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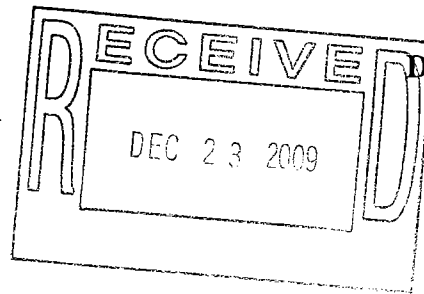
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DUODENAL OBSTRUCTION DUE TO A SWALLOWED NASOGASTRIC TUBE

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SUMMARY Nasogastric tubes are commonly used, not only in surgical practice but in all disciplines. Their use, however, is not without complications. We present the first reported case of duodenal obstruction due to a swallowed nasogastric tube, and recommend that nasogastric tubes be used in their entirety (uncut) with the splayed distal end intact. This simple procedure will prevent a rare but distressing complication that might be amenable only to laparotomy. (*Int J Clin Pract* 2000; **54**(2): 130)

A 62-year-old female presented with a two-month history of frequent vomiting and vague upper abdominal pain. During this time she had lost about 10 lb in weight. In the preceding year she had two admissions for intestinal obstruction due to adhesions (from a hysterectomy 15 years before). Both of these episodes had settled on conservative treatment with intravenous fluids and nasogastric tube drainage. Following her second discharge eight months ago she experienced episodic epigastric discomfort and six months later started to experience periodic vomiting. During this latter two-month period she was seen by her general practitioner and given analgesics and antiemetics. Her vomiting became increasingly severe and precipitated the current admission.

On examination, she was looking well except for some evidence of weight loss. There was mild epigastric tenderness without abdominal distension, signs of peritonitis or free-fluid in the abdomen. The presence of persistent bile-stained vomitus indicated a diagnosis of high intestinal obstruction. Plain X-rays of the abdomen, however, revealed a dilated stomach and a coiled nasogastric tube in the right epigastrium (Figure 1). At laparotomy, the nasogastric tube was palpably curled up in the second part of the duodenum,

while the first part was dilated. Through a duodenotomy, an 18 Fr nasogastric tube was removed along with much bezoar-type material trapped within its loops. Limited adhesiolysis was performed and she recovered uneventfully.

DISCUSSION

Gastrointestinal tract complications of nasogastric tubes include oesophageal perforation,¹ mucosal bridge formation² and duodenal perforation.³ In searching the literature we could find no case of duodenal obstruction due to a swallowed nasogastric tube.

The late presentation of this complication at 6-8 months may be due to the delay in gastric transit of the nasogastric tube, as well as the time taken for fibrous food material to become trapped in the loops of the tube. The splayed 'external' end of a nasogastric tube will normally prevent it from slipping down through the nostril. Often, however, nurses 'amputate' this portion so that it could be attached to an empty intravenous fluid bag – a cheap, resourceful and convenient method of gastric aspirate collection. Such a tube of uniform diameter throughout can easily slip inwards unless it is firmly secured to the nose.

We recommend that these tubes not be cut but instead that the collecting bag be tailored to fit the tube. In the event the tube has to be cut, meticulous secure anchorage to the nose/face must be ensured.⁴ Reliable fixation of the nasogastric tube to the drainage bag will also prevent this complication. Finally, this diagnosis should be considered in the rare case of previous nasogastric intubation who now presents with epigastric symptoms.

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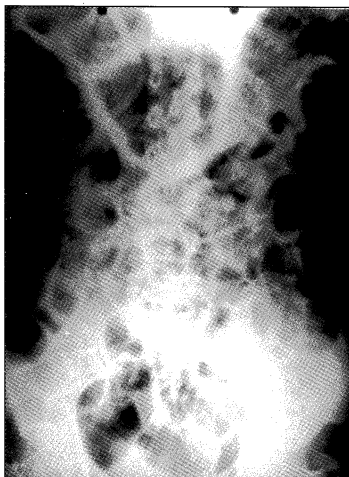


Figure 1.
Supine X-ray of the abdomen showing a nasogastric tube coiled in the duodenum

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