Subcutaneous emphysema, pneumoperitoneum, and pneumoretroperitoneum after gastrostomy tube placement in a cat

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A 17-year-old spayed female domestic shorthair was referred for palliative radiation treatment of an oral squamous cell carcinoma. The cat had been examined by the referring veterinarian for lethargy, intermittent anorexia, weight loss, dysphagia, and ptyalism of 1 month's duration. Clinical evaluation had revealed cachexia, mild dehydration, moderate gingivitis, and a large (2 cm × 4 cm) erythematous mass that originated from the base of the tongue and medial surface of the body of the right mandible. Signs of pain were elicited by manipulation of the mandible. Serum biochemical analyses revealed slightly increased creatinine concentration (2.2 mg/dl; reference range, 0.5 to 2.0 mg/dl) and mild hyperglobulinemia (5.6 g/dl; reference range, 2.1 to 4.3 g/dl). Results of CBC were unremarkable. Enzyme-linked immunosorbent assays for FeLV antigen and feline immunodeficiency virus antibody yielded negative results. Radiography revealed extensive bone lysis and fracture of the right mandible. Histologic examination of the oral mass confirmed a diagnosis of squamous cell carcinoma.

The cat was examined again 3 weeks later; clinical findings were unchanged. The cat was dehydrated, mildly hypothermic, and had a moderate increase in serum total protein concentration (9.5 g/dl; reference range, 5.5 to 7.5 g/dl). Urinalysis revealed low urine specific gravity (1.015) that, in association with dehydration, was suggestive of renal insufficiency.

The cat was anesthetized for radiography of the skull, percutaneous endoscopic gastrostomy (PEG) tube placement, and radiation treatment. Anesthesia was induced by administration of oxymorphone (0.1 mg/kg [0.045 mg/lb] of body weight, IM), diazepam (0.5 mg/kg [0.227 mg/lb], IM), and fentanyl (10 mg/kg [4.5 mg/lb], IV), and maintained with 1.5% isoflurane in oxygen. Fentanyl (0.03 mg/kg [0.014 mg/lb], IV) and etomidate (0.4 mg/kg [0.18 mg/lb], IV) were administered immediately prior to endoscopy to maintain an adequate plane of anesthesia. The cat was placed in right lateral recumbency. Gastroscopy revealed grossly normal gastric mucosa. The stomach was insufflated to the extent that the rugal folds were no longer visible, and it was tympanic on external palpation. A single stab incision was made caudal to the last rib, 7 cm ventral to the epaxial musculature, with a 16-gauge, over-the-needle, IV cannula. The needle passed easily into the gastric lumen and was readily identified endoscopically. The stomach then began to deflate rapidly, resulting in the loss of percutaneous luminal access. Three more attempts were made to insulate the stomach adequately and reintroduce the catheter. Luminal access was not achieved again. Subcutaneous emphysema that worsened with attempts to maintain gastric insufflation developed almost immediately at the point of catheter entry and spread rapidly to the thoracic inlet, dorsally over the spinous processes to the right thoracic wall and right abdominal wall, and caudally to the sacral region. The procedure was aborted.

Thoracic and abdominal radiographs revealed obvious subcutaneous emphysema and mild pneumoperitoneum and pneumoretroperitoneum (Fig 1). Exploratory laparotomy was performed 3 hours later, to investigate the possibility of gastric rupture and to place a gastrostomy tube. A 2- to 3-mm perforation was detected in the gastric fundus, with 3 pinpoint areas of serosal hemorrhage surrounding the perforation. A 2-cm diameter area of discolored serosa on the greater curvature of the stomach at the junction of the cardia and fundus was also observed. Additional intestinal perforations were not detected. Approximately 20 ml of a serosanguineous peritoneal effusion was collected and submitted for bacteriologic culture. Cytologic examination of the peritoneal effusion was not performed. Additional findings included a small pancreatic cyst-like structure, prominent mesenteric lymph nodes, and a small left kidney. Biopsy specimens from the stomach wall and mesenteric lymph node were taken, and 3 ml of brown fluid was aspirated from the pancreatic cyst. A gastrostomy tube was placed, and a gastroscopy was performed. The abdomen was flushed with 2 L of warm saline (0.9% NaCl) solution and closed in a routine manner. The cat received an analgesic (butorphanol, 0.1 mg/kg, IV, q 4 h) as required, broad spectrum antibiotics (ampicillin, 11 mg/kg [5 mg/lb], IV, q 6 h), mezlocillin (50 mg/kg [22.7 mg/lb], IV, q 6 h), and metoclopramide (1 mg/kg [0.45 mg/lb], IV, q 24 h) as a constant rate infusion, sucralfate (0.25 gm, administered via gastrostomy tube, q 6 h), and cimetidine (5 mg/kg [2.27 mg/lb], IV, q 8 h) for treatment of suspected gastritis. Radiation treatment was not performed.

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A CBC and serum biochemical analyses were performed 24 hours after surgery and revealed mild non-regenerative anemia (Hct, 26.3%; reference range, 27 to 45%), moderate hypoalbuminemia (albumin, 2.0 g/dl; reference range, 2.7 to 3.9 g/dl), decreased BUN concentration (14 mg/dl; reference range, 15 to 29 mg/dl), and mildly increased serum activity of aspartate aminotransferase (76 U/L; reference range, 1 to 37 U/L). Feeding through the gastrostomy tube was begun 24 hours after placement and was uncomplicated. The cat was discharged from the hospital 5 days later. The subcutaneous emphysema was almost resolved, and further complications had not developed. Pasteurella multocida and Enterobacter spp were cultured aerobiologically from the peritoneal effusion. Histologic examination of the stomach wall revealed chronic active erosive gastritis with foci of mucosal erosion and substantial attenuation of the surface epithelium, without evidence of goblet cell metaplasia. Cells of the neck region of the gastric glands were hyperchromatic, and there was an increase in the number of lymphocytes and plasma cells within the lamina propria. Cause of the gastritis was not determined. The mesenteric lymph node had reactive hyperplasia. The pancreatic cyst fluid was a modified transudate with numerous macrophages and large lymphoblasts, low numbers of neutrophils, and few eosinophils and plasma cells; a large amount of cellular debris was also evident. The severe inflammation and a sizable population of lymphoblasts raised suspicion of lymphosarcoma.

The cat was returned to the hospital 2 weeks later for reevaluation and initiation of chemotherapy. The cat's appetite had improved; it had gained 0.4 kg in body weight, and was more active than previously. Clinical signs of gastritis were not detected, and the cat was tolerating the gastrostomy tube feedings well. Results of CBC and serum biochemical analyses were unremarkable. Initial chemotherapy consisted of bleomycin (1 U/kg, SC) and mitoxantrone (6.5 mg/m², IV).

The cat was reevaluated regularly for 4 months. At that time, the gastrostomy tube was replaced with a button gastrostomy tube, as a more convenient method of long-term management. Clinical signs of gastritis were never reported, and complications associated with the gastrostomy tube did not develop. Because of progression of the oral squamous cell carcinoma and the associated discomfort, euthanasia was recommended. The owner declined this option, and the cat was lost to follow-up.

Percutaneous endoscopic gastrostomy tube placement is widely accepted in human and veterinary medicine as a rapid, simple, and cost-effective technique that allows permanent or temporary gastric access for patients rendered anorexic by physical, neurologic, or metabolic disorders. Complications associated with PEG tubes and their placement are documented in the human literature, and the incidence of serious complications is generally low. In the veterinary literature, complications of PEG tube placement and management are uncommonly reported and are usually of minor consequence.

The technique of PEG tube placement described by Gauderer and Ponsky and adapted for use in dogs by Mathews and Binington requires maximal insufflation of the stomach to place the greater curvature of the fundus against the left lateral abdominal wall; this reduces the incidence of splenic laceration or intestinal perforation during gastric puncture. Over-insufflation of the stomach leading to gastric rupture is rare during endoscopy and is usually accompanied by autonomic changes such as bradycardia and hypotension. Serosal tearing and mucosal and submucosal prolapse usually precede rupture. In the cat of this report, continuous cardiac and Doppler blood pressure monitoring indicated that bradycardia and hypotension did not develop during the endoscopy procedure. In addition, the gastric perforation was consistent with that made by a cannula and not with over-insufflation, particularly because serosal tearing and mucosal prolapse were not evident. Thus, over-insufflation of the stomach did not apparently contribute to the gastric perforation.

Intraluminal pressures > 70 mm Hg (95 cm water) can be achieved with air insufflation via a flexible endoscope, producing a considerable pressure gradient between the gastric lumen and the surrounding tissues, where the pressure is approximately 5 mm Hg. Subsequently, after needle puncture of the abdominal wall and stomach during PEG tube placement, an opportunity arises for air to enter the peritoneal cavity and surrounding tissues. Results of prospective and retrospective studies indicate that pneumoperitoneum is a common development after PEG tube placement in humans and does not necessitate immediate laparotomy unless concurrent signs of peritonitis develop. It is unknown whether pneumoperitoneum develops as a common complication of PEG tube placement in cats. In the cat of this report, the pneumoperitoneum was mild, and on its own, may not have necessitated exploratory surgery.

Pneumoperitoneum following PEG tube placement in humans is usually treated conservatively with broad-spectrum antimicrobials. In the cat of this report, the detection of Pasteurella multocida and Enterobacter spp, commensal organisms of the oral cavity and stomach of cats, respectively, in the peritoneal effusion, was strongly suggestive of leakage of gastric contents from the perforation site. Classification of the
fluid type and cytologic evaluation would have aided in further identifying the cause of the effusion. Further investigative procedures such as diagnostic peritoneal lavage have not been documented in humans with pneumoperitoneum following PEG tube placement, so it remains unknown whether leakage of gastric contents occurs simultaneously with pneumoperitoneum, and whether prophylactic administration of broad-spectrum antimicrobials is necessary in such cases. Resolution of pneumoperitoneum usually develops within 1 week, but sporadic cases of prolonged pneumoperitoneum have been reported in humans.15-18

Reports of subcutaneous emphysema and pneumoretroperitoneum following PEG tube placement in humans are rare, although subcutaneous emphysema and pneumoretroperitoneum did develop within hours of PEG tube placement in one instance.19 To the authors’ knowledge, however, this complication has not been reported in the veterinary literature. In the cat of this report, it is most likely that underlying gastric damage predisposed to air leakage into the peritoneal cavity after gastric puncture. Subcutaneous emphysema and pneumoretroperitoneum developed when the air dissected through the subcutaneous tissues around the point of catheter entry and along fascial planes into the retroperitoneum. Interestingly, pneumoretroperitoneum has not been reported with pneumoperitoneum or subcutaneous emphysema after PEG tube placement in humans. Two reports of retroperitoneal, mediastinal, and subcutaneous emphysema that developed secondary to endoscopy of the upper portion of the gastrointestinal tract, without evidence of gastric perforation, are documented in the human literature.19-20 Such reports are believed to support the theory that, during insufflation, air may enter damaged areas of the gastric mucosa and pass along perivascular and perineural tissues to reach the peritoneal, retroperitoneal, thoracic, and subcutaneous tissues, resulting in disseminated emphysema. It is possible that such a mechanism contributed to the development of disseminated emphysema seen in the cat of this report. However, because microscopic evidence of mucosal and submucosal emphysema was not detected in the gastric tissues, this cause seems less likely.

Positive pressure ventilation has been reported to cause subcutaneous emphysema, pneumothorax, pneumomediastinum, and pneumopericardium in a cat.21 In that situation it is believed that air passes across the wall of the pulmonary alveoli and along the connective tissue surrounding the pulmonary blood vessels into the mediastinum.22 However, positive pressure ventilation was not used in the cat of this report, and thoracic disease was not identified by radiography. It is of interest that the pneumomediastinum was mild, as determined by the abdominal radiographs. This may indicate that the pneumoretroperitoneum developed secondary to air dissection along fascial planes or that the subcutaneous emphysema was so extensive that it may have resulted in retrograde air movement from the subcutis into the retroperitoneal space.

Studies performed to determine predictors of outcome in human patients with PEG tubes have found a strong association between mortality and increasing age,23-24 low serum albumin concentration,25,26 decreased body mass index, and obstructive malignancies.2 In the cat of this report, low serum albumin concentration was considered to be secondary to malnutrition and, possibly, overhydration, and may have contributed to the complications that developed. However, wound healing after surgery was not compromised, and complications associated with the PEG tube were not detected. After PEG tube feeding for 2 weeks, the serum albumin concentration returned to reference range. It is arguable that hypoalbuminemia reflects the degree of malnutrition and general debility and as such may indicate an unsuitable candidate for PEG tube placement until the patient’s condition is improved. Unlike the situation in humans, age-related microscopic changes in the gastric wall have not been documented in cats. It may be speculated that age-related gastric mucosal atrophy may predispose to PEG tube complications, but evidence of such a relationship has not yet been detected in animals.

References

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