

References

- Kaplan PW. Nonconvulsive status epilepticus. *Semin Neurol* 1996; 16: 33–40.
- Fernández-Torre JL. De novo absence status of late onset following withdrawal of lorazepam: a case report. *Seizure* 2001; 10: 433–7.
- Agathonikou A, Panayiotopoulos CP, Giannakodimos S *et al.* Typical absence status in adults: Diagnostic and syndromic considerations. *Epilepsia* 1998; 39: 1265–76.
- Thomas P, Beaumanoir A, Genton P *et al.* 'De novo' absence status of late onset: Report of 11 cases. *Neurology* 1992; 42: 104–10.
- Thomas P, Lebrun C, Chatel M. De novo absence status as a benzodiazepine withdrawal syndrome. *Epilepsia* 1993; 34: 355–8.
- Thomas P, Andermann F. Late-onset absence status epilepticus is most often situation-related. In Malafosse A, Genton P, Hirsch E, Marescaux C, Broglin D, Bernasconi R, eds. *Idiopathic Generalized Epilepsies*. London: John Libbey & Company Ltd, 1994; 95–109.
- Primavera A, Giberti L, Scotto P *et al.* Nonconvulsive status epilepticus as a cause of confusion in later life: A report of 5 cases. *Neuropsychobiol* 1994; 30: 148–52.
- Labar D, Barrera J, Solomon G *et al.* Nonconvulsive status epilepticus in the elderly: A case series and a review of the literature. *J Epilepsy* 1998; 11: 74–78.
- Rees JH, Smith SJ, Kullmann D *et al.* Creutzfeldt-Jakob disease presenting as complex partial status epilepticus: a report of two cases. *J Neurol Neurosurg Psych* 1999; 66: 406–7.
- Bogdanovic MD, Kidd D, Briddon A *et al.* Late onset heterozygous ornithine transcarbamylase deficiency mimicking complex partial status epilepticus. *J Neurol Neurosurg Psych* 2000; 69: 813–5.
- Treiman DM, DeGiorgio CM, Salisbury SM *et al.* Subtle generalized status epilepticus. *Epilepsia* 1984; 25: 653.
- Treiman DM, Walton NY, Kendrick C. A progressive sequence of electroencephalographic changes during generalized convulsive status epilepticus. *Epilepsy Res* 1990; 5: 49–60.
- Privitera P, Hoffman M, Moore JL *et al.* EEG detection of nontonic-clonic status epilepticus in patients with altered consciousness. *Epilepsy Res* 1994; 18: 155–66.
- Drislane FW, Schomer DL. Clinical implications of generalized electrographic status epilepticus. *Epilepsy Res* 1994; 19: 111–21.

Received 17 March 2003; accepted in revised form 10 July 2003

Age and Ageing 2004; **33**: 81–82
DOI: 10.1093/ageing/afh012

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Small bowel obstruction from a dislodged feeding tube

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Abstract

Elderly nursing home patients may suffer from inadequate oral nutritional intake for a variety of reasons. In some of them, nutritional status cannot be maintained without the use of enteral feeding. Nasogastric tube feeding is associated with significant patient discomfort, and may lead to significant complications. Thus, in those who require long-term enteral tube feeding, a gastrostomy tube may be necessary. Although surgical insertion may occasionally be required, percutaneous insertion with upper endoscopy assistance is usually safe and feasible. This case represents an unusual complication of such a gastrostomy tube, which draws attention to the need for appropriate care of these tubes.

Keywords: enteral feeding, nasogastric tube feeding, gastrostomy tube

Case report

A 92-year-old woman was admitted with severe sepsis and bilious vomiting. The patient, a resident of a nursing home, had a significant medical history of dementia and several cerebral vascular attacks. She was fed through a gastrostomy tube which had been inserted endoscopically 1 year earlier. Two weeks prior to this admission the Foley catheter used for the gastrostomy disappeared and, assuming it had fallen out, it was replaced by another. On admission the patient presented with small bowel obstruction. A CT scan with contrast material showed the new gastrostomy tube placed in the stomach, distended small bowel loops and a collapsed colon. In the mid jejunum a transitional zone was seen with a Foley catheter proximal to it. The cause of this patient's small bowel obstruction was a dislodged Foley catheter with an inflated bulb which had managed to pass the pylorus and then obstructed the mid jejunum. The patient was taken to the operating room, and the catheter was extracted surgically, via an enterotomy above the inflated balloon. Her post-operative course was uneventful, and she was discharged 4 days later.

Comment

Small bowel obstruction by foreign bodies is a well-known entity. Obstruction due to Foley catheters used for gastrostomy

has rarely been reported in adults and children [1, 2], and a Medline search revealed only a few reports of obstruction of the duodenum [3–5].

It is important for physicians and nursing staff to be aware of the potential of feeding tubes to migrate and cause gastric or small bowel obstruction. Since these patients are often elderly and debilitated, this can cause severe morbidity and potentially may be fatal. Feeding tubes must be well fixed to the patient's skin at all times.

References

1. Tibbits M, Sorrel J. Duodenal obstruction from a gastric tube. *N Engl J Med* 1999; 340: 970–1.
2. Losancof JE, Kjossev KT. Foreign body impaction in the duodenum. *J Gastroenterol* 1999; 34: 294–5.
3. Hussein M, Fawzy M, Carey D. Percutaneous endoscopic gastroscopy tube migration: a rare cause of a common surgical problem. *Int J Clin Pract* 2001; 55: 557–9.
4. Foksalsrud EW. Intestinal obstruction from gastrostomy tube in infants. *J Pediatr* 1996; 69: 809–11.
5. O'Keefe KP, Dula DJ, Varano V. Duodenal obstruction by a nondeflating Foley catheter gastrostomy tube. *Ann Emerg Med* 1990; 19: 1454–7.

Received 19 July 2003; accepted 6 August 2003