



CLINICAL IMAGE IN GASTROENTEROLOGY

Gastric outlet obstruction in a patient with percutaneous gastrostomy[☆]



Obstrucción pilórica en un paciente con gastrostomía percutánea

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A 44-year-old man residing in a nursing home was receiving enteral nutrition through percutaneous endoscopic gastrostomy (PEG) after suffering an embolism 2 years earlier. He accidentally pulled out his feeding tube. In order to prevent closure of the gastrostomy, a Foley catheter was



Figure 1 The Foley catheter progressing through the antrum.

immediately put in place. Several hours later the patient

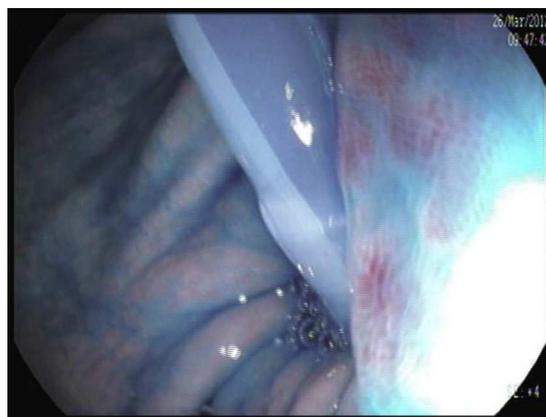


Figure 2 The catheter crosses the pylorus migrating into the duodenum.

presented with vomiting. The next day, after the administration of methylene blue through the catheter, the patient underwent an endoscopy, which revealed that the Foley catheter had passed into the pyloric antrum (fig. 1), with the balloon migrating into the duodenum (fig. 2), causing partial obstruction (fig. 3).

The catheter was removed, a 20F Bard® PEG tube was inserted, and the obstruction was resolved. In cases of accidental PEG tube extraction, Foley catheters are frequently used to prevent gastrostomy closure because they are easily passed through the gastrostomy and they are available at the majority of health facilities. However, they do not have an external bumper and peristalsis can pull the balloon into the duodenum, causing gastric outlet obstruction. Rather than

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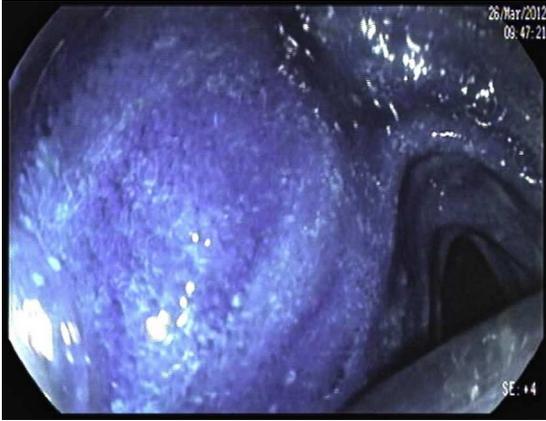


Figure 3 Partial obstruction of the duodenum.

having Foley catheter insertion, patients should be rapidly referred to a hospital center within the first 24h so that a PEG tube can be adequately placed. If early referral is impossible, the Foley balloon should be minimally inflated to prevent migration into the duodenum and gastric outlet obstruction (figs. 1–3).

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Conflict of interest

The authors declare that there is no conflict of interest.