Complications of percutaneous endoscopic gastrostomy

Sir,
I read with interest the case report highlighting two complications of percutaneous endoscopic gastrostomy (PEG). The colonic injury is avoidable if attempts to insert PEG are only made when the parietes at the selected site is transilluminable after gastric insufflation, finger indentation of the selected site is seen on endoscopy and air aspiration through the trocar corresponds to its entry into stomach and not earlier. The complication of PEG site metastasis is extremely rare and unpredictable – akin to the port-site metastases in laparoscopic surgery for intra-abdominal malignancy, where the ‘chimney effect’- leakage of pneumoperitoneum through and around the ports allow seeding of shed but viable tumour cells. This effect is much less with an insufflated stomach. A more plausible explanation is contamination of the retaining flange of the PEG tube during its passage through the tumour-bearing area of the upper aero-digestive tract during the ‘pull’ technique of insertion. Therefore, a logical approach would be to insert the PEG intraoperatively after excision of laryngeal or oral cancers whenever possible to minimise contamination of PEG tube. This has been practised in our institution to good effect. (Data presented at the Annual Conference of Association of Surgeons of India, Hyderabad, December 2005.) Alternatively, the more technically difficult ‘push’ technique of PEG can be used, which uses the Seldinger technique of PEG placement in an insufflated stomach, avoiding contact or friction of the tube with the tumour. Just as port-site metastases (incidence comparable to wound metastases after open surgery) have not deterred laparoscopy in malignancy, the even rarer instances of PEG site metastasis (20 odd cases in the last two decades) should not prevent its use in either operable or in inoperable tumours. I would also like to contend the authors’ recommendation of laparoscopic enteral access as the simplicity and advantages of PEG in head and neck cancer patients far outweigh its disadvantages. Laparoscopic placement requires general anaesthesia, which is more expensive and can also cause serious complications and occasionally requires conversion. The expertise of interventional radiological placement is not widely available making PEG the preferred enteral access procedure for medium/long-term nutritional support in many head and neck/surgical gastroenterology units including ours.

REFERENCES

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