

CORTRAK* 2

This document is intended for qualified healthcare professionals only. Users should always consult their facility's guidance on the use of products at their facility. Do Not Use the CORTRAK* 2 Enteral Access System unless you have received training and have been deemed competent by your facility.

TOPIC

METHODOLOGY

Patient Positioning^{1,2,3}



Supine Position



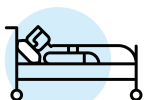
Reverse Trendelenburg Position

Consider Reverse Trendelenburg for patients at risk for aspiration

- ▲ Ideal position is 30° or supine
- ▲ Position head forward (chin on chest) to direct the tube into the esophagus
- ▲ After tube is in the stomach, flatten abdomen (put patient flat) to decrease resistance against the pylorus

Air Insufflation¹

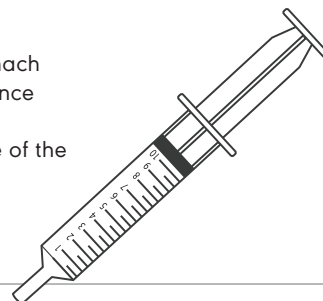
Note: Do so only if no patient contraindications (e.g. septic bowel)



Insufflate air to aid tube advancement:

- ▲ When tube is coiling: stuck on rugae of the stomach
- ▲ At pyloric sphincter (quick burst of air and advance tube simultaneously)
- ▲ Especially helpful in navigating the tight C-curve of the 1st/2nd portions of the duodenum-small bowel

Catheter, Oral, or ENFit® Tip Recommended



Transmitting Stylet & Tube Advancement^{1,2,3}



Floppy Tip:

- ▲ Pull back Transmitting Stylet (5-10 cm) to soften the tube tip
- ▲ Advance tube slowly a few cm, then re-advance stylet to see tube progression

Note: Remove Transmitting Stylet from proximal Y port with 2 hands

Prokinetics^{1,3} (Reglan, Erythromycin)



Stimulates peristalsis:

- ▲ Add to order set for CORTRAK* 2 tube placement or obtain MD order

Patience at Pylorus^{1,3,9}



- ▲ Slow advancement/progression works with delayed gastric peristaltic wave
- ▲ Wait for peristalsis return

Coiling⁸



Once in the stomach or small bowel, if Green Dot (represents stylet tip) is not advancing forward, the tube is coiling

- ▲ Pull back the tube until Green Dot moves backwards to eliminate slack/coil

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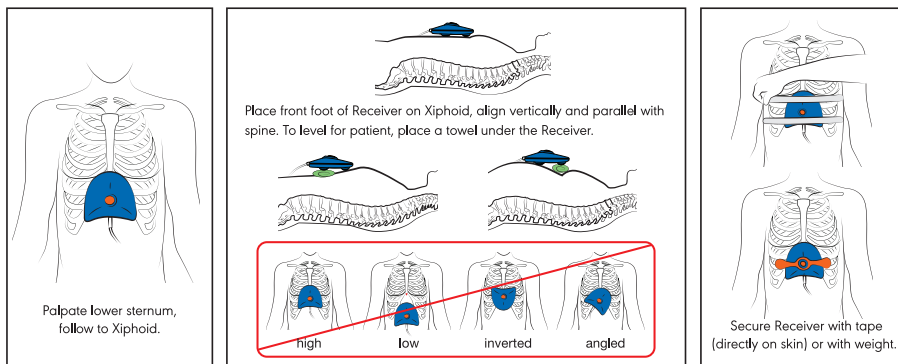
TOPIC

Receiver Unit Positioning^{7,8}



METHODOLOGY

Place Front Foot of Receiver on Xiphoid Process

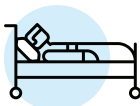


Transmitting Stylet Reinsertion, Storage and Handling^{1,2,3}

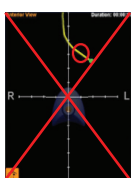


- △ Store the Transmitting Stylet loosely coiled and place in bag provided
- △ Do not kink
- △ When reinserting Transmitting Stylet, if Failure Message occurs: disconnect then reconnect Transmitting Stylet from Monitor
- △ If failure message continues replace tube and Stylet

Safe Placement^{4,5,7}



Quick deviation above midline



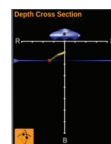
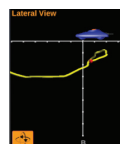
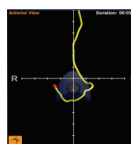
Deviation and continued placement



If tube deviates from vertical midline or patient coughs, potential lung placement. Immediately withdraw tube.

- △ Focus on Anterior View until the tracing shows entry into the stomach
- △ Estimated tube length for adult lung deviation at bifurcation: ~20-35cm markings^{4,5}
- △ Monitor for deviation above the horizontal midline

Effective Use Depth Cross Section and Lateral View Screens^{4,7,8}



- △ Monitor the Depth Views for the Anterior (high position) to Posterior drop (low position) as the tube passes midline and into the duodenum
- △ 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.

- 1 Powers Jan, et al, Bedside Placement of Small-Bowel Feeding Tubes: In the Intensive Care Unit, Critical Care Nurse, 2003; 23:16-24
- 2 AACN Procedure Manual for High Acuity, Progressive and Critical Care, 7th Edition, Procedure 140, Small-Bore Feeding Tube Insertion Using an Electromagnetic Guidance System, Edited by Debra Wiegand, Elsevier, 2016
- 3 Cresci Gail, et al, The History of Nonsurgical Enteral Tube Feeding Access, Nutrition in Clinical Practice (NCP), Oct. 2006, 21:522-528
- 4 Welch S., Certification of Staff Nurses to Insert Enteral Feeding Tubes Using a Research-Based Procedure, Nutrition in Clinical Practice (NCP), February 1996, 11:21-27
- 5 Gilbert P., et al, Verification of Feeding Tube Placement, Perspectives, 2012 Vol 9, No 4
- 6 Marderstein EL, Patient safety: effect of institutional protocols on adverse events related to feeding tube placement in the critically ill. J Am Coll Surg. 2004 Jul;199(1):39-47; discussion 47-50.
- 7 CORTRAK 2 Feeding Tube Instructions for Use
- 8 CORTRAK 2 Enteral Access System Operator's Manual
- 9 International Foundation for Functional GI Disorders, Disorders of the Stomach, Feb 24, 2016 <https://www.aboutgimotility.org/disorders-of-the-stomach.html>
- 10 U Gungabissoon, et al, Prevalence, Risk Factors, Clinical Consequences, and Treatment of EN Feed Intolerance During Critical Illness, JPEN Vol.39 No4, May 2015
- 11 S. Taylor, et al, Treating Delayed Gastric Emptying in Critical Illness: Metaclopramide, Erythromycin, and Bedside (Cortrak) Nasointestinal Tube Placement, JPEN, Vol 34 No.3, May 2010