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APGNN
The Association of Pediatric Gastroenterology and Nutrition Nurses

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President's Message

Dear Membership,

I am so pleased that spring is finally around the corner; it has been a long winter here in Minnesota! Those of you on the east coast have had challenging weather these past couple of months and I'm sure you are ready for the change in seasons!

Your Board, Committee Chairs and committee members have been off to a busy start this year with many plans for the advancement of our organization. We can always use additional input, please consider joining one of our committees! The most pressing project is to polish our website which we will continue to work on. Please check the website periodically for updates and bear with us as we make improvements.

We would like to continue to increase awareness of APGNN's mission and expand our membership while continuing to promote retention of existing membership. Please remember that dues run from January to January and are easily paid on-line. Take a moment to review our list of "Membership Benefits" found on the website and share it with your colleagues. Our ability to influence pediatric GI care depends on the strength of our membership.

In late January, I had the opportunity to attend the Children's Digestive Health and Nutrition Foundation (CDHNF) Board Meeting in New Orleans. CDHNF was created by NASPGHAN with a mission to support research in pediatric GI (including a research grant for APGNN) and provide invaluable educational resources for healthcare professionals, patients and families. Please visit their website for a wealth of information (www.cdhnf.org). On the same weekend I attended the NASPGHAN Leadership Retreat. APGNN is highly valued and strongly supported by our NASPGHAN colleagues for which we are so grateful. We are involved in several collaborative projects including patient and family education. (continued on page 2).

"APGNN Board and Committee Chairs will be meeting in April in Philadelphia for a leadership retreat of our own."

President's Message Continued

APGNN Board and Committee Chairs will be meeting in April in Philadelphia for a leadership retreat of our own. As our organization has grown more complex it has become apparent that limiting ourselves to one face-to-face meeting a year will no longer meet our needs. The Program Committee is already hard at work organizing our next meeting in New Orleans this October and we have many other projects to work on. Please stay tuned!

Feel free to contact me, or anyone on the APGNN Leadership team, if you have questions, comments or wish to become more involved. Happy Spring!

Robin Shannon, MS, RN, CPNP

Clinical Practice Committee Update

If you have an idea for a clinical practice area/problem that we should explore as a group, contact LeAnn Vitito.

This committee is looking to recruit new members who are interested in taking part in clinical practice activities that will impact practice for our membership. Your involvement could include sharing information on identified practice issues, gathering and organizing information from other members, disseminating practice information to the membership via poster, presentation, articles, etc.

Some of the ideas we are looking at include problem solving and care of g-tubes for nurses, treatment and interventions used in practice for constipation/encopresis and their impact on patient outcomes, developing guidelines for telephone triage of GI patients.

If you have an idea for a clinical practice area/problem that we should explore as a group, let me know.

We are a small energetic group looking to have an impact on clinical practice issues. However, we are in need of more interested individuals to make this work successful. Please consider being part of the Clinical Practice Committee by sending me an email at lvitito@unmc.edu.

Also, I would encourage you to start to think about ideas for a clinical vignette poster. (Continued page 3)

Clinical Practice Committee Update

The poster would be presented at the educational course October 21–23rd in New Orleans. More information regarding deadlines and abstract details will be posted soon on the APGNN web site.

Respectfully submitted,

LeAnne Vitito MS, APRN, CGRN

Save the Date

Plan on Attending APGNN's 21st Annual Meeting

Future Trends and New Horizons

October 22-23, 2010

New Orleans, Louisiana

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"What are the differential diagnoses for a patient with failure to thrive without identifiable GI losses?"

Clinical Vignette

LD was sent from a local cardiologist to your office for a new patient visit for failure to thrive.

PMH: 3.64 kg term infant born to a mother G1P1 mother with tobacco and cannabis use during the first few weeks of pregnancy. Pt had a prenatal diagnosis of HLHS (hypoplastic left heart syndrome) and was subsequently diagnosed with a diaphragmatic hernia and numerous other congenital anomalies at birth. He underwent surgical repair the first week of life, and developed oral feeding aversion and dysphagia as well as severe gastroesophageal reflux disease post operatively. He subsequently underwent surgical gastrostomy and Nissen fundoplication. He tolerated tube feedings very well, and was discharged home on "fortified breast milk" gavage feeds q3hours with a weight of 3.95 kg.

HPI: LD is brought in by both parents, who seem appropriately concerned. They indicate that they don't understand "what's wrong with him now." He was frequently irritable but was gaining weight well until one week ago, when his surgical G-tube was changed to a MIC-Key low profile (button) device, and since then he had retching (no spit up) and irritability with bolus feedings. Interventions have included a Farrell bag valve device, and decreasing the water in the MIC-Key button balloon to 2.5mL (from 5) to increase effective gastric volume. Finally, feeds were modified to from his previous regimen of 75 mL boluses five times a day, to continuous feedings at 30 mL/hour. His retching, crying with feeds, and arching improved, however he remained mildly irritable and developed a 100 gram weight loss from his home health weight check from the previous week. He had been having hard, infrequent stools until 2 weeks ago, when he was placed on lactulose 2.5ml daily, which has resulted in soft, tan stools once or twice a day. Urine output is normal. No respiratory distress or signs of systemic illness. No seizure activity noted.

CURRENT MEDICATIONS: Phenobarbital, ASA, Enalapril, Lasix, Lactulose, Zantac.

ALLERGIES: He has no known drug allergies.

IMMUNIZATIONS: Up-to-date.

PE pertinent findings: Pale, irritable, emaciated with very little fat, VSS. Tube site wnl, easily flushed. Wt: 3.8 kg (less than original hospital discharge weight)

What are the differential diagnoses for a patient with failure to thrive and no identifiable GI losses?
CF/pancreatic insufficiency? Undiagnosed metabolic or genetic condition? Insensible fluid loss? Neglect/feeding mismanagement? Tube malfunction? (continued on next page).

Clinical Vignette Continued

Plan: Admit to hospital for feeding observation, screening labs and stool studies to assess for organic causes. While preparing admission orders, the dietician went to the room to determine mixing instructions for his "fortified breast milk". Parents had been discharged home with the following instructions: half scoop plus 3 tablespoons of Enfamil powder with 345 mL of breast milk. Over the past few weeks, the mother's breast milk supply slowly dwindled down, and had actually dried up completely prior to his tube change the following week. She had been adding more water as needed to keep the volume at 345ml total, and had been using water exclusively for the past 1 week. This produced essentially a 10 calorie per ounce formula, which was likely responsible for the irritability, and weight loss.

Labs on admission were significant for a Hgb of 15, sodium of 130 and potassium of 6.2. Cautious re-feeding was initiated at 15cal/oz, and then slowly increased over the next few days to original goal of 27 calories per one ounce. Labs normalized, irritability dissipated, and pt tolerated feeds well. Pt was discharged home with a weight of 4.7 kg. Pediatrician, cardiologist, and home health companies all notified, and a decision was made that the mistake was a result of unclear hospital discharge instructions in a well meaning, but uneducated family. No further action was taken against these first time parents. Support and teaching was emphasized during hospitalization, and subsequent follow-up visits. A PI team has also formed to create standardized, concise discharge instructions for formula/breast milk preparation for gtube fed infants upon discharge.

Clinical pearl: Parents should be questioned specifically about all intake at each visit, to ensure appropriate mixing instructions and assess for any changes.

Submitted by Ryan Shonce

Is there a topic you are the expert on? Is there a question you'd like to ask your APGNN colleagues? The newsletter is a great way to communicate with our membership between meetings. Submit articles of interest to Diane.Kocovsky@boystown.org by May 1st for publication in the June Newsletter.

Happy

Spring!

Editor's Note

It looks like Spring may actually be on it's way. I am looking forward to our Leadership Retreat in April. Many of the Board members will be attending the Seventh Annual Regional Pediatric GI Nursing and Nutrition Conference at the Children's Hospital of Philadelphia. Look for updates in the June Newsletter from the conference. Please note the plea for topics for our new interactive column. I am hoping to provide a place to ask your APGNN colleagues your burning questions on the latest trends in pedi GI. I would also like to thank Nancy Rayhorn for volunteering to help with the quarterly newsletter.

See you all in New Orleans, it will be here before we know it!

Diane Kocovsky, APRN