

World Journal of *Clinical Cases*

World J Clin Cases 2022 February 16; 10(5): 1457-1753



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RESPONSIBLE EDITORS FOR THIS ISSUE

Production Editor: Lin-YuTong Wang; Production Department Director: Xiang Li; Editorial Office Director: Jin-Lei Wang.

NAME OF JOURNAL

World Journal of Clinical Cases

ISSN

ISSN 2307-8960 (online)

LAUNCH DATE

April 16, 2013

FREQUENCY

Thrice Monthly

EDITORS-IN-CHIEF

Bao-Gan Peng, Jerzy Tadeusz Chudek, George Kontogeorgos, Maurizio Serati, Ja Hyeon Ku

EDITORIAL BOARD MEMBERS

<https://www.wjgnet.com/2307-8960/editorialboard.htm>

PUBLICATION DATE

February 16, 2022

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STEPS FOR SUBMITTING MANUSCRIPTS

<https://www.wjgnet.com/bpg/GerInfo/239>

ONLINE SUBMISSION

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Uncommon complication of nasoenteral feeding tube: A case report

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Author contributions: Lin RH helped to design the manuscript; Jiang YP helped to write the manuscript; Zhang S helped to revise the manuscript; all authors issued final approval for the version to be submitted.

Informed consent statement: Informed written consent was obtained from the patient for publication of this report and any accompanying images.

Conflict-of-interest statement: The authors declare that they have no conflict of interest.

CARE Checklist (2016) statement: The authors have read the CARE Checklist (2016), and the manuscript was prepared and revised according to the CARE Checklist (2016).

Supported by The Science and Technology Project of Taizhou, No.1902KY02.

Country/Territory of origin: China

Specialty type: Critical Care Medicine

Provenance and peer review: Unsolicited article; Externally peer reviewed.

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Abstract

BACKGROUND

The jejunal nutrition tube has increasingly been used in clinical practice, and the results in frequent complications.

CASE SUMMARY

We present the case of a 74-year-old male patient who had been admitted to the intensive care unit for aspiration pneumonia and respiratory failure. When confirming the position of the jejunal tube by X-ray, we found that the feeding tube had been placed into the chest. The complications was a disaster, though the misplacement of jejunal feeding tube are uncommon.

CONCLUSION

We introduced a way of ultrasound-guided jejunum feeding tube placement to avert the disaster, which was convenient and economical.

Key Words: Nasoenteral feeding tube; Nutritional support; Complication; Ultrasound-guided; Feeding tube placement; Case report

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Core Tip: We report a case of a patient who has a serious complication during the catheterization of the jejunal tube and introduce a way of using of bedside ultrasound to guide the placement of the jejunal tube to avert the disaster, which was convenient and economical.

Citation: Jiang YP, Zhang S, Lin RH. Uncommon complication of nasoenteral feeding tube: A case report. *World J Clin Cases* 2022; 10(5): 1598-1601

URL: <https://www.wjgnet.com/2307-8960/full/v10/i5/1598.htm>

Peer-review model: Single blind**Peer-review report's scientific quality classification**

Grade A (Excellent): 0

Grade B (Very good): B

Grade C (Good): 0

Grade D (Fair): 0

Grade E (Poor): 0

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Received: July 15, 2021**Peer-review started:** July 15, 2021**First decision:** October 18, 2021**Revised:** January 7, 2022**Accepted:** January 11, 2022**Article in press:** January 11, 2022**Published online:** February 16, 2022**P-Reviewer:** Soares RLS**S-Editor:** Li JH**L-Editor:** A**P-Editor:** Li JH**DOI:** <https://dx.doi.org/10.12998/wjcc.v10.i5.1598>

INTRODUCTION

Early enteral nutrition in critically ill patients who cannot eat by mouth is widely recommended by the clinical practice guidelines of nutrition[1]. For patients at high risk of aspiration and who were intolerant of oral or gastric feeding the advice is to place a post-pyloric feeding tube[2,3]. Complication of jejunal feeding tubes are rare. A recent report revealed that a jejunal tube caused gastrointestinal perforation[4]. In this case report, we will present a case where a jejunal feeding tube was placed into the chest and provide a brief overview of a method to avoid the complication of placing a jejunal feeding tube. Written informed consent was obtained from the patient's family for publication of this manuscript and any accompanying images.

CASE PRESENTATION

Chief complaints

A 74-year-old male patient who with a history of chronic obstructive pulmonary disease (COPD) was admitted to the intensive care unit (ICU) for aspiration pneumonia and respiratory failure.

History of present illness

He had a prolonged course of treatment and a nasoduodenal feeding tube blind placed at the bedside.

Imaging examinations

A chest X-ray revealed that the position of the nasoduodenal feeding tube was in the chest (Figure 1A). An abdominal X-ray also made it clear that the nasoduodenal feeding tube was not placed in the abdomen (Figure 1B). Visual laryngoscopy revealed that the tube entered the airway together with the windpipe (Figure 2).

FINAL DIAGNOSIS

The patient suffered from pneumothorax due to tracheal pleura leakage, which occurred when the feeding tube was immediately removed.

TREATMENT

We administered chest drainage in the middle of the clavicle and second ribs.

OUTCOME AND FOLLOW-UP

However, the patient died as a result of the aggravation of the lung infection.

DISCUSSION

The most commonly used non-invasive method of enteral nutrition is a nasogastro-jejunal tube. The jejunal nutrition tube has increasingly been used in clinical practice, and the results in frequent complications[4,5]. The traditional method of intubation depends on the operator experience, X-ray, and gastroscope. Nasogastrojejunal tube insertion based on a minimally invasive catheterization procedure, combined with ultrasound guidance, is becoming more prevalent[6]. The use of bedside ultrasound to guide the placement of the jejunal tube is safe, convenient and economical. One of the common complications of indwelling jejunal tubes is the misplaced airway as reported in this case. How can we avoid it? When the cannula is about 30 cm, we need to

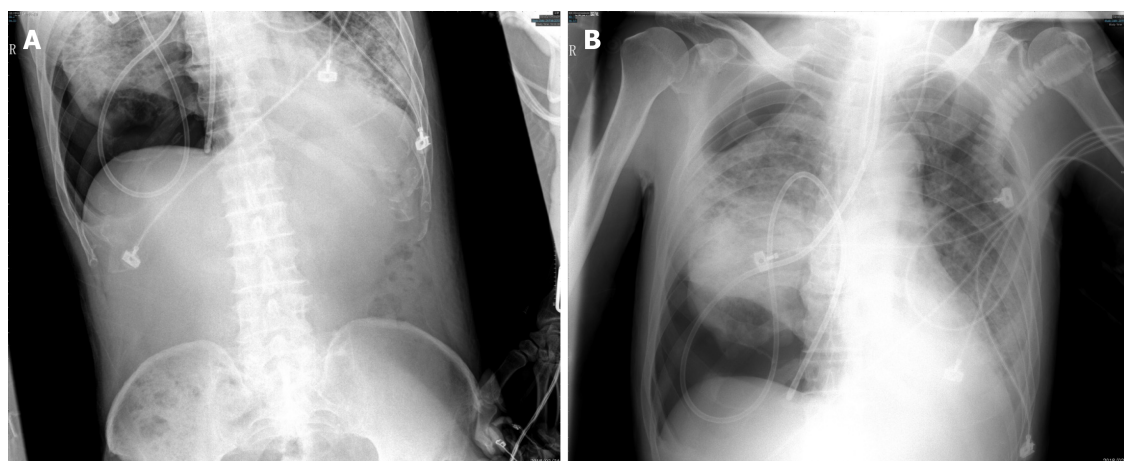


Figure 1 X-ray after placement of the feeding tube. A: Abdominal X-ray shows there is no jejunal tube in the abdomen, and the jejunal tube is on the diaphragm; B: Chest X-ray shows the jejunal tube is in the chest.

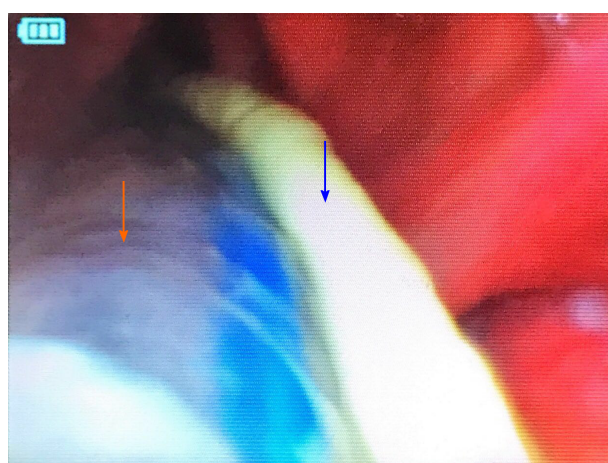


Figure 2 Visual laryngoscopy after placement of the feeding tube. The blue arrow is feeding tube and the orange arrow is windpipe.

observe the patient's response and ventilator condition. Even neck ultrasound determines access to the esophagus. If the patient has a severe cough response or a leak and a high pressure alarm, it may suggest that the tube has entered the airway. When the tube is placed around 50 cm, we need to complete a test of pumping. If you can hear the gas over water (bubble sound), then the catheter head has entered the stomach. If not, the patient should be reintubated.

CONCLUSION

The complication of blind bedside jejunal feeding tube placement was a disaster. Ultrasound guidance under visualization can avoid serious complications. Practitioners need to pay attention to patient response and the ventilator during catheterization.

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