

## Inadvertent insertion of nasogastric tube into the trachea of a conscious patient

Sir,

A 50-year-old man with oral carcinoma was transferred to our ICU from the radiotherapy ward with a complaint of sudden respiratory distress. History indicated that the patient developed severe coughing, choking and

difficulty in breathing after nasogastric tube placement. On arrival, he was awake, extremely restless and unable to maintain saturation on room air. His heart rate was 130 bpm and BP was 130/87 mmHg, with rapid and shallow respiration. Auscultation showed bilateral coarse crepts. We decided to intubate the patient. On laryngoscopy, the nasogastric tube was seen entering the vocal cords [Figure 1]. We removed the tube with a Magill's forcep and, to our surprise, about 16 cm length of it was lying inside the trachea. After 3 days of mechanical ventilation, he was transferred back to the ward after extubation and proper nasogastric tube placement, which was later confirmed by chest Xray.

Insertion of feeding tubes although stated to be easy is not without complications, although the problem is underreported.<sup>[1]</sup> The rate of malposition of feeding tubes into the trachea and distal airways ranges from 2 to 2.5%.<sup>[1,2]</sup> Sorokin and Gottlieb (2006)<sup>[1]</sup> reported 50 cases of nasogastric tube malposition into the right or left bronchus out of 2000 tube insertions over a period of 4 years, with two mortalities. The complications are more frequently seen in the elderly, mentally unsound, neurologically impaired and critically ill patients,<sup>[3]</sup> with occasional reports in awake patients.<sup>[4]</sup> Failure to recognize a malpositioned feeding tube may lead to serious injuries to the tracheo-bronchial pleural tract, such as pneumothorax, pleural-effusion and even death.<sup>[4]</sup> Therefore, radiographic confirmation must be done before starting nutrition. Most case reports of malposition are with the use of narrow bore tubes with stiff inner guide wire.<sup>[5]</sup> In contrast, in our patient, the complication occurred with a wide bore 16F soft tube. In this patient, the tube was inserted by an inexperienced resident and the position was confirmed by auscultation only, which is often fallacious. Fortunately, no feeding or medication was instilled into the tube. Reporting such



Figure 1: Nasogastric tube inside the glottis

events will make the clinicians aware about the potential morbidity and mortality associated with such a simple procedure often done unsupervised by junior staff and nurses. Further, this may lead to formulation of a plan to contain this problem and, thus, enhance the safety.

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