heard to lock the cover in place (allow approximately 1cm (10mm) of movement between the base and the abdominal skin).



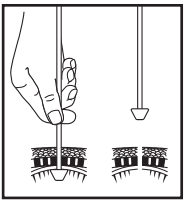
26. Following gastric decompression, the Tube Fixation Device should not indent the skin. If it does, adjust as necessary.
27. Apply povidone iodine ointment to exit site. No dressing is necessary.
Note: *The 20 Fr. Tube Fixation Device (illustrated) has a circular disc. The 12 Fr. and 16 Fr. Tube Fixation Devices do not have the circular discs.*

An optional silicone fixation bar with retention sleeve is included. This fixation bar is provided as an alternative to the Tube Fixation Device.

⚠ **Warning: Excessive traction may cause premature removal. Use of PEG tube may commence 4 hours after insertion usually starting with sterile water – refer to local policy.**



Tube Removal Traction Method



The feeding tube may be removed without endoscopy if the PEG is free moving in the tract:

1. Sedate patient if required.
2. Remove Tube Fixation Device Cover from Base and slide both away from abdomen.
3. Cut the tube below the Y-Adapter to open air lumen.
Note: *If a jejunal tube is in place, remove it prior to cutting PEG tube. DO NOT clamp the PEG tube during removal as this will prevent internal bumper compression.*
4. Lubricate the PEG tube and skin around stoma. Rotate and advance several centimeters into the stomach in order to disengage tube from the stoma and to lubricate the tract.
⚠ **Warning: If tube is not free moving within the stoma tract do not attempt to use traction as a method of removal.**
5. Support the abdomen around the stoma with your hand and apply gentle downward pressure to the abdomen – pull the PEG tube until it exits the stoma in a firm, single motion.
⚠ **Caution:** Removal of feeding tubes using traction may result in trauma to the tract and associated complications.

Endoscopic Method

1. Lubricate the PEG tube and skin around stoma. Rotate and advance several centimeters into the stomach in order to disengage tube from the stoma and to lubricate the tract.
2. Scope patient and grasp bumper with forceps or snare.
3. Cut the PEG tube near the skin line and endoscopically retrieve the PEG bumper.

The stoma tract should close within 24 hours of removal.

⚠ **Warning: It is not recommended to cut the PEG tube and let the bumper pass through the intestines due to risk of obstruction.**

Note: *Placement and use of any gastrostomy tube may result in minor abdominal irritation or patient discomfort. Infrequently occurring factors as a result of use or misuse may include peritonitis, allergic reaction, GI perforation, tissue necrosis, contamination, medication or nutrition delay and related complications or the need for additional medical procedures.*

Interconnectability to Non-Enteral Medical Devices

The ENFit® connectors were designed in order to prevent misconnections between enteral devices and other devices used in various medical applications. However, the design of the ENFit® connector cannot overcome all chances of misconnection. The following connector types are potential misconnections for the ENFit® connector (feeding/medication access port) of this enteral feeding tube:

- Suction ports on Endotracheal Suction Systems
- Respiratory circuit filtration connectors
- Oxygen inlet connectors for Resuscitation Devices
- Baxter IV Solution Bag ports (such as NaCl, Ringers Solution, etc.)
- Sample ports on drainage bags
- Peritoneal Dialysis connectors
- Cones & sockets of ISO 5356-1:2004 & ISO 5356-2:2004
- Temperature sensor connectors & mating ports of ISO 8185:2007
- Oxygen nipples as defined in EN 13544-2:2002

Diameter	Single Use Only	STERILE EO Sterilized using ethylene oxide	Do not use if package damaged
Do not resterilize	LATEX Not made with natural rubber latex	DEHP Product is not made with DEHP as a plasticizer	BPA Product is not made with BPA
Rx Only	Caution	Consult instructions for use	

www.avanos.com

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CE 2797

The CE mark is valid only if it is also printed on the device label.