Intragastric Knot of Gastro-Duodenal Tube

Case Report

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Complications during anaesthesia:
Intragastric knot.

Case report

A 47 yr old female, starved and premedicated, was presented in the operating theatre for elective cholecystectomy. Anaesthesia was induced with thiopentone 4 mg kg^{-1}. Tracheal intubation was carried out using 6mg pancuronium, after the larynx had been sprayed with Xylocain 4% and lungs were ventilated with nitrous oxide and oxygen.

Fentanyl 10 μg kg^{-1} was given i.v. for analgesia, supplemented with N_2O: O_2 6:4 1 min^{-1}, and artificial ventilation commenced. Soon after the skin incision was done a lubricated gastroduodenal tube, with a metal olive (Sonjet, Laboratories, Peters, France) was introduced into the stomach through the left nostril. There was no difficulty in passing the tube. Peritoneal cavity was explored and moderate distension of the stomach persisted. The surgeon could palpate the tube in the stomach but when aspiration was attempted neither gastric content nor air was sucked out. The tube was then repositioned by pulling and pushing but this was to no avail. Finally, it was decided to remove the tube and re-insert it again.

It was a surprise for all to see that a knot on the distal part of the gastro-duodenal tube was formed, so that suction was virtually impossible. The first side-hole in this kind of tube is located at 7cm from the tip. If more side-holes are located higher up, it may be possible that when a knot in the stomach occurs a few holes proximal to the knot remain free thus making gastric suction possible.

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