CORTRAK® 2 Enteral Access System™ (EAS™)

Advanced Placements Techniques and Assessment Skills from the Point of Care

NOTE: DO NOT USE THE CORTRAK 2 EAS UNLESS YOU HAVE BEEN TRAINED

PRE INSERTION

- Flush tube before insertion to activate inner lumen of feeding tube to aid in stylet removal and insertion during placement. Flush again just prior to Transmitting Stylet removal at the end of the procedure.
- Smart Receiver Unit (SRU) Self Tests and Fault Messages
  - Solid green indicates that SRU is working appropriately at power on.
  - Flashing green light indicates SRU is working appropriately throughout the procedure
  - An "error message" on the ALL-In-One Monitor indicates a direct action that needs to be taken. Refer to the Operator's Manual or Tips Cards for additional information.

SMART RECEIVER UNIT PLACEMENT

- Position the patient so that the front foot of the SRU is aligned at the Xyphoid Process and parallel to the spine. This is critical for accurate interpretation (refer to Figure 1).
- If SRU is angled more than 30° utilize the Leveling Device, a towel or washcloth to properly align the SRU then secure it with tape or use the orange weighted Stabilizer. Gowns do not stay in position.
  - Place under the front foot of the SRU for bariatric patients
  - Place under the back 2 feet for thinner patients

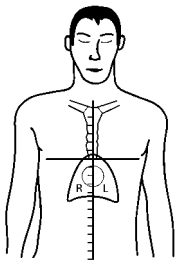

FIGURE 1

- The SRU does not have to rest on the skin, it can be held above the chest when the SRU cannot be leveled and stabilized. For example, when an oscillator is being used, over an open chest, or if abdomen is extremely rotund with ascites.

POST PYLORIC INSERTION TECHNIQUES

NOTE: Delayed gastric function is prevalent in 30 to 70% of the ICU population. Obtaining post pyloric placement can be more challenging due to narcotic use, immobility, fluid, and electrolyte imbalance. The CORTRAK 2 EAS does not change peristalsis, but the CORTRAK 2 EAS real time visualization allows the user to use skills and techniques more efficiently for advancing the feeding tube.

Patient History of diabetes, gastric scarring from ulcers, hiatal hernias, and previous gastric surgeries can make pyloric access more difficult.

- To avoiding stomach coiling:
  - Use slow advancement technique to avoid coiling. Moving a few centimeters at a time will help advance the feeding tube with the ratio of peristalsis. Normal gastric contraction only occurs 3 to 5 times per minute. With delayed gastric function gastric and pyloric contraction is slower or even absent. Waiting for peristaltic return may be necessary.
  - When meeting resistance, the tube will spring back when released and usually indicates coiling in the stomach location.
  - When the green ball is not moving and the tube is being advanced, usually indicates that coiling is happening behind the tip. When this happens, pull the tube back slowly until the green dot moves, then continue to advance the tube forward.
  - Air bolus simultaneous with forward advancement can aid in moving the tube through the stomach antrum to the pylorus.
  - Monitor for the backward "C" indicating the movement to the pylorus, if it makes a "U" the tip is moving the wrong direction and it will continue to coil. Pull back the tip toward the X-Y axis and advance the tube using air.
  - Inflating the stomach with air via syringe can aid in advancing the feeding tube.

PYLORUS/DUODENAL ADVANCEMENT

NOTE: Right and left sided placement is a technique used with blind technique and will alter organ alignment in the body. It is not recommended and can skew tip position interpretation on the placement screens.

- When the tip is at the vertical sagittal axis an air bolus can aid in pyloric advancement.
- Withdrawing the Transmitting Stylet from the tube 3 to 4 inches or approximately 10 cm. can reduce the resistance of the tip allowing natural peristalsis to advance the tube.
- Having the patient cough or performing ET suction can force a contraction of the diaphragm and the stomach.

DUODENAL PLACEMENT AND THE DEPTH VIEWS: DEPTH CROSS SECTION AND LATERAL SCREENS

- Monitor for the duodenal drop on either the Depth Cross Section or Lateral View screen. The duodenal drop is noted on the left side of midline on the Anterior Placement Screen which represents the patient's vertical sagittal axis.
- A bowel that loops behind the stomach (posterior bowel position) can appear as a coil on the Anterior screen (and on X-ray).
- The bowel is a negative pressure environment, a snap test can indicate post pyloric placement. When the plunger is retracted no air will come back and when the plunger is released it will retract back.
- If difficulty passing into distal portion of bowel, with tight bowel curvature, consider gentle palpation of abdomen to aid in bowel reposition.
- The biliary/ pancreatic duct is approximately at the junction of the 2nd and 3rd portion of the duodenum, aspiration of bile secretions may be obtained.

TRANSMITTING STYLET REINSERTION – CHECK FOR KINKS

- Before reinserting the Transmitting Stylet, cap one port and check for kinking by air bolus in the auxiliary port. If kinked the air will not be able to flow into the tube.

TUBE OCCLUSIONS

- Consider use of Clog Zapper®

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