61) The most common acute complication of percutaneous endoscopic gastrostomy (PEG) insertion is:

A. Gastric perforation  
B. Colonic perforation  
C. Peritonitis  
D. Bleeding at insertion site  
E. Wound infection

Answer:

Enteral feeding via tube >400 years history  
Need nutrition to improve disease/ functional status/ QOL  
Can improve/ stabilise weight and ↑ albumin within 2 months of commencement

Indications
- Dysphagia (eg secondary stroke/ neurodegenerative disease/ post radiotherapy)  
- Altered mental state and cannot eat (dementia, anorexia nervosa)  
- Hypermetabolic state and weight loss (eg AIDS or cancer)

Temporary access
- Naso gastric tube or naso-small-bowel tube  
- Often short term and fail due to dislodgement, clogging or poorly tolerated

Permanent access
- **Gastrostomy or jejunostomy**
  - Jejunostomy preferred if recurrent aspiration, delayed gastric emptying, dysmotile oesophagus with regurgitation
- Either inserted **percutaneously/ endoscopically or surgically**
  - No difference in mortality/ morbidity (up to 90% survival rate in 1/12; early mortality due to underlying disease rather than tube placement)  
  - PEG cheaper and faster  
  - Surgical should be reserved for those already having intra-abdominal procedure or known anatomical variant
- Higher risk PEG patients
  - Obesity  
  - Pregnancy (safe up to 26 weeks gestation)  
  - Ascites (usually contraindicated unless large volume drained and ABx cover)  
  - Prior abdominal surgery

PEG

<table>
<thead>
<tr>
<th>Minor complications</th>
<th>Wound infection</th>
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<tbody>
<tr>
<td></td>
<td>- Commonest</td>
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<td>- More likely if contaminated field, unwell patient or no ABX prophylaxis</td>
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Peristomal leakage
- Within 1st few days  
- More likely in diabetics/ malnourished (poor wound healing)  
- Worse if junction is tight -> peristomal necrosis

Pneumoperitoneum
Bleeding (very rare)
### Major complications

<table>
<thead>
<tr>
<th>Major complications</th>
<th>Details</th>
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<tbody>
<tr>
<td>Buried bumper syndrome</td>
<td>Internal bumper erodes into gastric mucosa, Pain and inability to continue feeds</td>
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<tr>
<td>Necrotising fasciitis (rare)</td>
<td>In diabetic, immunosuppressed or malnourished</td>
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<tr>
<td>Gastric and oesophageal perforation (very rare)</td>
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<td>Colocutaneous fistula (rare)</td>
<td>Interposition of colon (usually splenic flexure) between abdominal wall and gastric wall, PEG inserted through skin though colon to stomach, Usually asymptomatic apart from intermittent fever and ileus</td>
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<td>Inadvertent removal (common)</td>
<td>If within 4/52 of insertion: should not be reinserted blind at bedside, and should be treated with IV Abx, When replaced can confirm position with water soluble gastrostomy study prior resuming feeds to prevent peritonitis</td>
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Thus the answer is E
- Usually skin flora and usually responsive to oral antibiotics (cephalosporins often 1st line)
- MRSA increasing incidence especially in hospital/ institutionalised setting