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IMAGE | LIVER

Intrahepatic Migration of Gastrostomy Tube after Inadvertent Transhepatic PEG Placement

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CASE REPORT

A 55-year-old man with nasopharyngeal carcinoma and liver metastasis presented with sudden abdominal pain after administration of water through the percutaneous endoscopic gastrostomy (PEG). The PEG was placed 1 year prior at another hospital by the pull technique with endoscopic confirmation and used without intercurrence (Figure 1). Hepatomegaly related to liver metastasis was already known at the time of PEG placement. After chemotherapy 6 months prior, the patient resumed oral intake and the PEG was no longer used. At physical examination, he presented with signs of peritoneal irritation. The PEG had no evidence of local infection, and the tube was easily mobilized but caused worsening pain. Abdominal computerized tomography showed a massive hepatomegaly crossing the midline with multiple nodules and an internal bumper localized in the hepatic parenchyma, with no communication with the stomach and no evidence of pneumoperitoneum or hemoperitoneum (Figure 2). Urgent laparotomy identified the internal bumper in the hepatic parenchyma with a transhepatic tract. It was removed without significant bleeding. No orifice was observed in the stomach wall, and this was confirmed with gastric instillation of methylene blue. The surgery was well tolerated.

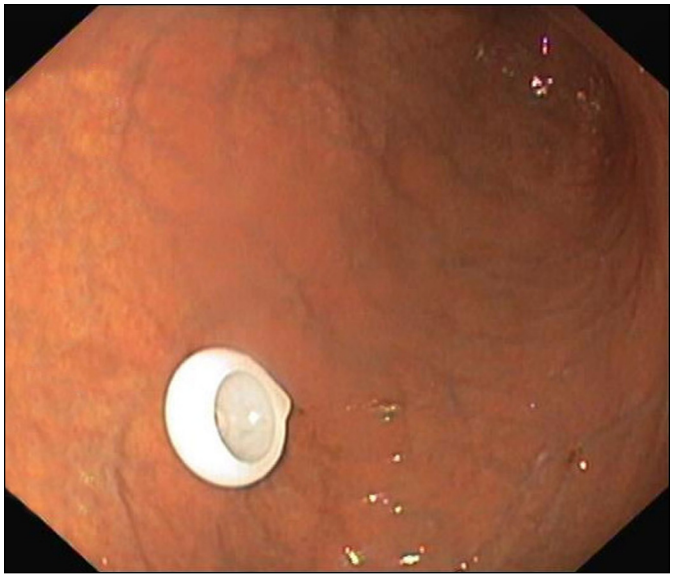

Figure 1. Endoscopic confirmation of correct intragastric PEG position.

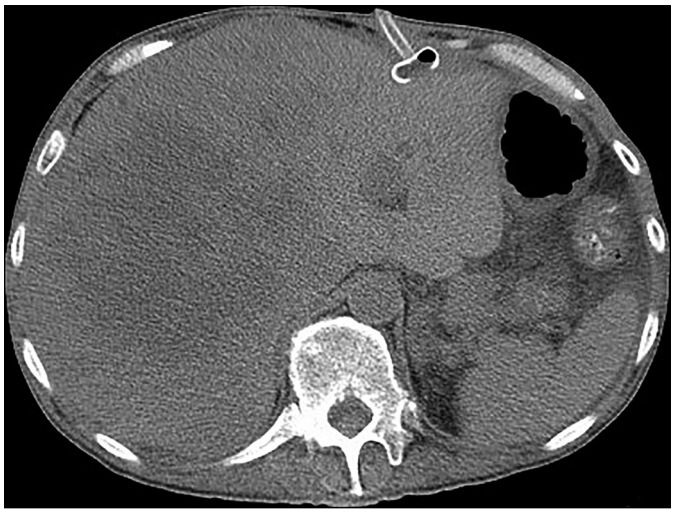

Figure 2. Abdominal computerized tomography showing the internal bumper localized in the left hepatic lobe with no communication with the gastric tract.

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We speculate an inadvertent transhepatic PEG placement with posterior buried bumper and intrahepatic migration through liver gastrocutaneous fistula as the most likely etiology. Hepatomegaly was a contributing factor. Formation of a transhepatic fibrous pathway may have prevented major complications, and the correct initial intragastric position of internal bumper before migration allowed its asymptomatic use. Transhepatic PEG placement is a rare but potentially life-threatening complication.[1] There are several reports of transhepatic-placed PEG, but there is only one case with hepatic migration 7 weeks later.[1-5] Clinical manifestations vary from post-procedure abdominal pain to difficulty pushing a replacement tube in an asymptomatic patient 2.5 months after PEG placement.[1,2] Management varied from surgical to conservative. Surprisingly, reported cases were relatively well tolerated and had benign outcomes. Several transhepatic PEG were left in place and used without remarkable intercurrences.[1,2]

DISCLOSURES

Author contributions: C. Atalaia-Martins wrote the manuscript and is the article guarantor. S. Barbeiro, P. Marcos, and I. Gil collected the clinical data and reviewed the literature. I. Cotrim reviewed the article.

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