CASE REPORTS

An unusual and overlooked complication of nasogastric tube feeding

AMIT ARORA, CHRISTINE ROFFE, PETER CROME

Department of Geriatric Medicine, School of Medicine, Keele University, Stoke on Trent, UK

Address correspondence to: A. Arora. Email: amitmonaarora@hotmail.com

Abstract

Rechecking the position of the nasogastric tube after oropharyngeal suction is not common practice. Our patient deteriorated after oropharyngeal suction was performed, whilst nasogastric feeding continued. We suggest that nasogastric feeding should be stopped during oropharyngeal suction and the tube position should be checked every time an oropharyngeal suction is performed.

Keywords: nasogastric feeding, oropharyngeal suction, complications, elderly

A 91-year-old gentleman with a longstanding history of Parkinson’s disease was admitted with a mild right hemiparesis. He was independent in activities of daily living prior to this admission. Because his swallowing was impaired with a reduced cough reflex and accumulation of saliva in the oropharynx, he was kept nil by mouth and oropharyngeal suction was performed as necessary. Although his chest X-ray was clear (see Appendix 1 available as supplementary data at the journal website: http://www.ageing.oupjournals.org) he was treated with antibiotics for a presumed chest infection and given 24% oxygen. A nasogastric tube was inserted for feeding and medication, and its correct position was confirmed by aspiration of gastric fluid and pH testing. Nasogastric feeding was commenced in the morning and he appeared to tolerate it well. At lunchtime oropharyngeal suction was performed, and within 30 minutes he became severely breathless and distressed. His oxygen saturation fell from 94 to 81%. Nasogastric feeding was discontinued, the tube was removed and a repeat chest X-ray arranged. It showed complete collapse of the left lung with mediastinal shift and hyperinflated right lung (Figure 1). Within an hour he suffered a respiratory arrest. Although resuscitation was successful initially, he died within 12 hours from respiratory failure.

Discussion

The patient described here deteriorated suddenly after oropharyngeal suction. The feeding tube was confirmed to be placed correctly before the suction, and there was no clinical evidence of tube dislodgement after suction. The sequence of events makes it likely that during the process of suction the nasogastric tube was dislodged from the stomach into the left main bronchus. This may have been the reason why there was no external sign of tube displacement or visible coiling of the tube in the oropharynx.

We are not aware of any previous reports of nasogastric tube displacement related to oropharyngeal suction. While
we have no definite proof of a causal link between the suction and the clinical deterioration in this case, the sequence of events and the rapidity and severity of deterioration would support our hypothesis. Although the case is not proven, the clinical link is compelling and the consequences were devastating. We feel that it is important to draw attention to this potential complication of nasogastric feeding.

**Conclusion**

Currently there are no guidelines regarding stopping nasogastric feeds whilst oropharyngeal suction is carried out. Discussions with nursing, physiotherapy and intensive care colleagues revealed that rechecking the position of the nasogastric tube after oropharyngeal suction is not common practice. We suggest that nasogastric feeding should be stopped during oropharyngeal suction and the tube position should be checked every time an oropharyngeal suction is performed.

**Key points**

- Nasogastric feeding should be stopped during oropharyngeal suction.
- The position of the nasogastric tube should be checked every time an oropharyngeal suction is performed.

**Conflicts of interest**

We confirm that there are no conflicts of interest.

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**Giant cell arteritis presenting as peri-orbital ecchymosis**

**SWAPNA FERNANDEZ, VEDAMURTHY ADHIYAMAN**

Department of Geriatric Medicine, Glan Clwyd District Hospital, Rhyl, Denbighshire LL18 5UJ, UK

Address correspondence to: V. Adhiyaman. Fax: (+44) 1745 534441. Email: adhiyaman@yahoo.co.uk

**Abstract**

Neuro-ophthalmic manifestations are common in giant cell arteritis (GCA) and sometimes may be the only presenting feature. Clinicians should be aware of typical and atypical features of GCA in order to intervene in time before permanent damage occurs.

**Keywords:** giant cell arteritis, peri-orbital ecchymosis, elderly

**Case report**

A 77-year-old lady was admitted with spontaneous bruising (ecchymosis) around the left eye. She was a diabetic and hypertensive and was not on any anti-thrombotic drugs. Detailed history revealed sudden onset right-sided headache (contralateral side) and jaw claudication. She had no visual or systemic symptoms.

Examination showed bilateral tender and nodular temporal arteries and ecchymosis around the left orbit. Ophthalmological examination was normal. Erythrocyte sedimentation rate (ESR) was 71 mm/hour and C-reactive protein was 180 mg/l. There were no signs or symptoms suggestive of an infective or an inflammatory focus elsewhere.

A diagnosis of giant cell arteritis (GCA) was made and she was commenced on high-dose prednisolone. A biopsy of the temporal artery on the left side confirmed the diagnosis. Her symptoms and her inflammatory markers settled very rapidly and she continues on a tapering course of steroids.