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Reader Seeks Advice About Prophylactic Feeding Tubes

We have a multidisciplinary head and neck group at the cancer center where I work. We are meeting again next week and will discuss the article “Nutritional Support During Radiotherapy for Head and Neck Cancer” (December 2007 issue of the *Clinical Journal of Oncology Nursing*) and some of our ongoing issues related to feeding tubes. The article will help us in our discussions with some of our newer physicians about the importance of prophylactic tubes, looking at some different criteria and risk factors. I think a few have shied away after a few patients experienced some significant complications.

Presently, we also have several patients being treated with unknown primaries. Many are receiving external radiation therapy or intensity-modulated radiation therapy (IMRT) and don't have feeding tubes. Several have needed supportive hydration and are taking liquid supplements, but one patient just had a feeding tube placed mid-treatment. He couldn't tolerate feedings, and they changed him to a gastrojejunostomy tube. In two days, that tube was found to be coiled. Yesterday, they had to try a weighted tube. He had a history of reflux prior to his cancer treatment. Do you have any experience noting history of gastric reflux to better determine the type of tube to be placed?

If you have patients receiving external radiation therapy only, not having a tube, will you support them with scheduled IV fluids or as needed? Our patients all are seen and followed by a dietitian, who determines the number of liquid supplements and calories,

but some patients have a hard time with free water and fluids.

I enjoyed reading the article and would appreciate any comments from the author.

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The Author Responds

Thanks for your letter, and good luck trying to bring the newer physicians in your group on board with this. Although it may initially be a “hard sell” (to patients and physicians alike), in our practice at Virginia Mason we have had a better experience placing tubes early rather than waiting for people to become depleted. Even with IMRT plans, if you're treating a relatively big field and/or sensitive structures (pharynx and bilateral neck), often considerable toxicity and nutritional compromise can be expected. We would probably recommend a percutaneous endoscopic gastrostomy (PEG) tube up front, or at least watch closely and try to put one in as soon as weight loss becomes apparent. At-risk patients who are reluctant to have a PEG tube placed prophylactically are educated and evaluated constantly, so we can intervene as soon as swallowing becomes a challenge, at which point patients are generally agreeable. We do not schedule patients for routine IV hydration (no need because they can accomplish this on their own with a tube). If we have to start hydrating people regularly, we recommend putting a PEG tube in (unless they continue to refuse

or are very close to being done and we think they can limp through). Most patients, in retrospect, are glad they did this; they don't like having to stay in the infusion center so long for fluids and find that using a tube for medications, etc., is preferable to struggling with swallowing (and/or dysgeusia) even if they still can swallow a bit. I have seen only the rare patient who managed to get all the way through treatment without needing a PEG tube at all (so few that I remember them clearly). If not completely dependent on it by the end of therapy, most at least use it to supplement their nutrition or for medication administration even if swallowing still is possible.

We have had some PEG complications, mostly dislodgment and infection and one or two cases of obstructive issues related to the tube (and a kink related to a malplaced suture). I am not sure about the issue of reflux and using a weighted tube, but your local gastroenterologist could probably give you some recommendations. Reflux and symptoms of dysmotility (fullness, nausea, and regurgitation) are not uncommon with enteral feedings; we place many of our patients on metocloperamide for this and advise small, frequent feedings and avoidance of recumbent positioning during and after.

Tracking how much weight your patients are losing, how many require routine IV hydration, and how many toxicity admissions you have (correlating with diagnosis, field, and dose, with or without chemotherapy and cetuximab) might be useful for understanding who