

Unrecognized Gastrostomy Tube Migration Eventually Causing Bowel Obstruction

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Case Report

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Abstract

A 45 year old female initially presented with traumatic evisceration of bowel requiring gastrostomy tube (G-tube) placement. An initial CT showed the G-tube to be in appropriate position. An additional inpatient CT scan performed 2 weeks later for abdominal pain showed unrecognized, and therefore not reported, distal migration of the G-tube to the proximal duodenum without signs of obstruction at that time. Fluoroscopy performed prior to discharge demonstrated the G-tube to be intraluminal; however, the G-tube did not appear to terminate within the stomach, which was not reported. Additional oblique views may have demonstrated the G-tube balloon to be deep within the abdomen rather than opposed to the skin surface. The patient was then discharged. The patient presented 2 weeks later with symptoms of nausea and bilious emesis and CT scan obtained at that time showed the G-tube balloon to be in the proximal jejunum causing obstruction of the more proximal bowel. This case illustrates a likely preventable G-tube malposition related complication due to failure to recognize and report the G-tube's migration on CT and failure to obtain oblique images during the fluoroscopic tube placement verification study.

Keywords: Gastrostomy tube; Migration; Bowel obstruction

Introduction

Percutaneous gastrostomy tubes are routinely placed in patients with an inability to feed by mouth and requiring long term (>4-6 weeks) enteral nutrition. They are considered safe and have been commonly placed since 1980, with an estimated 160,000-200,000 placement procedures performed annually. Procedure-related morbidity has been reported at 9.4% and a mortality of 0.53%, with 1-3% of procedures associated with major

complications. Major complications include aspiration, peritonitis, hemorrhage, migration, buried bumper syndrome, gastrocolocutaneous fistula, infection, and inadvertent removal. Minor complications include leakage and blockage. Complications of migration can include acute pancreatitis and bowel obstruction. Treatment of tube migration includes endoscopic or surgical retrieval (Figures 1-4).

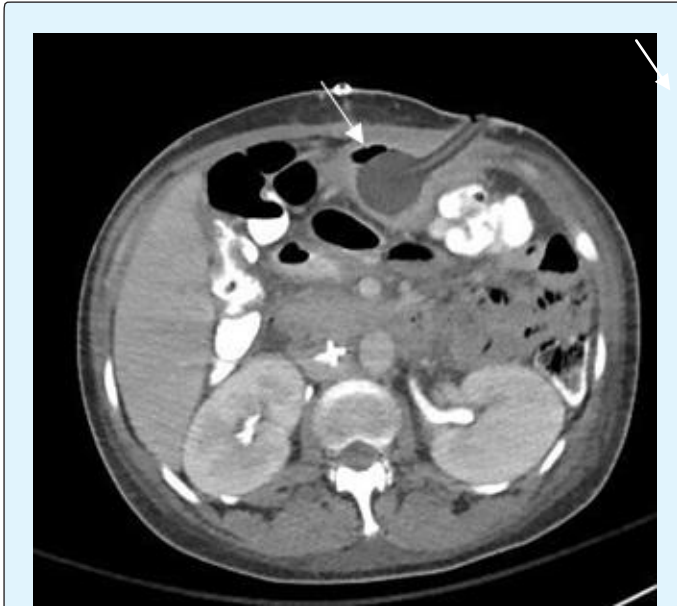


Figure 1: Axial abdominopelvic CT image (2/22/2017) shows a gastrostomy tube within the gastric lumen near its entry site.



Figure 3: Fluoroscopic image (3/7/2017) demonstrates a percutaneous enterostomy tube, with contrast seen in proximal small bowel loops. No definite contrast is seen in the gastric lumen.



Figure 2: Axial abdominopelvic CT image (3/7/2017) shows distal migration of the gastrostomy tube into the proximal duodenum.

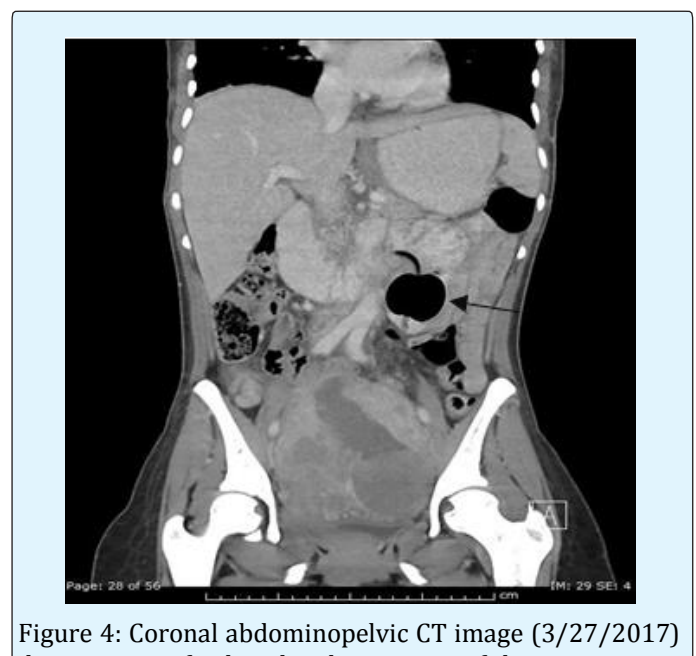


Figure 4: Coronal abdominopelvic CT image (3/27/2017) demonstrates further distal migration of the gastrostomy tube balloon within the proximal jejunum with small bowel obstruction more proximally. Incidentally, an enlarged myomatous uterus is seen.

References

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