**INTRODUCTION**

Enteral nutrition is preferred for patients who cannot take food from oral route, either due to chronic neurological or mechanical dysphagia. Feeding jejunostomy is a common surgical procedure for enteral feeding following oesophagogastrectomy. It can be used either preoperatively or postoperatively in individuals having esophageal carcinoma.

The complication of dislodgment of the entire feeding tube from the skin, and migration into the small bowel is very rare. Complete enteral migrations have been reported in a few case reports till todate. Patients with their family members are counselled and referred to the chronic care centres for maintenance of feeding tube. However, despite proper guidance and awareness some patients may develop complications.

We hereby report a first case from Pakistan encountering a rare complication, i.e. complete impulsive migration of feeding tube due to small bowel intussusception in an old woman with advanced esophageal carcinoma.

**CASE REPORT**

A 60-year old female, suffering from complete dysphagia due to advanced carcinoma of esophagus, was re-admitted in the Surgical Ward of a Government Hospital, with complaints of blocked Foley's catheter jejunostomy. Foley's catheter was working properly since placement 3 weeks ago. The patient was admitted for a change of the feeding catheter.

Physical examination showed an emaciated, anxious, and pale looking old lady, lying on bed. Her vital signs were within normal limits. Abdomen showed an upper midline surgical scar. A three-way Foley's catheter was present at the left lumbar region as feeding tube. Skin around the feeding catheter site was excoriated and inflamed. An attempt was made to adjust the catheter but it was blocked and stuck; therefore, replacement of the feeding catheter under general anesthesia was planned. However, on the evening of admission, the patient developed colicky abdominal pain and the entire catheter disappeared into the abdomen. Therefore, urgent exploratory laparotomy was planned.
Abdomen was opened through the midline and 500 ml of intestinal contents were aspirated. On exploration, jejunum was found to be congested, multiple erosions were present along the antimesentric border, and an intussusception was found with approximately 4 inches of intussuscepted. Catheter balloon was palpable beyond the intussusception. After reducing the intussusception, catheter was kneaded out gently and removed (Figures 1 and 2). The viability of ulcerated and intussuscepted part of the jejunum was doubtful; therefore, that part was resected and end-to-end anastomosis was made. A new feeding catheter was also placed for future feeding. Patient, however, died on the following day.

**DISCUSSION**

In this case, patient had severe dysphagia due to esophageal cancer. Enteral feeding is the best option for such patients who cannot tolerate oral feed. Esophageal carcinoma can cause severe dysphagia that leads to anorexia, malnutrition, and weight loss secondary to the tumors. To improve the nutritional status, feeding tubes should be maintained timely to lessen the surgical or radiotherapy complications.

Here Foley’s catheter was used for feeding jejunostomy. The sudden disappearance of feeding catheter in this case can be explained by the development of intussusception around the catheter balloon in due course, which could be the cause of vigorous peristalsis and sudden disappearance of whole catheter into the intestine. The most likely cause of intussusception in this case was Foley’s catheter balloon acting as the lead point. Another contributory factor may be the retrograde hyper peristaltic bowel movements due to pressure exerted by the feeding tube and infusion on intestine. Surgery is the standard treatment for intussusception in adults.

Intestinal feeding tubes are also linked with certain complications which can be grouped into mechanical, metabolic, nutritional, infection, and others (Table I). Table I: Complications of feeding tubes

- **Mechanical:**
  - Tube displacement
  - Migration
  - Bowel perforation
  - Clogged tube
  - Malfunctioning pump
  - Aspiration
  - Fistulas
  - Skin irritation
  - Catheter knotting
  - Looping and coiling
  - Nutritional
  - Infectious
  - Others

In 3 cases of complete migration, where Malecot catheter, Levin tube, and Foley’s catheter were used as feeding jejunostomy tubes, the migrated tubes were expelled out spontaneously without any complications. In this case, fearing peritonitis, patient underwent exploratory laparotomy to remove the displaced tube.

A study conducted in two hospitals of Pakistan, assessed the complications of percutaneous endoscopic gastrostomy (PEG) in 50 patients and reported 6% cases of PEG displacement, while 4% PEG blockage. They did not mention about the complete disappearance of feeding tube unlike this case.

Feeding jejunostomy is usually associated with the minor complications. Small bowel intussusception secondary to complete tube migration is rarely seen and reported. In patients with persistent gastrointestinal (GI) obstructive symptoms, a clinical suspicion of intussusception should be made for early diagnosis and to avoid serious complications. Hyper peristalsis may be the underlying factor. Use of small bore feeding tubes and avoidance of balloon tip tubes, help prevent the major complications.

**REFERENCES**

3. Narendra H, Ramesh A, Tankshali RA. A rare case of spon-


