Dysphagia due to tumor ulcers and stomatitis induced by chemoradiotherapy is painful; it is therefore crucial and urgent to establish a surgical enteral feeding route in patients with head and neck cancer to avoid malnutrition and improve treatment compliance [1]. However, common trismus caused by surgical resection, reconstruction, and, mostly, radiation fibrosis often compromise flexible endoscope passage; furthermore, an oral tumor would raise concern of cancer contamination and inoculation upon percutaneous endoscopic gastrostomy (PEG) [2, 3]. Herein, we demonstrate the use of an ultrathin endoscope (5.3 mm diameter; Olympus VISERA Transnasal Esophagovideoscope, PEF-V; Olympus Medical Systems, Tokyo, Japan), via the transnasal route as a good alternative for better instrument passage in patients with head and neck cancer with trismus or when buccal reconstruction integrity would be a concern.

Patients were placed under transoral or transnasal endotracheal intubation general anesthesia. The transnasal approach would be preferred in patients with an inter-incisor distance of less than two fingers for both endotracheal intubation and PEG. The pull method was our procedure of choice owing to greater control of stomach puncture and less premature extrusion [4, 5], and we routinely used a 20 Fr tube (Flow 20 Pull Method; Cook Medical Inc., Bloomington, Indiana, USA) (▶Video 1). The puncture site chosen was the most transilluminated area over the gastric antral portion under a dark setting. Our tip to avoid nostril trauma upon passage of the PEG bumper is to squeeze the bumper with one hand while gently pressing the ipsilateral nose alae with the other hand to provide proper counter-support (▶Fig. 1). After the PEG procedure, the pressure of the bumper on the gastric mucosa was checked to avoid buried bumper syndrome, and 2–30 mL distilled water was irrigated.
over the mucosa in contact with the bumper to prevent tumor inoculation. We have not encountered nasal bleeding in our series of 20 cases. Our experience showed that PEG using a transnasal ultra-thin endoscope could be a good alternative approach when the transoral route is compromised, especially in cases of head and neck cancer.

References


Corresponding author

Kam-Hong Kam, MD
Division of Thoracic Surgery, Department of Surgery, Chia-Yi Christian Hospital, 539 Jhongsiao Road, Chia-Yi 600, Taiwan
Fax: +886-5-2774511
hongsurgeon@gmail.com

Competing interests

None

The Authors

Jia-Ming Chang1,2,3, Yi-Ting Yen2,4, Chao-Chun Chang1, Yau-Lin Tseng2, Wu-Wei Lai4, *, Kam-Hong Kam1,4

1 Division of Thoracic Surgery, Department of Surgery, Chia-Yi Christian Hospital, Chia-Yi, Taiwan
2 Institute of Clinical Medicine, National Cheng Kung University, Tainan, Taiwan
3 Graduate Institute of Medical Sciences, College of Health Science, Chang Jung Christian University, Tainan, Taiwan
4 Division of Thoracic Surgery, Department of Surgery, National Cheng Kung University Hospital, Tainan, Taiwan

* These authors contributed equally to this work.