

“Blood, Blood Everywhere”: A Case of Buried Bumper Syndrome Presenting as Melena and Hematochezia

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Abstract

Gastrostomy tubes are frequently placed for a variety of conditions that cause interference with oral intake or gastric decompression and are used for enteral feeding, hydration, and medication administration in patients who are likely to have prolonged inadequate oral intake. Buried bumper syndrome is an extremely rare, but major complication of gastrostomy tubes which results due to tight apposition of the external bumper against the abdominal wall and erosion of the internal bumper of the gastrostomy tube against the gastric wall. The overall incidence has been reported to be 0.3 to 2.6 % of all patients with gastrostomy tubes. We present a patient who presented with melena, hematochezia and severe blood loss anemia, and was found to have buried bumper syndrome.

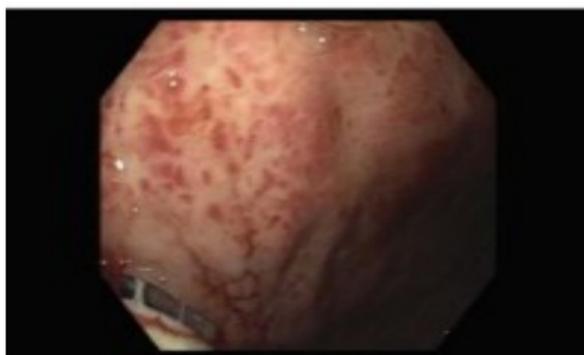
Case Description

A 55-year-old female, who is a long-term nursing home resident presented to our emergency department (ED) in late April with altered mental status, shortness of breath with agonal breathing, melena, and hematochezia. Her past medical history is significant for a cerebro-vascular accident with residual right hemiparesis, grade III diastolic dysfunction with an ejection fraction of 55-60%, hypertension, hyperlipidemia, severe pulmonary hypertension, gastroparesis secondary to diabetes mellitus type II, end stage renal disease on hemodialysis, and morbid obesity with a body mass index of 44. She had a percutaneous endoscopic gastrostomy (PEG) tube placed to help meet her nutritional requirements 5 months prior to the current presentation. In the ED she was intubated due to a low Glasgow coma scale (GCS) and failure to protect her airways. Initial labs showed a hemoglobin level of 4.8g/dl, a drop of almost 6g/dl from her baseline of 11g/dl, for which she required 6 units of packed red blood cell transfusions. Imaging studies revealed extensive amounts of left-sided anteriorly located subcutaneous emphysematous changes from a dislodged feeding tube with no surrounding fluid collections or pneumoperitoneum as depicted in figure-1. After initial stabilization, an esophagogastroduodenoscopy (EGD) was performed which revealed several non-bleeding superficial gastric ulcers with erythematous hemorrhagic mucosa in the gastric body (Figure 2&3), with the largest lesion measuring about 6 mm. Furthermore, there was evidence of erosion of the PEG tube through the stomach wall (Figure 4&5) The PEG tube inner bumper was loosened to promote healing (Figure 6&7). Patient was treated with pantoprazole 40 mg daily per PEG for two weeks, metoclopramide 5mg IV daily, and PEG feeds were started at a slow rate. The PEG tube was eventually surgically removed. Her hemoglobin remained stable at around 8 to 9 g/dl since this intervention and the PEG tube was able to be used for tube feeds moving forward. Due to her overall progressively worsening poor clinical picture, the family decided to pursue comfort care measures and she eventually passed away in the last week of May.

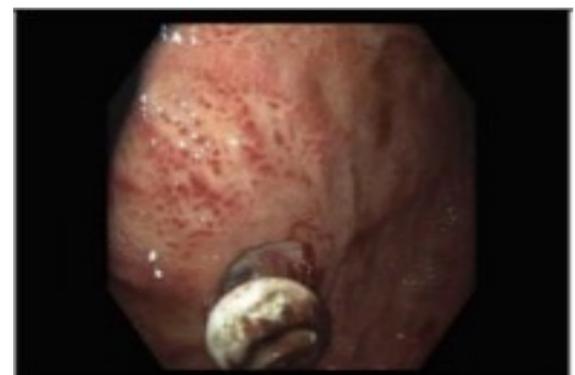
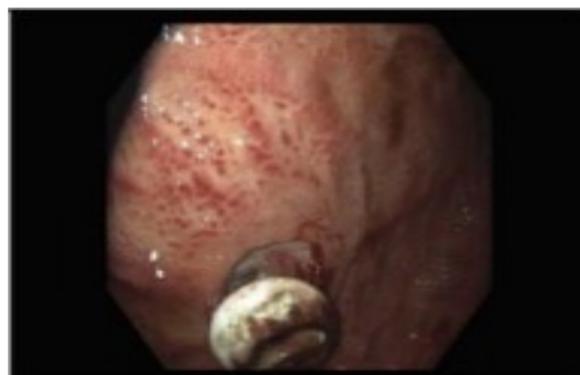
Discussion

Buried Bumper Syndrome is a rare but major long-term complication of gastrostomy tubes occurring in about 0.3 to 2.6 % of patients who have a gastrostomy tube in place. Daily care and periodically measuring the PEG tube to recognize early migration should be done to prevent this syndrome. Diagnosis can be made with imaging such as CT scan which may show migration of the tube, however EGD remains the ideal method to diagnose buried bumper syndrome, which will show the internal bumper buried within the gastric wall. Treatment of this complication is specific to the PEG tube, and includes simple external traction, cut with the push-pull technique, incising the gastric mucosa with a needle knife or papillotomy, or surgical removal.

Images



The internal bumper was loosened during the EGD and photos were taken after.



Conclusion

Buried bumper syndrome is an uncommon and usually late complication of PEG tube. Regular follow up along with patients and care givers education will help minimizing its incidence and allowing for an early diagnosis. Clinicians should consider buried bumper syndrome as a differential for gastrointestinal bleed, particularly in patients with a PEG tube.

Acknowledgements

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