

## **Palliative Care Rounds**

# Complications of a Gastrostomy Tube Used for Decompression of an Inoperable Bowel Obstruction in a Patient with Advanced Cancer

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### **Abstract**

*Percutaneous gastrostomy tubes (G-tubes) are used to decompress symptomatic patients with inoperable malignant bowel obstruction. Complications of G-tubes have rarely been reported in the palliative care literature. Nonetheless, complications are not uncommon and could interfere with the quality of life of patients, as illustrated by our case report. Given the increased use of percutaneous G-tubes, more attention needs to be paid to the prevention, early detection, and treatment of potential adverse events. Patients and their caregivers must receive appropriate education about complications of G-tubes and be made aware of the early signs and symptoms that must be brought to the attention of health care providers.*

*Management of complications requires the use of health care resources that often can be found only in an acute care setting, and often requires referral to an interventional radiologist or endoscopist. Routine referral for G-tube placement before medical management has been maximized may not minimize suffering in patients with life-limiting illnesses. J Pain Symptom Manage 2009;38:466–472. © 2009 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

### **Key Words**

*Gastrostomy tube, complications, malignant bowel obstruction, palliation*

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## **Introduction**

Malignant bowel obstruction (MBO), a common complication in patients with advanced

cancer, can significantly affect a patient's quality of life.<sup>1</sup> Over the past 20 years, percutaneous gastrostomy tubes (G-tubes), placed under fluoroscopic guidance by an interventional radiologist or during endoscopy by a gastroenterologist, have been widely used for decompression of inoperable MBO.<sup>2,3</sup> Often, G-tubes are safely placed, well tolerated, and easily managed by health care providers, even in the home setting. However, complications of G-tubes, if not detected early and managed appropriately, can lead to unnecessary suffering or even death in advanced cancer patients with MBO. Such complications have been infrequently reported in palliative care journals.

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We report the case of a patient with advanced colon cancer who experienced multiple serious complications of a G-tube placed to treat MBO.

### Case Report

A 41-year-old man was diagnosed in 2002 with a T4N1M0 right-sided colon cancer and underwent a right hemicolectomy followed by adjuvant chemotherapy consisting of fluorouracil (5-FU) and leucovorin. In March 2005, he developed a recurrence of cancer involving his rectum and, subsequently, received radiation at the site of recurrence and additional chemotherapy consisting of oxaliplatin, 5-FU, and folinic acid. In July 2005, he developed liver metastases with omental and peritoneal implants. The patient received further chemotherapy consisting of bevacizumab, irinotecan, and cetuximab. In January 2006, he developed multiple pulmonary metastases and his performance status progressively declined. His clinical course also was complicated by a small bowel obstruction that required the placement of a 14-French G-tube, placed under radiological guidance, for gastrointestinal decompression.

Three weeks after the placement of the G-tube, the patient was admitted to the hospital with symptoms of nausea and abdominal pain. In the emergency room, his caregivers reported diminished output from his G-tube. A work-up, including an abdominal radiograph, revealed recurrence of the small bowel obstruction. Fluoroscopic evaluation of the G-tube revealed a kinked catheter with the tip oriented toward the antrum of the patient's stomach. The catheter was exchanged and properly positioned with the tip oriented toward the fundus, which led to the resolution of his symptoms. The patient was eventually discharged home.

Ten days after discharge from the hospital, the patient's nausea, vomiting, and abdominal pain returned and required admission to an inpatient palliative care unit. Abdominal radiographs were obtained, and they revealed dilated loops of small bowel consistent with another small bowel obstruction. The patient was treated with methadone for pain control, haloperidol for nausea, and dexamethasone

to decrease his overall symptom burden. His symptoms improved remarkably, and plans for discharge home were initiated.

However, when the patient attempted to move, he felt a "pop" in his epigastric area associated with pain and an increase in nausea. The results of physical examination were unchanged, but during the next 24 hours, the nursing staff reported a decrease in output from the patient's G-tube. Repeat abdominal radiographs were unremarkable, and the G-tube was examined at bedside by a clinician who found it to be functional. Because his symptoms persisted, computed tomography scan of the abdomen and pelvis was performed and revealed that the G-tube had gone astray and was lying in a fistulous tract formed by his G-tube in the anterior stomach wall. Contrast material was administered through the G-tube, and a trail of dye was noted leading through the fistula to the stomach (Fig. 1). The patient's G-tube was examined fluoroscopically by an interventional radiologist, who found that the catheter tip was misplaced outside the gastric lumen. The G-tube was subsequently exchanged and a new tube properly positioned, resulting in improvement of symptoms.

Two days after the G-tube exchange, leakage around the insertion site was noted. The G-tube was reexamined, and the catheter tip was found to have migrated into the patient's duodenum (Fig. 2). The G-tube was then



Fig. 1. Computed tomography scan of the abdomen revealing the G-tube lying in the anterior stomach wall with a trail of contrast material leading into the patient's stomach.

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