A 40-year-old man, with no significant history of past illness, presented to our emergency department with classic features of perforation peritonitis. Exploratory laparotomy showed duodenal perforation, which was closed with an omental patch. Before suturing the perforation, however, a nasojejunal tube was inserted for feeding. The postoperative period was uneventful and the patient was allowed oral feeding 1 week later. After 2 weeks, the nasojejunal tube was removed with some difficulty with its distal part missing. Abdominal radiography showed the distal end of the nasojejunal tube retained inside the intestine (Fig. 1). Upper gastrointestinal endoscopy showed narrowing of the D1–D2 junction with the proximal end of the fractured part of the nasojejunal tube lying just beyond the junction. We tried to grasp this end of the fractured tube with punch biopsy forceps but failed. We then decided to use a polypectomy snare to grasp the proximal end and the fractured tube was removed successfully (Fig. 2 and Video 1).

The nasojejunal tube was probably sutured along with the duodenal wall during closure of the duodenal perforation, and thus it fractured during removal. There is little literature on endoscopic removal of such long foreign bodies. Only a few case reports had been published on endoscopic retrieval of sutured, knotted, or fragmented nasogastric tubes from the stomach or the posterior pharynx in humans as well as in animals [1–4]. Thus, utmost care should be taken while suturing the bowel with any tube inside, however, endoscopic techniques can be used successfully to retrieve broken tubes.

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