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Subject: PEG Tubes with EnFit Connectors are Prone to Clogging

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ENFit PEG (with twist on connector)

vs.



"legacy" PEG (with plug in connector)

We are seeing a significant number of reports of ENFit PEG tubes clogging when used with medical aid in dying medication regimens. Therefore, clinicians should consider not using the PEG route with an ENFit PEG for aid-in-dying due to the high risk of obstruction. Clinicians should confirm which type of PEG the patient has, and if it is an ENFit, consider having it exchanged for a standard “legacy” 22–24 Fr PEG, which is typically easily done by IR, or pivot to using the rectal route (see our instructions and recommendations for using the rectal route here). Below is a brief explanation to keep in mind when planning and supporting medical aid in

dying via PEG access.

ENFit PEG tubes tend to clog more easily with aid-in-dying medication slurries because of a combination of design features and the physical characteristics of aid-in-dying drug mixtures:
• The ENFit male connector, located just proximally to the Y-port/medication port cluster and distal to the syringe or feeding set, has a narrow internal diameter (2.9mm/9 Fr) creating a tighter “choke point” where flow is most restricted.
• This constriction is located at the connector “neck,” which becomes the critical site for obstruction, even when the distal tube itself is of adequate diameter.
• Also, the internal threads and small recesses within the ENFit connection can trap viscous medication, which may dry and harden, which increases the risk of occlusions.
• An FDA and Mayo study comparing legacy vs ENFit, low-profile ENFit and low-profile legacy devices, found that both ENFit designs had similar clogging rates and both clogged more than standard G-tubes, mainly because of narrower internal passages in the button/extension geometry.
• Legacy PEGs, especially 22–24 Fr, often have a distal/internal lumen that stays relatively wide all the way to the funnel connector, so the connector section does not significantly narrow the flow path.
• Aid in dying medications involve thick, high-particulate suspensions that do not fully dissolve, and that agglomerate/clump easily. These mixtures are inherently high risk for tube occlusion.

Practical implications and tips:
• We recommend considering not using the PEG route with an ENFit PEG for aid-in-dying regimens due to the high risk of obstruction.
• If aid in dying is planned via enteral access, consider whether the existing ENFit PEG can be replaced with a PEG that has no connector and a wider internal diameter before the ingestion date.
• If the PEG cannot be replaced in time, clinicians may need to pivot to the rectal route for medication administration, following established protocols.
• When discussing options with patients and families, include the potential for ENFit clogging and the possibility of needing a rectal route if reliable PEG access cannot be ensured.

Please feel free to share local strategies or experiences so we can continue refining best practices together.

https://pmc.ncbi.nlm.nih.gov/articles/PMC11472396/
Guha S, Herman A, Antonino M, Silverstein JS, Venkataraman-Rao P, Myers MR. Synthesis of research on ENFit gastrostomy tubes with potential implications for US patients using these

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