A 53-year-old gentleman presented in the A and E Department of Barnett and Chase Farm Hospital in the first week of May 2003 with sudden onset of stridor. Further investigations revealed large subglottic squamous cell carcinoma. Debulking of tumor was performed by ENT surgeons and the patient was referred to North Middlesex Hospital, London, for chemotherapy. The patient had recurrence of stridor in June 2003, and tumor was again debulked and postoperative radiotherapy was started, along with high doses of steroids. Ultrasoundography, computed tomography (CT) of the abdomen and bone scan performed at that time was normal. Pathologically the tumor was graded as T3 No Mx. After starting radiotherapy, patient began having difficulty in eating, so it was decided to insert PEG in the middle of June 2003. Unfortunately, the transverse colon was perforated during insertion of PEG and the patient underwent subsequent laparotomy during which defunctioning loop transverse colostomy and closure of leaking gastrostomy opening were performed. The patient remained well till the end of September 2003, when he was readmitted under a surgical team with complaints of nonfunctioning of colostomy. The patient noticed a swelling around colostomy 2 weeks prior to this admission. On examination, there was an oval shaped 5-cm diameter nontender well-defined nodular surfaced, hard consistency mass on the medial aspect of colostomy, which was compressing the lumen of proximal stoma. Clinically the mass appeared to be arising from the abdominal wall. Computed tomography of the abdomen revealed a large lobulated parastomal mass with metastatic deposits in the liver. Trucut biopsy taken from the stomal mass revealed metastatic squamous cell carcinoma. The patient underwent chemoradiotherapy for this metastatic abdominal wall lesion. Colostomy started functioning well after proximal stomal wash.

**DISCUSSION**

Abdominal wall metastasis normally does not occur in carcinoma larynx. However, recently there are reports of abdominal wall metastasis around the stoma following PEG, thus giving rise to a serious doubt about the utility of PEG in patients with upper aerodigestive tract malignancies.

**ABSTRACT**

Percutaneous endoscopic gastrostomy (PEG) is a safe and easy procedure to provide enteral nutrition in patients suffering from advanced malignancy of upper aerodigestive tract. However, with published reports of abdominal wall metastasis after PEG in Head and Neck malignancies, a serious doubt has been raised about continuation of PEG in upper aerodigestive malignancies. In this communication, we report one such case along with relevant review of literature.

**Key Words:** Metastasis, percutaneous endoscopic gastrostomy, PEG, carcinoma larynx

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Digestive malignancy. Till date, there are reports of 21 cases of abdominal wall metastasis around the stoma following PEG in patients suffering from Head and Neck malignancy.\cite{1,2} Primary tumor in these cases included carcinoma of esophagus, pharynx, larynx, and oral cavity. Computed tomography is an effective method for evaluation of these patients. A lobulated mass around the stoma is highly suggestive of tumor implantation, especially if the thickness of one side exceeds 1cm.\cite{2} The preponderance of evidence from existing literature points to direct implantation during endoscopic placement\cite{2} rather than hematogenous spread. Chances of implantation increase many folds if the tumor is constricting with a high risk of losing tumor cells. After the experience of the present case and review of the literature, we strongly recommend operative or laparoscopic placement of gastrosotomy or jejunostomy tube rather than PEG, for enteral nutrition.

**REFERENCES**