

# Medical Safety Information

Pharmaceuticals and Medical Devices Agency

 No.1 November, 2007

## Points to note in case of obstruction of feeding tube

### POINT Key points for safe use

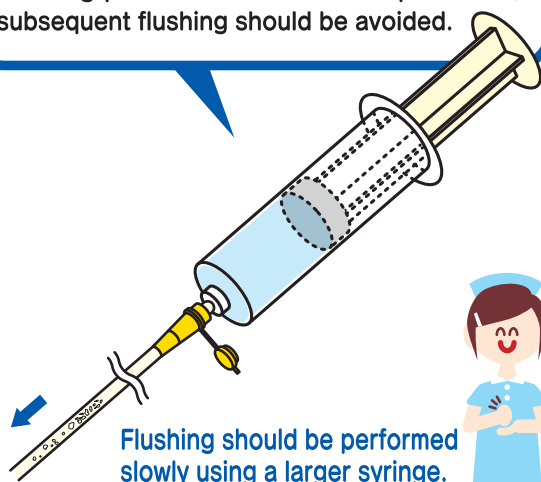
(Case 1) An obstructed feeding tube was flushed by applying pressure. Patency was reestablished. A patient was placed on the feeding tube through which a formula was administered. Later, however, the formula was discovered leaking out from the patient's nasal passage. On inspection, a crack was identified in the feeding tube removed from the patient.

#### 1 Precautions for clearing obstruction of feeding tube — 1

- A larger size syringe should be used (refer to the syringe sizes recommended in the package inserts by the manufacturer of each brand). Using a small syringe will increase the injection pressure and the risk of breaks and cracks forming in the feeding tube.
- If strong pressure resistance is experienced, subsequent flushing should be avoided, and the tube should be removed.

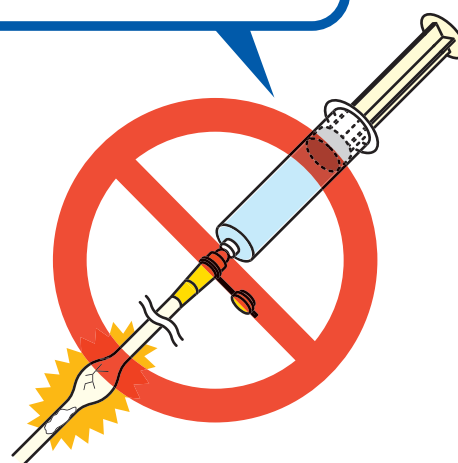
##### Example of proper flushing

Flushing should be performed slowly using a larger syringe filled with a suitable amount of lukewarm water without applying force. If strong pressure resistance is experienced, subsequent flushing should be avoided.



##### Example of improper flushing

Using a small syringe is associated with the increased flushing pressure and the risk of breaks and cracks.



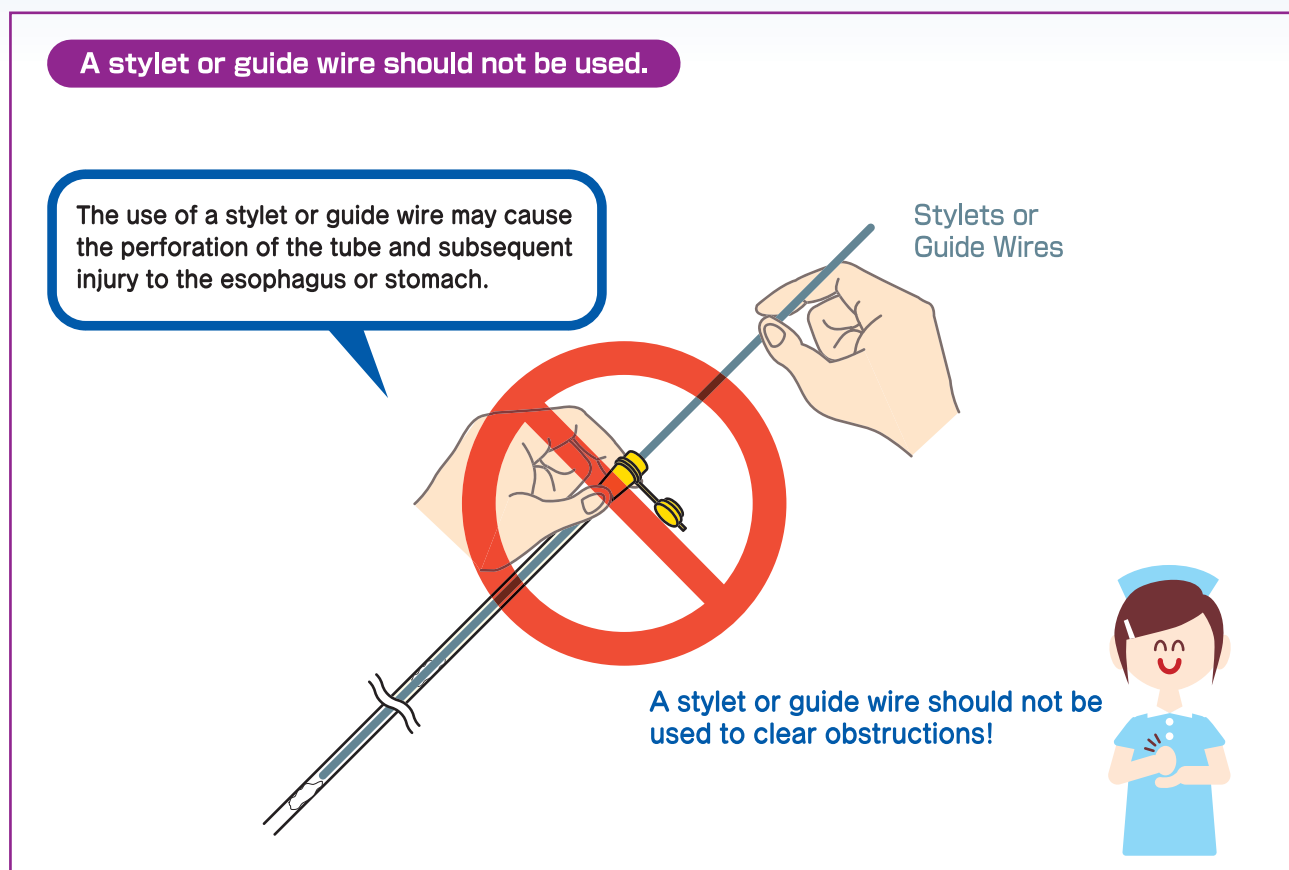
\* In the event of obstruction of a feeding tube with a small diameter and thin wall thickness used for newborns, infants and children, the above procedures should not be performed, and the tube should be removed.

*This translation of the original Japanese text is for information purpose only (in the event of inconsistency, the Japanese text shall prevail).*

(Case 2) A stylet was used for clearing the obstruction of a feeding tube. The feeding tube was perforated by the use of the stylet, with subsequent injury to the esophagus.

## 2 Precautions for clearing obstruction of feeding tube — 2

- A stylet or guide wire should not be used to clear the obstruction.



Refer to PFSB/SD Notification No. 0615001 "Instructions to revise the package inserts of enteral feeding tubes etc." issued by the Pharmaceutical and Food Safety Bureau of the Ministry of Health, Labour and Welfare on June 15, 2007.

This notification is carried on the Pharmaceuticals and Medical Devices Information website (<http://www.info.pmda.go.jp/mdevices/md2007-0615001.html>) (in Japanese).

### About this information

- \* PMDA Medical Safety Information is issued by the Pharmaceuticals and Medical Devices Agency for the purpose of providing healthcare providers with clearer information from the perspective of promoting the safe use of pharmaceuticals and medical devices. The information presented here has been compiled, with the assistance of expert advice, from cases collected as Medical Accident Information Reports by the Japan Council for Quality Health Care, and collected as Adverse Drug Reaction and Malfunction Reports in accordance with the Pharmaceutical Affairs Law.
- \* We have endeavored to ensure the accuracy of this information at the time of its compilation but do not guarantee its accuracy into the future.
- \* This information is not intended to impose constraints on the discretion of healthcare professionals or to impose obligations and responsibility on them, but is provided as a support to promote the safe use of pharmaceuticals and medical devices by healthcare professionals.