

November 2012

Percutaneous gastrostomy (PEG) tube placement in patients with continuous flow left ventricular assist device. (LVAD).

Hitoshi Hirose
Thomas Jefferson University


Chris Rizzi
Thomas Jefferson University

Linda Bogar
Thomas Jefferson University

Jay S. Jenoff
Thomas Jefferson University

Nicholas Cavarocchi
Thomas Jefferson University

Follow this and additional works at: <https://jdc.jefferson.edu/surgeryfp>

 Part of the [Surgery Commons](#)

[Let us know how access to this document benefits you](#)

Recommended Citation

Rizzi C, Bogar L, Jenoff J, Cavarocchi N, Hirose H. Percutaneous gastrostomy (PEG) tube placement in patients with continuous flow left ventricular assist device. (LVAD). Presented at Cardiovascular Thoracic Critical Care 2012, Washington DC, October 4-6, 2012.

This Article is brought to you for free and open access by the Jefferson Digital Commons. The Jefferson Digital Commons is a service of Thomas Jefferson University's [Center for Teaching and Learning \(CTL\)](#). The Commons is a showcase for Jefferson books and journals, peer-reviewed scholarly publications, unique historical collections from the University archives, and teaching tools. The Jefferson Digital Commons allows researchers and interested readers anywhere in the world to learn about and keep up to date with Jefferson scholarship. This article has been accepted for inclusion in Department of Surgery Faculty Papers by an authorized administrator of the Jefferson Digital Commons. For more information, please contact: JeffersonDigitalCommons@jefferson.edu.

Percutaneous gastrostomy (PEG) tube placement in patients with continuous flow left ventricular assist device (LVAD)

Chris Rizzi, BS, Linda Bogar, MD, Jay Jenoff, MD, Nicholas Cavarocchi, MD, Hitoshi Hirose, MD.

From Thomas Jefferson University Hospital, Philadelphia, PA, USA

Introduction

Inadequate nutritional support after LVAD placement is known to increase postoperative infections and to decrease survival.

The LVAD patients with complicated postoperative recovery requiring prolonged mechanical ventilation may require long-term tube feedings.

Placement of a PEG requires knowledge of the location of the LVAD pocket and driveline to avoid device infection and injury.

Methods

Study period: August 2008 -December 2011

Total Number of Heartmate II LAVD: 39 for either bridge to transplant or destination therapy.

PEG placement after LVAD: 5 patients

Procedure management:

Cessation of anticoagulation at midnight
Correction of abnormal coagulation profiles
Monitoring of VAD during PEG with a cardiothoracic surgeon or intensivist
a pefusionist or VAD coordinator in the operating room.

Results

PEG placement after LVAD: 5 patients

3 males and 2 females

Age of 58 +/- 5.0

Interval of LVAD to PEG : 21 +/- 8.8 d.

PEG was successfully performed in the operating room in all patients.

There were no LVAD device or driveline injuries related to the PEG procedure.

There were no postoperative short-term or long-term PEG related complications such as acute gastric bleeding or dislodgement of the PEG tube.

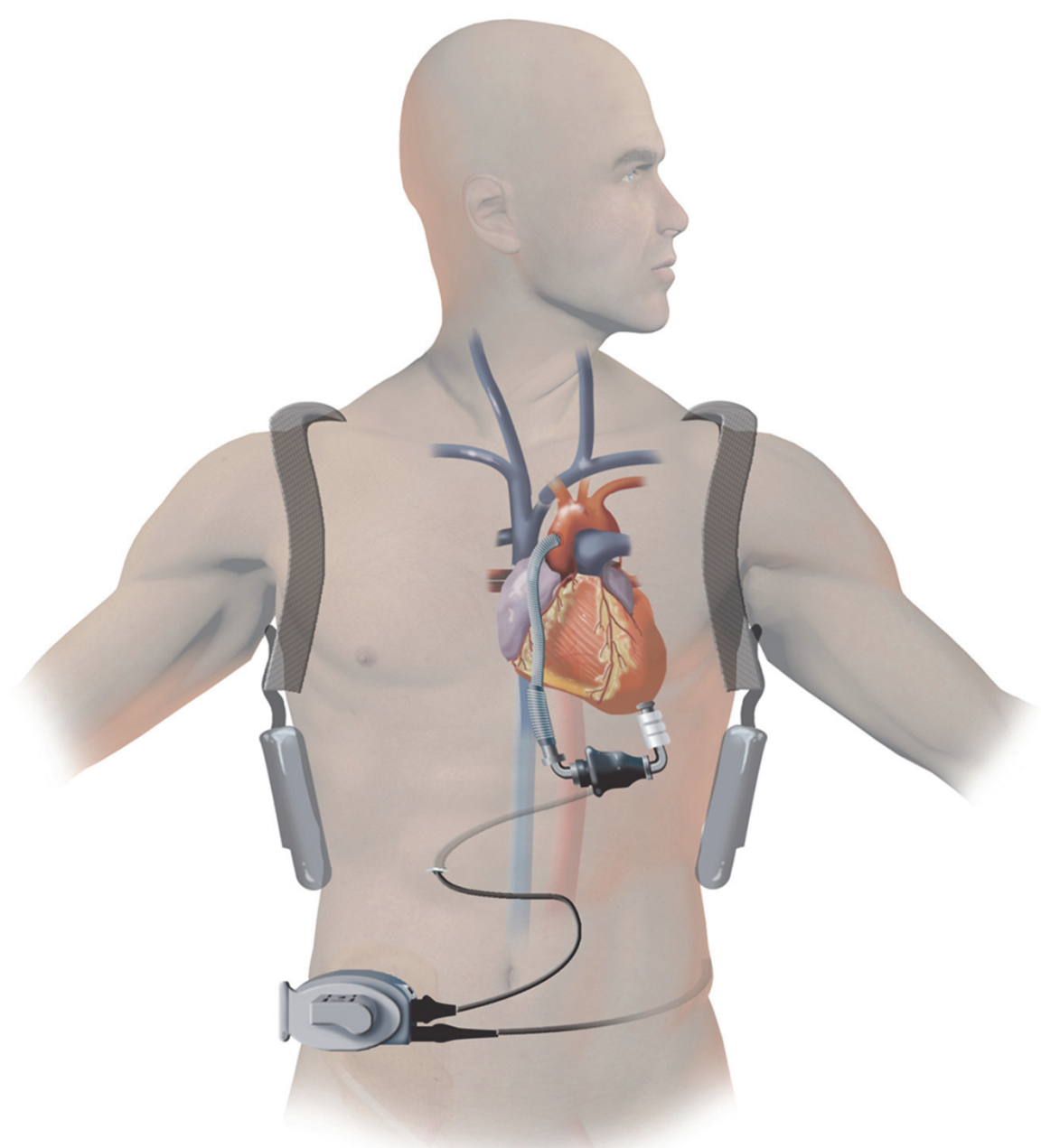
Key points of Peg Procedure

Appropriate monitoring

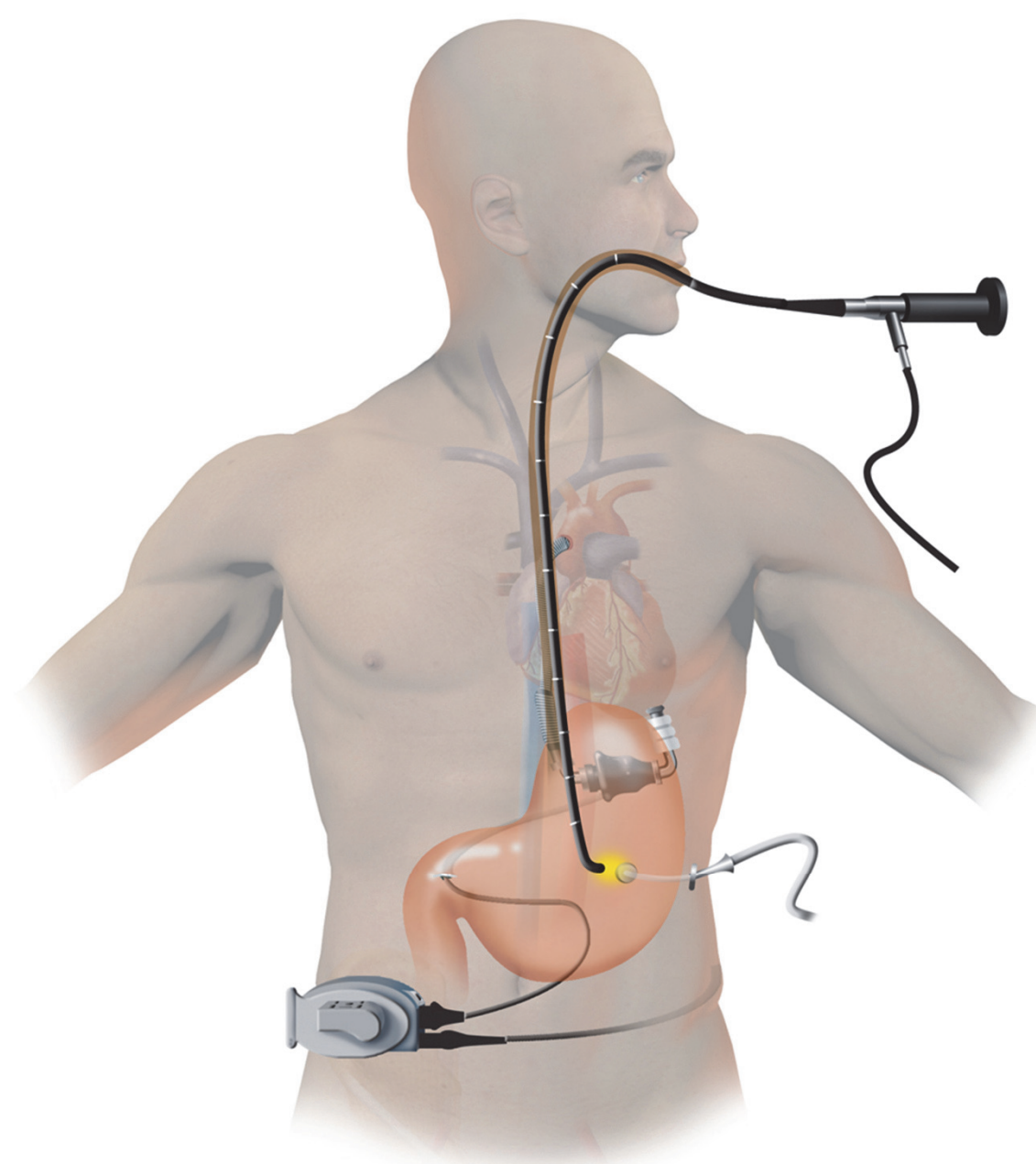
Knowledge of the VAD and drive line
Avoid L upper quadrant
Avoid drive line

Chest and ABD x-ray prior to procedure

HeartMate II



PEG procedure on HM II



CT scan of the patient



Conclusions

PEG placement for Heartmate II LVAD patients can be done without increasing the risk of device or intraabdominal organ injury.

Careful coordination efforts from both the mechanical support team and surgical services is important.

Contact information

Hitoshi Hirose, MD, Ph D.
genex@nifty.com

Associate Professor of Surgery
Division of Cardiothoracic Surgery
Thomas Jefferson University