



Time for the world to move beyond the percutaneous endoscopic gastrostomy

Ah San Pang

Ah San Pang, LP Surgery, Mount Alvernia Hospital, 820 Thomson Road, Singapore 574623, Singapore

Author contributions: Pang AS wrote this letter.

Correspondence to: Ah San Pang, FRCSEd, LP Surgery, 820 Thomson Road, #02-05 Mount Alvernia Medical Centre A, Singapore 574623, Singapore. pangahsan@gmail.com

Telephone: +65-63563260 Fax: +65-63563261

Received: December 7, 2010 Revised: December 28, 2010

Accepted: January 4, 2011

Published online: June 21, 2011

Abstract

Percutaneous endoscopic gastrostomy (PEG) is a proven feeding tube, just as the nasogastric tube is proven to be able to deliver enteral nutrition. For long-term use, both patient and caregiver want neither. What is desired is the LOOPPEG® 3G tube, more secure than the PEG, and less risky to change than the nasogastric tube. Future clinical research should focus on this high-comfort low-risk tube.

© 2011 Baishideng. All rights reserved.

Key words: Tube feeding; Enteral nutrition; Dysphagia; Stroke

Peer reviewer: Damian Casadesus Rodriguez, MD, PhD, Calixto Garcia University Hospital, J and University, Vedado, Havana City, Cuba

Pang AS. Time for the world to move beyond the percutaneous endoscopic gastrostomy. *World J Gastroenterol* 2011; 17(23): 2877-2878 Available from: URL: <http://www.wjgnet.com/1007-9327/full/v17/i23/2877.htm> DOI: <http://dx.doi.org/10.3748/wjg.v17.i23.2877>

TO THE EDITOR

I found "Survival of geriatric patients after percutaneous

endoscopic gastrostomy in Japan" by Yutaka Suzuki *et al*^[1] to be an interesting and timely article.

With an aged population and several centers working together, they were able to recruit a large sample and, consequently, produce robust results. The first lesson to be learnt is that collaboration can produce better results. The second lesson is that, for the Japanese population at least, the percutaneous endoscopic gastrostomy in geriatrics is proven. To the co-authors and their institutions, I offer my heartiest congratulations. My country, Singapore, is ageing rapidly and their experiences can offer valuable lessons.

I emphasize that my subsequent suggestion for future research should not be taken as criticisms of their work, which is an unqualified success. By way of introducing my comments, I pose two questions.

First, since elderly patients in other countries might react differently from Japanese patients, should we not do a similar study of the PEG in Singapore? My answer is no, for the following reason. The difference in year (or mo) is unlikely to be important to the geriatric patient, in whom compassion is more valued than cure.

Second, since the nasogastric tube might give a better survival than the PEG, should we not do a similar study on this feeding tube? Again, my answer is no, for the following reasons. Feeding tube and survival of the elderly have a correlation but not a cause-effect relationship. Both nasogastric tube and PEG can deliver the enteral nutrition, and the choice is determined more by the risk/comfort profile of the tube. Statistical significance does not mean clinical significance. Conversely, lack of the former does not mean that the PEG is not a clinically better tube. The relationship between nasogastric tube and PEG is predictable, independent of age and race, and unlikely to be affected by the study findings, however robust.

This relationship is illustrated in Figure 1. There are enough published data to show that the nasogastric tube is low in risk and low in comfort, whereas the PEG is very comfortable but also high in risk^[2]. For long-term use, both patients and caregivers want neither option! What

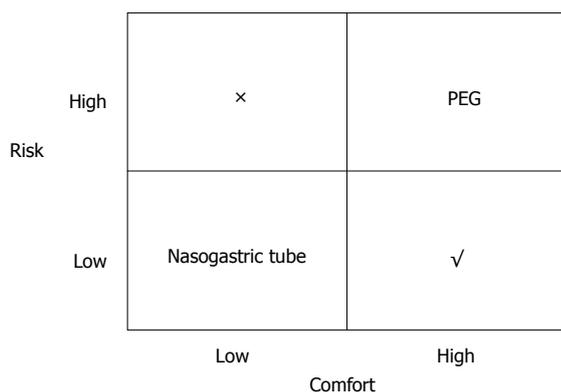


Figure 1 Risk/Comfort Chart. The desired tube is the high-comfort low-risk option (✓). PEG: Percutaneous endoscopic gastrostomy.

they need is a very comfortable but low in risk option.

In my opinion, there is only one feeding tube which meets this profile. The LOOPPEG® 3G tube is comfortable because it bypasses the nose and low in risk because it cannot be dislodged^[3]. Also, it is less risky to change than the nasogastric tube. Consequently, the 3G tube can be made 15 Fr or smaller because tube blockage is a non-issue, having been negated by easy tube change. Thus, the trauma of changing the tube - physical, psychological and financial - is minimized.

However, no case series has been published. It may

take forever for a sizeable sample and robust results to come out from my part of the world. Hence, I hope our Japanese colleagues, having published a solid study, will take up the challenge to move beyond the PEG, research the 3G tube, and report their findings in this fine Journal.

ACKNOWLEDGMENTS

Iruru Maetani, MD, FJSIM, Professor and Chairman, Division of Gastroenterology/Department of Medicine, Toho University Ohashi Medical Center, Tokyo, Japan, encouraged me in my work on the 3G tube.

REFERENCES

- 1 **Suzuki Y**, Tamez S, Murakami A, Taira A, Mizuhara A, Horiuchi A, Mihara C, Ako E, Muramatsu H, Okano H, Suenaga H, Jomoto K, Kobayashi J, Takifuji K, Akiyama K, Tahara K, Onishi K, Shimazaki M, Matsumoto M, Ijima M, Murakami M, Nakahori M, Kudo M, Maruyama M, Takahashi M, Washizawa N, Onozawa S, Goshi S, Yamashita S, Ono S, Imazato S, Nishiwaki S, Kitahara S, Endo T, Iiri T, Nagahama T, Hikichi T, Mikami T, Yamamoto T, Ogawa T, Ogawa T, Ohta T, Matsumoto T, Kura T, Kikuchi T, Iwase T, Tsuji T, Nishiguchi Y, Urashima M. Survival of geriatric patients after percutaneous endoscopic gastrostomy in Japan. *World J Gastroenterol* 2010; **16**: 5084-5091
- 2 **Baeten C**, Hoefnagels J. Feeding via nasogastric tube or percutaneous endoscopic gastrostomy. A comparison. *Scand J Gastroenterol Suppl* 1992; **194**: 95-98
- 3 **Pang AS**. A new feeding tube which is secure and easy to change. *Singapore Med J* 2009; **50**: 740-742

S- Editor Tian L L- Editor Wang XL E- Editor Ma WH