Since the 1980s the use of percutaneous endoscopic gastrostomy (PEG) has been a safe and reliable method of enteral feeding in patients with functioning normal bowel [1]. A 74-year-old woman with Alzheimer’s disease and a history of a cerebrovascular accident (CVA) was admitted after dislodgement of her PEG feeding tube. It had been placed 3 years previously using a standard pull-through technique, but had required replacement on several occasions due to dislodgement. She was found to have a large (8 x 9 cm) prolapse of engorged gastric mucosa protruding from the tube tract (Figure 1). At laparotomy the prolapse was found to consist of everted full-thickness stomach wall. This was reduced and the defect was repaired in two layers (Figure 2). A further PEG tube was placed at a distant site. The patient made a full recovery.

Following a CVA, up to 75% of patients can require long-term PEG tube enteral feeding [2]. A number of well-documented complications have been described [3]. Cellulitis is by far the most common, followed by bleeding and leakage of gastric contents, either around the tube or intra-peritoneally, causing chemical peritonitis. More unusual complications include viscerocutaneous fistulae and colocutaneous fistulae formation [4,5]. The complication described here may partly be due to the repeated track dilations to aid tube re-insertion.

**References**


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