Transhepatic endoscopic gastrostomy

A 55-year-old woman was referred for insertion of a percutaneous endoscopic gastrostomy (PEG) feeding tube prior to surgical treatment of a squamous cell carcinoma of the tongue. Clinical signs and biological data did not indicate liver disease, except for chronic alcohol consumption. A 20-Fr gastrostomy tube (MIC PEG tube; Kimberly-Clark Health Care) was placed endoscopically using the pull technique [1] after transillumination and finger pressure, without any immediate complications.

Tube feeding was well tolerated until 1 week later, when the patient complained of local pain around the gastrostomy, but with no local or biological inflammatory signs. A computed tomography (CT) scan revealed marked hepatomegaly with the PEG tube incorrectly placed within the liver. (Fig. 1)

As a precaution we removed the PEG tube. No hemorrhage occurred. Three months later, there had been no complications relating to the incorrect placement of the tube. The patient was being fed by a surgical gastrostomy.

To avoid such adverse events, we could have used the safe-tract technique [4], in which suction is applied with a syringe as the angiocath is advanced, an interposed lumen being detected if air or fluid is drawn into the syringe. However, this test might have been uninformative in this case because passage through the liver parenchyma may not cause a return of blood into the syringe. In patients such as this woman with squamous cell carcinoma of the head and neck, alternative push techniques such as Russell’s transabdominal introduction of a gastrostomy tube under endoscopic visualization [5] or a percutaneous radiological gastrostomy (under fluoroscopic guidance) [6] would have been preferable as they avoid the risk of developing metastatic tumor deposits at the gastrostomy site, which carry a grave prognosis [7].

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References

Bibliography
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