Spontaneous enteral migration of feeding jejunostomy tube

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Spontaneous migration of enteral feeding tubes is unusual. We report an 18-year-old man with corrosive stricture of the upper esophagus in whom feeding jejunostomy was performed using an 18F Levine's tube. Thirteen months later, he presented with absence of the tube. The patient was tolerating liquid diet and was managed conservatively. Serial radiographs and colonoscopy showed a steady progress of the tube through the gut. The tube was passed out spontaneously after 20 days. [Indian J Gastroenterol 2005;24:74]

Spontaneous intraluminal migration of enteral feeding tubes is a rare mechanical complication in patients on enteral nutrition. To our knowledge, only a single case of enteral migration and spontaneous elimination of a feeding jejunostomy tube has been reported.1 There have been reports of cases where peristalsis-induced antegrade migration of the distal end of feeding jejunostomy tubes resulting in bypassing of most of the small bowel has led to malnutrition and death.2,3 Another unusual complication reported to be associated with ballooned feeding tubes is the migration of their tips resulting in bowel obstruction.4

An 18-year-old man presented with history of consumption of a corrosive substance (aqua regia). He had extensive burns of the upper digestive tract. Witzel feeding jejunostomy was performed using a 100-cm-long 18F Levine’s tube and the patient was put on enteral nutrition. Subsequently, the patient developed a corrosive stricture just distal to the cricopharynx. The stricture was managed by regular endoscopic dilatations.

Thirteen months later, the patient presented with absence of the jejunostomy tube. Clinical examination revealed a mature jejunostomy tract. The stitches anchoring the tube to the skin had cut through, probably due to infection. There was no clinical evidence of peritonitis or obstruction. The patient was tolerating liquid diet. Erect abdominal skiagram revealed the tube in the small bowel. The patient was managed conservatively. Serial abdominal radiographs showed steady progress of the tube through the gut; 10 days following presentation, abdominal skiagram showed the tube in the region of the transverse, descending and sigmoid colon. Fiberoptic colonoscopy confirmed the distal end of the tube in the sigmoid colon (Fig). The patient was asymptomatic and was discharged 14 days after admission with an advice for check abdominal skiagram after a week. However, the tube was passed out spontaneously 6 days later.

Polychronidis et al1 reported the ‘disappearance’ of a 28F Pezzer catheter, 2 months following a Stamm jejunostomy. The tube was passed out 5 days later spontaneously. Nutritional failure and death due to intraluminal migration of jejunostomy tubes is a grave complication.2,3 The peristalsis-induced intraluminal antegrade migration of the distal end of a jejunostomy tube with concomitant retrograde movement of the small bowel over the tube ultimately resulted in the jejunostomy feedings entering the distal ileum, bypassing most of the small intestine. This was discovered at autopsy.2

In our institution, wide-bore Levine’s tubes are used for jejunostomy; these are anchored to the abdominal wall with two ligatures of non-absorbable material on the skin side. An inexpensive, easily learned stabilization method for chronic enteral feeding tubes using sterile gauze pads and tape has been described by Tuel et al.5 It is quite unusual for the entire length of the tube to be drawn inside the gut. In the present case there was uneventful spontaneous elimination of the tube. It can be concluded that an expectant line of management may be adopted in a patient with antegrade enteral migration of feeding jejunostomy tube.

References

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Received May 3, 2004. Accepted July 26, 2004