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IMAGE | ENDOSCOPY

Proximal Migration of Jejunostomy Extension Tube Causing Recurrent Aspiration

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CASE REPORT

A 67-year old woman presented with worsening dyspnea, productive cough, and fever. She denied oral intake, and her symptoms were worse with tube feeds. Her medical history was significant for chronic obstructive pulmonary disease, gastric esophageal reflux disease (GERD), and severe oropharyngeal dysphagia status post percutaneous endoscopic gastrostomy (PEG) tube with jejunal extension placement one year prior. Physical exam was notable for bilateral end expiratory wheezes with right-sided basilar rales on auscultation of the lungs. PEG insertion site looked clean with no signs of infection or abnormal drainage. Chest x-ray showed right lower-lobe consolidation. Blood and sputum cultures were obtained and broad-spectrum empiric antibiotic coverage was initiated for a diagnosis of aspiration pneumonia.

The patient had multiple witnessed tube feed-related aspiration events during the hospital stay. An esophagogastroduodenoscopy revealed Los Angeles grade D esophagitis with a jejunal extension of PEG tube coiled back into the esophagus, with the tip of the extension placed above the upper esophageal sphincter in the oropharynx (Figure 1). The jejunal extension was held with a stent grasper and pulled through the stomach and into the duodenum. This abnormal migration of the PEG tube extension was the cause of recurrent aspiration in this patient. A decreased lower esophageal sphincter tone in the setting of this patient's long-standing GERD may have contributed to the migration of the PEG tube into the esophagus. It was recommended that a feeding jejunostomy tube be surgically placed and a gastrostomy tube to be only used for decompression purposes.

PEG tube placement is a commonly performed procedure for patients who suffer from the inability to feed by mouth. One of the complications that can develop after placement of this tube is migration. Migration of the tube into the pylorus of stomach has been described, causing gastric outlet obstruction.[1] PEG tube extension migration in the esophagus is an extremely rare complication and has not been previously published in literature. Our patient experienced the first aspiration event within a month of PEG tube insertion, but she had continued to eat and drink by mouth. After multiple aspiration events, she finally maintained a strict none-per-oral (NPO) status. Feeding tube migration into the esophagus should be considered if a patient adheres to the strict NPO restriction yet develops aspiration pneumonitis/pneumonia. Several studies have revealed an increase in the risk of aspiration events and mortality rates associated with tube feeding.[2-4] Hence, tube feeding should be sought as a temporary solution to dysphagia, and emphasis should be made to address the underlying pathology.

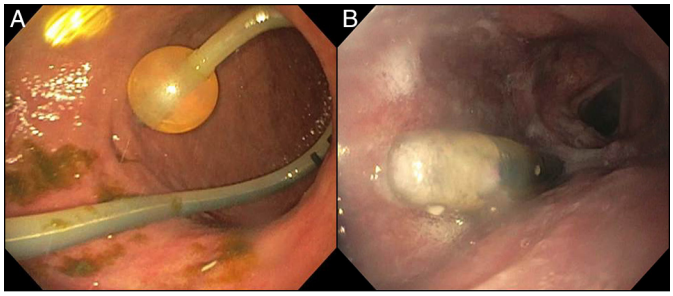

Figure 1. (A) Proximal view of PEG tube extending toward the esophagus instead of the pylorus, with (B) the tip of the PEG tube extension placed above the upper esophageal sphincter in the oropharynx.

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DISCLOSURES

Author contributions: A. Pervez wrote the manuscript, researched the literature, and is the article guarantor. M. Aziz, S. Thomas, and E. Sidorenko researched the literature and revised the manuscript.

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Informed consent was obtained for this case report.

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