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Oesophageal perforation - A life threatening complication of balloon tamponade with a sengstaken-blakemore tube for bleeding oesophageal and gastric varices

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Introduction: Balloon tamponade using a Sengstaken- Blakemore (SB) tube is an effective lifesaving option in the management of acute oesophageal and gastric variceal bleeding. The procedure is often used as a temporising measuring to achieve short term haemostasis by applying direct compression to varices until more definitive treatment can be instituted. However, the use of a Sengstaken-Blakemore tube has been associated with a number of complications including aspiration pneumonia, airway obstruction, and oesophageal erosion and perforation.

Case Report/Method: We present a case of a patient who developed an oesophageal perforation following the insertion of a Sengstaken-Blakemore tube and performed a literature review of similar cases.

Results: A 53 year-old male presented with haematemesis and melena on the background of Child-Pugh B cirrhosis secondary to hepatitis C virus. The patient was commenced on Octreotide and Pantoprazole infusions, and endoscopic band ligation of oesophageal varices was later performed. Following the procedure, the patient suffered ongoing haematemesis and was transferred to the intensive care unit for resuscitation and urgent intervention. Rapid endotracheal intubation was followed by a gastroscopy that revealed fresh blood in the stomach. A Sengstaken-Blakemore tube was inserted and the gastric balloon inflated following confirmation of tube position with auscultation. A subsequent chest radiograph revealed a round radiolucent area corresponding to the gastric balloon projecting over the right hemi-thorax. The gastric balloon was immediately deflated and removed. A full thickness oesophageal tear was further confirmed by a repeat gastroscopy and computed tomography imaging.

Conclusions: Oesophageal perforation secondary to Sengstaken-Blakemore tube misplacement is a relatively rare complication, however it carries a high incidence of associated mortality. This case supports the literature and illustrates that auscultation alone is not an adequate method to confirm Sengstaken-Blakemore tube placement. We recommend the use of routine chest radiography or ultrasonography before and after balloon inflation. Endoscopic guided insertion is another method that can be utilised to ensure correct balloon positioning.

Biography

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