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Inflated Foley Catheter Balloon Causing Small Bowel Obstruction Following FJ: A Rare Complication - A Case Report

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ABSTRACT

Feeding Jejunostomy (FJ) is an established method of providing postoperative enteral nutrition after major abdominal surgeries including esophagectomy, radical gastrectomy and pancreaticoduodenectomy. Various tubes have been used for FJ, including dedicated feeding catheters, Malecot catheters and Foley urinary catheters. In our institution, either 12/14 Fr rubber Malecot catheter or 14/16 Fr Foley urinary catheter are used for this purpose. These are soft, inexpensive, readily available and less likely to injure the bowel. Tube fixation is performed using the standard Witzel technique. Reported complications of FJ include tube blockage, tube migration, peritubal leakage, infection, skin irritation, accidental dislodgement, bowel obstruction, volvulus, adhesions, kinking, angulation and jejunojejunal intussusception. However, bowel obstruction secondary to inadvertent inflation of a Foley catheter balloon has not been reported previously. We present what appears to be the first reported case of mechanical intestinal obstruction caused by inflation of the balloon of a Foley catheter used as a Feeding Jejunostomy (FJ) tube.

Introduction

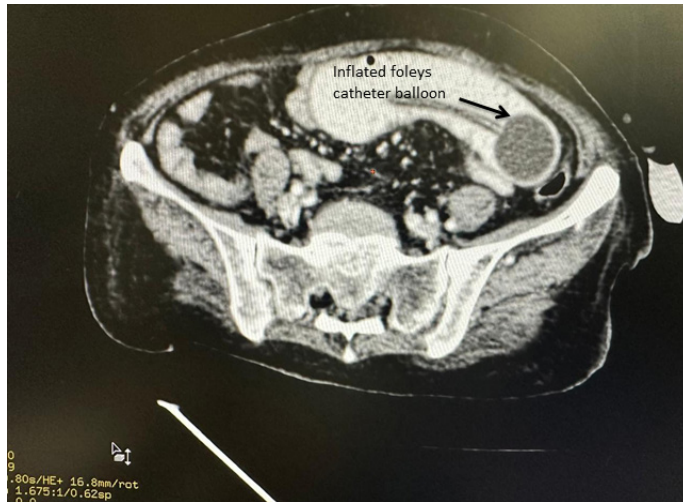
Feeding Jejunostomy (FJ) is an established method of providing postoperative enteral nutrition after major abdominal surgeries including esophagectomy, radical gastrectomy and pancreaticoduodenectomy. Various tubes have been used for FJ, including dedicated feeding catheters, Malecot catheters and Foley urinary catheters. In our institution, either 12/14 Fr rubber Malecot catheter or 14/16 Fr Foley urinary catheter are used for this purpose. These are soft, inexpensive, readily available and less likely to injure the bowel. Tube fixation is performed using the standard Witzel technique. Reported complications of FJ include tube blockage, tube migration, peritubal leakage,

infection, skin irritation, accidental dislodgement, bowel obstruction, volvulus, adhesions, kinking, angulation and jejunojejunal intussusception. However, bowel obstruction secondary to inadvertent inflation of a Foley catheter balloon has not been reported previously. We present what appears to be the first reported case of mechanical intestinal obstruction caused by inflation of the balloon of a Foley catheter used as a Feeding Jejunostomy (FJ) tube.

2. Case Presentation

A 70-year-old female presented with a one-month history of epigastric pain, poor appetite and recurrent non-bilious vomiting. Evaluation revealed adenocarcinoma of the stomach

for which palliative subtotal gastrectomy along with Feeding Jejunostomy (FJ) is done. FJ is done with 14Fr Foley catheter using the Witzel technique. she was discharged on 7th pod with an instruction to feed orally and through FJ. On postoperative day 12, the patient developed recurrent episodes of vomiting and was readmitted and investigated. Contrast-Enhanced Computed Tomography (CECT) of the abdomen demonstrated an inflated Foley catheter balloon within the jejunal lumen causing mechanical small bowel obstruction (Figure 1). The balloon was deflated, following which the patient's symptoms resolved completely. The vomiting ceased, the jejunostomy leak subsided, enteral feeding was resumed and no further surgical intervention was required.



3. Discussion

FJ is considered a relatively safe procedure; however, tube-related complications continue to occur. Mechanical small bowel obstruction is an uncommon but potentially serious complication.

Nulukurthi, et al.¹ reported a case of jejunostomy tube-induced intussusceptions; however, the type of feeding tube was not specified. Kitagawa, et al.² conducted a retrospective study of patients undergoing thoracoscopic esophagectomy and reported bowel obstruction in 17 of 100 patients using a 30-cm Kangaroo jejunostomy catheter placed by the Witzel technique. Approximately half required reoperation, with kinking, torsion and adhesions identified as the primary causes. Koterazawa, et al.³ found that postoperative bowel obstruction occurred in 11.5% of patients who underwent FJ after esophagectomy, compared with none in those who did not receive FJ and therefore recommended selective rather than routine FJ placement. Similarly, Choi, et al.⁴ observed small bowel obstruction in three of 49 patients following gastroesophageal cancer surgery. None of these studies involved the use of Foley urinary catheters as FJ tubes and none described bowel obstruction caused by inflation of the catheter balloon. In the present case, the inflated Foley balloon acted as an intraluminal obstructing mass, resulting in mechanical intestinal obstruction. The diagnosis was established on CECT imaging and simple balloon deflation immediately relieved the obstruction, thereby avoiding reoperation. This case highlights an important technical consideration when Foley catheters are used for feeding jejunostomy. The balloon should never be inflated. Alternatively, the catheter tip containing the balloon may be excised before insertion to eliminate the possibility of

accidental balloon inflation and the resulting bowel obstruction.

4. Conclusion

Mechanical intestinal obstruction caused by inadvertent inflation of the balloon of a Foley urinary catheter used as a FJ tube is an extremely rare but potentially preventable complication. To the best of our knowledge, this is the first reported case in the literature. This case highlights the importance of meticulous attention to tube selection and handling when Foley catheters are used for feeding jejunostomy. The balloon should not be inflated under any circumstances, as inadvertent inflation within the jejunal lumen may result in mechanical intestinal obstruction. Increased awareness of this rare complication may facilitate early diagnosis, prevent unnecessary surgical intervention and improve patient outcomes.

5. References

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