Sir,

A 29-year male, previously diagnosed with carcinoma of mastoid bone, was referred to the GI clinic for Percutaneous Endoscopic Gastrostomy (PEG) insertion. He had undergone two previous attempts at resection. However, at this time, his tumor had metastasized. There was a plan for a third surgery for debulking followed by radiotherapy. He was diagnosed as the case of situs inversus totalis (SIT) on the basis of Chest X ray and ultrasound abdomen while being prepared for surgery. In order to maintain his nutritional status and facilitating his quality of life prior to surgery and radiotherapy, PEG tube insertion was undertaken for dysphagia.

Prior to the procedure, he was conscious and well oriented to the surroundings with temperature of 37°C, pulse rate of 72 beats/min, blood pressure of 110/78 mmHg and respiratory rate of 16 breaths/minute. His chest was clear with normal vesicular breathing bilaterally, heart sounds were of normal intensity. Abdominal examination was unremarkable.

His blood counts showed haemoglobin of 11gm/dl, total leucocyte count of 6,180/mm³ and platelets count of 210,000/mm³. Coagulation profile and serum biochemistry was within normal ranges. Esophagogastrroduodenoscopy was conducted in supine decubitus position. With intra-procedure monitoring of pulse rate and oxygen saturation, midazolam (3 mg) and nalbuphine (3 mg) were administered via intravenous injection as pre-treatment.

The gastroscope was turned counterclockwise when it was passed from the bulb to the descending part of the duodenum. Retroflexion performed at the level of angularis, revealed mirrored anatomy from its normal position (Figures 1a and 2b). A gastrostomy site was identified after applying insufflation and darkening the room. The point of maximum transillumination is usually located in the epigastrium, slightly to the left; but in this case, it was on the right side, which was punctured.

Subsequently, a gastrostomy feeding tube (PEG-24-Pull: Wilson-Cook Medical GI Endoscopy), was inserted into the anterior wall of the lower gastric body through the Pull or Ponsky-Gauderer method (Figures 2a and 3b). The feeding through PEG tube was started after 24 hours and no specific complications were observed.

SIT requires comprehensive radiological investigations to identify the presence of associated anatomic variations before undergoing invasive procedures such as surgery, hemostasis of gastrointestinal bleeding and endoscopic procedures; because it may associated with accessory spleen and anomalies in vasculature.1,2 PEG insertion is an effective and highly successful procedure for patients having dysphagia due to aero-digestive tumors with normal gastrointestinal function.3 In particular, when performing PEG in patients with SIT, the procedure requires extra care because of the unfamiliar anatomical variations associated with this condition. Similar to previous reports, careful preparation was required for a successful procedure with minimal or no complications in a patient with SIT.4

PEG is a feasible and safe procedure in patients presenting with SIT, without the need for major changes to the technique.

REFERENCES


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