

SPONTANEOUS KNOTTING OF RYLES TUBE IN A POST OPERATIVE PATIENT

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SUMMARY

Spontaneous knotting of nasogastric tube is a rare complication. A similar case encountered in a postoperative patient is reported.

KEY WORDS: Ryles tube, Knotting.

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INTRODUCTION

Naso-gastric tube insertion is a simple clinical procedure with occasional unexpected and life threatening complications.¹⁻⁵ Majority of these occurs due to faulty insertion techniques.¹ Complication rates vary widely from 0.3% to 8%.² We present a case of spontaneous knotting of nasogastric tube.

CASE REPORT

A female patient of fifty-six years was admitted in female surgical ward with obstructive jaundice. Ultrasonography revealed chronic calculous cholecystitis with choledocholithiasis. She underwent cholecystectomy

with choledocholithotomy. Besides other pre-operative measures a nasogastric tube was introduced. When the patient had shown considerable postoperative improvement and nasogastric tube had become nonfunctional a decision was made to remove the tube on the fourth postoperative day. Attempts at removal were met with resistance and on further traction it came out causing visible nasal bleed. The tube was found knotted in its terminal part near its tip (Fig-1). A hemostatic nasal pack was left for twenty-four hours. A thorough nasolaryngeal examination was performed after removal of nasal pack. The postoperative period was uneventful and the patient was discharged on the tenth postoperative day after stitch removal. The patient is doing well after six months follow-up without any complications.

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Fig-1: Picture showing ryles tube knotted near the tip.

DISCUSSION

Nasogastric tube placement is often associated with minor and major complications.^{3,4} Minor complications include nasal irritation, epistaxis and sinusitis. Major complications are tracheobronchopleural complications, intravascular penetration, enteral complications and intracranial entry. Factors responsible for such complications include faulty insertion techniques, tube design, peristalsis of stomach, and anatomical abnormalities together with high threshold pressure during extraction.⁴

Confirmatory tests to detect tube position after insertion include X-ray and air insufflations with epigastric auscultation, pH of aspirate and bilirubin, capnography and endoscopy.⁵

High-risk cases prone to develop such complications include intubated and sedated

patients, elderly mentally obtunded, following lung transplantation and repeated attempt after earlier pulmonary misadventure.^{4,5} Therefore, careful insertion together with high index of suspicion could minimize such complications.

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