

# Endoscopic Removal Of Percutaneous Endoscopic Gastrostomy (PEG) Tube Bumper

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## Citation

R Jeganathan, G K., P Sidhu. *Endoscopic Removal Of Percutaneous Endoscopic Gastrostomy (PEG) Tube Bumper*. The Internet Journal of Gastroenterology. 2004 Volume 4 Number 1.

## Abstract

We report about a patient presenting with a complication of a Percutaneous Endoscopic Gastrostomy (PEG) tube.

## CASE REPORT

A 65 year old lady with a previous history of surgical resection of a benign brain tumour in the posterior fossa with subsequent insertion of a silicone PEG tube (Kimberly-Clark® MIC-PEG PUSH) and tracheostomy (size 7) for poor brain stem function, came in for a replacement of her blocked PEG tube 13 months later. In the interim period, her tracheostomy had been changed to a smaller fenestrated tube (size 5). During removal of the PEG tube, the bumper portion failed to be extracted externally. The external tube was then divided and the bumper and remaining tube displaced into the stomach. Under local anaesthesia, oesophagogastrroduodenoscopy (OGD) with a snare failed to remove the bumper past the level of the cricopharyngeus.

She was taken to theatre the following day and under general anaesthesia the scope was re-passed. However, it was still not possible to easily extract the bumper past the cricopharyngeus. The tracheostomy cuff was then deflated, and using a combination of rigid and flexible oesophagoscopy, the bumper was extracted with more ease. Palpation of the bumper showed that its integrity had changed (see figure).

## Figure 1

Figure 1: Retrieved PEG tube bumper.



## DISCUSSION

Enteral feeding via PEG tube is a well established method in a variety of clinical scenarios. However it is not without its complications. It has been documented that by just cutting the tubing at the skin and allowing the internal components to pass through the gastrointestinal tract when extraction of the bumper is difficult, is in itself associated with morbidity and mortality (1, 2). Blacka et al demonstrated that a greater proportion of silicone PEGs developed intraluminal colonization and altered tube integrity than with polyurethane (3). Hence, it is important to replace PEG tubes within the manufacture's dwell time.

We recommend that when removing PEG tubes that have failed to be extracted externally, the external tubing should not be cut until the patient is in theatre with the availability of both the rigid and flexible oesophagoscope. If the external tubing was cut and there was a delay in getting the patient to theatre, the bumper portion could pass through the pylorus

into the lower gastrointestinal tract and cause an obstruction. In patients with a tracheostomy, the cuff should be deflated to ease the passage of the bumper especially if the integrity has changed.

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