T-tube drains

T-tube drains

A T-tube (Figure 7.21) may be inserted after exploration of the common bile duct and stone retrieval or following repair of a damaged common bile duct. The principle is to allo w bile to Indications for placement of the nasogastric tube /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Summary box 7.13 Placement of nasogastric tubes /uni25CF - /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF - Figure 7.21

Drainage purposes Conservative management of postoperative paralytic ileus Conservative management of bowel obstruction (adhesional or partial) Decompression of the stomach before an emergency operation Prophylactically, when postoperative ileus is anticipated following extensive bowel handling Feeding purposes Following procedures in the upper aerodigestive tract (nasogastric or nasoenteral) In patient with motor neurone disease or stroke Contraindications Suspected or proven base of skull fracture as this may result in inadvertent cranial injury Oesophageal stricture or recent oesophageal surgery (unless under vision) Complications Upper airway damage – pressure necrosis of the nasal ala owing to the placement of an oversized tube or following prolonged placement Re /f_l ux oesophagitis Pulmonary aspiration due to impaired function of the lower gastro-oesophageal sphincter Inadvertent placement into the lungs Traumatic placement causing bleeding and perforation T-tube.

and to act as a safety valve if there are any stones retained in the distal common bile duct. Despite its perceived uses, the T-tube is not without problems; a recent Cochrane analysis concluded that it is associated with increased bile leakage and increased hospital stay and cost with minimal benefits. Once inserted, a T-tube should remain in place for at least 2–3 weeks to encourage fistulous tract formation, thereby minimising the risk of biliar y peritonitis after removal of the T-tube. Before removal, a T-tube cholangiogram should demonstrate the free flow of bile into the duodenum with no retained stones or bile leak. The T-tube is then clamped for 24 hours and removed. The T-tube is clamped to allow pref erential drainage of bile to the duodenum; if there is no distal obstruction the patient will be asymptomatic. Once the T-tube is removed, there will be minimal bile leakage through the fis tulous tract for a few days. This should stop as a fistula will close if there is no distal obstruction. T-tube drains

A T-tube (Figure 7.21) may be inserted after exploration of the common bile duct and stone retrieval or following repair of a damaged common bile duct. The principle is to allo w bile to Indications for placement of the nasogastric tube /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Summary box 7.13 Placement of nasogastric tubes /uni25CF - /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF - Figure 7.21

Drainage purposes Conservative management of postoperative paralytic ileus Conservative management of bowel obstruction (adhesional or partial) Decompression of the stomach before an

emergency operation Prophylactically, when postoperative ileus is anticipated following extensive bowel handling Feeding purposes Following procedures in the upper aerodigestive tract (nasogastric or nasoenteral) In patient with motor neurone disease or stroke Contraindications Suspected or proven base of skull fracture as this may result in inadvertent cranial injury Oesophageal stricture or recent oesophageal surgery (unless under vision) Complications Upper airway damage – pressure necrosis of the nasal ala owing to the placement of an oversized tube or following prolonged placement Re /f_l ux oesophagitis Pulmonary aspiration due to impaired function of the lower gastro-oesophageal sphincter Inadvertent placement into the lungs Traumatic placement causing bleeding and perforation T-tube.

and to act as a safety valve if there are any stones retained in the distal common bile duct. Despite its perceived uses, the T-tube is not without problems; a recent Cochrane analysis concluded that it is associated with increased bile leakage and increased hospital stay and cost with minimal benefits. Once inserted, a T-tube should remain in place for at least 2–3 weeks to encourage fistulous tract formation, thereby minimising the risk of biliar y peritonitis after removal of the T-tube. Before removal, a T-tube cholangiogram should demonstrate the free flow of bile into the duodenum with no retained stones or bile leak. The T-tube is then clamped for 24 hours and removed. The T-tube is clamped to allow pref erential drainage of bile to the duodenum; if there is no distal obstruction the patient will be asymptomatic. Once the T-tube is removed, there will be minimal bile leakage through the fis tulous tract for a few days. This should stop as a fistula will close if there is no distal obstruction. T-tube drains

A T-tube (Figure 7.21) may be inserted after exploration of the common bile duct and stone retrieval or following repair of a damaged common bile duct. The principle is to allo w bile to Indications for placement of the nasogastric tube /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Summary box 7.13 Placement of nasogastric tubes /uni25CF - /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF - Figure 7.21

Drainage purposes Conservative management of postoperative paralytic ileus Conservative management of bowel obstruction (adhesional or partial) Decompression of the stomach before an emergency operation Prophylactically, when postoperative ileus is anticipated following extensive bowel handling Feeding purposes Following procedures in the upper aerodigestive tract (nasogastric or nasoenteral) In patient with motor neurone disease or stroke Contraindications Suspected or proven base of skull fracture as this may result in inadvertent cranial injury Oesophageal stricture or recent oesophageal surgery (unless under vision) Complications Upper airway damage – pressure necrosis of the nasal ala owing to the placement of an oversized tube or following prolonged placement Re /f_l ux oesophagitis Pulmonary aspiration due to impaired function of the lower gastro-oesophageal sphincter Inadvertent placement into the lungs Traumatic placement causing bleeding and perforation T-tube.

and to act as a safety valve if there are any stones retained in the distal common bile duct. Despite its perceived uses, the T-tube is not without problems; a recent Cochrane analysis concluded that it is associated with increased bile leakage and increased hospital stay and cost with minimal benefits. Once inserted, a T-tube should remain in place for at least 2–3 weeks to encourage fistulous tract formation, thereby minimising the risk of biliar y peritonitis after removal of the T-tube. Before removal, a T-tube cholangiogram should demonstrate the free flow of bile into the duodenum with no retained stones or bile leak. The T-tube is then clamped for 24 hours and

removed. The T-tube is clamped to allow pref erential drainage of bile to the duodenum; if there is no distal obstruction the patient will be asymptomatic. Once the T-tube is removed, there will be minimal bile leakage through the fis tulous tract for a few days. This should stop as a fistula will close if there is no distal obstruction.

Revision #1
Created 2025-12-31 15:26:06 UTC by Omar Ayman
Updated 2025-12-31 15:26:06 UTC by Omar Ayman