

Since the 1980s the use of percutaneous endoscopic gastrostomy (PEG) has been a safe and reliable method of enteral feeding in patients with functioning normal bowel [1]. A 74-year-old woman with Alzheimer's disease and a history of a cerebrovascular accident (CVA) was admitted after dislodgement of her PEG feeding tube. It had been placed 3 years previously using a standard pull-through technique, but had required replacement on several occasions due to dislodgement. She was found to have a large (8 × 9 cm) prolapse of engorged gastric mucosa protruding from the tube tract (Figure 1). At laparotomy the prolapse was found to consist of everted full-thickness stomach wall. This was reduced and the defect was repaired in two layers (Figure 2). A further PEG tube was placed at a distant site. The patient made a full recovery.

Following a CVA, up to 75% of patients can require long-term PEG tube enteral feeding [2]. A number of well-documented complications have been described [3]. Cellulitis is by far the most common, followed by bleeding and leakage of gastric contents, either around the tube or intraperitoneally, causing chemical peritonitis. More unusual complications include visceral perforation with subsequent enterocutaneous and colocutaneous fistulae formation [4,5]. The complication described here may partly be due to the repeated track dilations to aid tube re-insertion.

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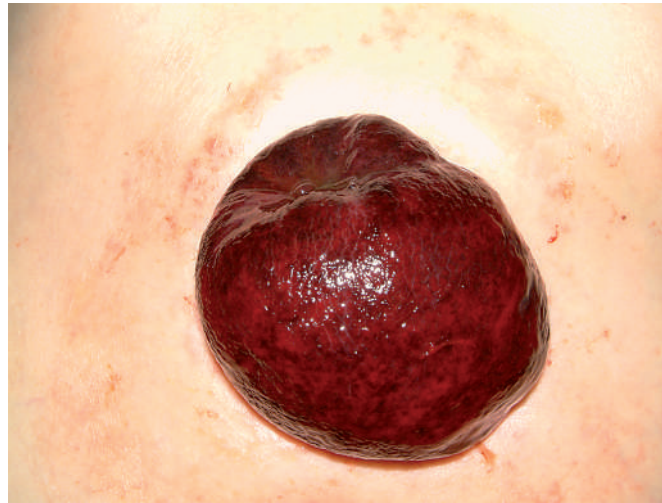


Figure 1 Full-thickness gastric mucosal prolapse.



Figure 2 Repair of the prolapse.

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