Dear Editor,

A 75-year-old woman living in a nursing home presented with a 24-hour history of abdominal cramping and vomiting. Medical history was remarkable for dementia and a percutaneous endoscopic gastrostomy (PEG) was performed 3 years earlier. The day before the admission the feeding tube was accidentally pulled out and a Foley catheter was placed in order to avoid stoma closure. On physical examination, there was extravasation of the gastric content through the stoma. The base of the “Y” of the Foley catheter was introduced in the gastric stoma and a pulling sensation was felt when it was mobilized. The remainder abdominal examination was unremarkable.

On esophagogastroduodenoscopy the Foley catheter was identified passing the pylorus and pulling duodenal bulb towards the antrum (Fig. 1). There was no mucosal injury so the balloon was deflated and the catheter removed. A PEG tube was later placed.

Gastric outlet obstruction is an unusual adverse event of PEG tubes (1). In adults it is usually related to Foley catheters use as peristalsis can pull the balloon into the duodenum in the absence of an external bumper (1,2). A clinical picture of abdominal cramping, vomiting and resistance to the attempt of percutaneous reposition should raise the suspicion of gastrostomy tube migration through the pylorus (2). Foley catheters are easily available and some may use it to prevent gastrostomy closure after accidentally PEG tube extraction (3). We have performed more than 800 PEG and assisted several cases of gastric outlet obstruction and even stoma damage in this setting (3,4). This case emphasizes the importance of receiving an early PEG tube with external bumper replacement to prevent this adverse event (5).

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References


