and was unremarkable except for a small hiatus hernia and mild esophagitis and gastritis. The patient underwent a PEG safely the next day. The removed NG tube was extremely stiffened and the lumen of the alpha portion was filled with amorphous whitish material.

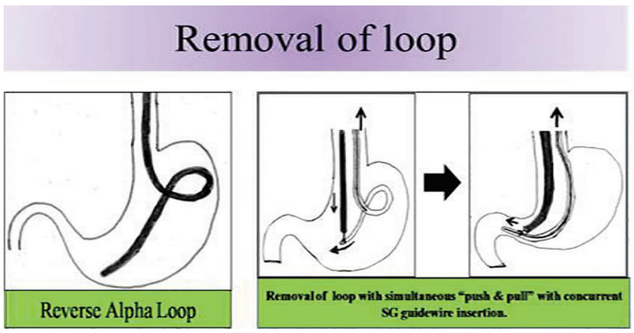

Figure 2: Manoeuvres to reduce reverse alpha loop

Discussion

NG tube feeding is a very common modality used to maintain the nutritional status of patients who are unable to take food orally. However, this simple tube can rarely cause complications including a few serious ones. The reported complication rates range from 0.3% to 8%.[1] NG tube looping, knotting and impaction are amongst the rare complications.[3] The NG tube can coil back on itself forming a loop or a knot when an excessive length of the tube is introduced into the stomach; however, the reported incidence of this is low.[4] Risk factors associated with looping and knotting of the NG tube are small bore tubes, patients with small stomachs, insertions of excessive length of the NG tube into the stomach, repetitive advancement of the tube and endotracheal intubation.[1] Loop formation may occur as a result of excessive manipulation of the NG tube after being placed, either by medical personnel or due to coughing or neck movement of patient.[2] It is also necessary to measure the appropriate NG tube length to be placed so that only the necessary length of the tube is inserted and any unrecognized tube movement can be detected.[1] This is done by measuring from the nostril along the side of the face past the ear and up to the xiphisternum and marking this length on the tube with a marker or a tape. The possibility of NG tube knotting should be kept in mind if a resistance is felt during its attempted removal. It can be confirmed by a plain x-ray or a film with water soluble contrast rendered via the NG tube.[1]

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References

1. Awe JAA. Self knotting of Nasogastric tube: An unusual and rare complication. *Global Advanced Research Journal of Microbiology*. 2014; 3(4):64-7.
2. Agarwal A, Gaur A, Sahu D, Singh PK, Pandey CK. Nasogastric tube knotting over the epiglottis: A cause of respiratory distress. *Anesth Analg*. 2002; 94:1659-60.
3. Liao GS, Hsieh HF, Wu MH, Chen TW, Yu JC, Liu YC. Knot formation in the feeding jejunostomy tube: a case report and review of the literature. *World J Gastroenterol*. 2007; 13:973-4.
4. Dasani B, Sahdev P. Knotting of a nasogastric tube: a case report. *Am J Emerg Me*d. 1991; 9(6):565.

Carcinosarcoma of Gall Bladder

Introduction

Carcinosarcomas of the gall bladder are rare neoplasms that constitute less than 1% of gall bladder malignancies[1]. The diagnosis of carcinosarcoma requires the presence of both malignant epithelial and mesenchyma[l] components. The other uncommon sites are the uterus, lung, oesophagus, kidney and pancreas.[2]

Case report

A 50 year old lady presented with the complaint of pain in the right upper quadrant of the abdomen. Complete

blood counts and liver and renal function tests were unremarkable. Serum CA 19-9 and CEA levels were within normal limits. An ultrasound abdomen showed a well distended gall bladder with thickened walls (7.2mm) with the presence of sludge. An abdominal CECT showed asymmetrical mural thickening predominantly in the body and neck region of the gall bladder with prominent intrahepatic biliary radicles and subcentimeter lymphadenopathy in the pre- aortic and para-aortic regions. In view of the radiological findings, the patient was planned for radical cholecystectomy. Per- operatively, the gall bladder was found to be totally replaced by a hard mass involving its fundus, body and neck but sparing the cystic duct and this was confirmed by a frozen section examination . A radical cholecystectomy was performed. The histopathology report was suggestive of carcinosarcoma of the gall bladder (pT2N0M0). Grossly there was a 5 x 4 cm tumor involving the body and fundus of the gall bladder with a large area of central necrosis. On microscopic examination, the tumor showed poorly differentiated epithelial and sarcomatous components infiltrating the perimuscular connective tissue with large areas of necrosis but no lymphovascular or perineural invasion. The serosa and peripheral rim of liver tissue were not involved. Immunohistochemistry supported the diagnosis of carcinosarcoma with the carcinomatous epithelial component expressing cytokeratin and the stromal component positive for vimentin and SMA. The patient had a steady, uneventful recovery in the post-operative period and was discharged on the sixth post-operative day. Keeping in mind the rarity of carcinosarcoma of the gall bladder and the fact that there was no established optimal adjuvant treatment defined in literature for the same, the case was discussed by a multidisciplinary tumor board. Following the board's approval, the patient was subjected to postoperative concurrent chemo-radiotherapy with weekly leucovorin and 5-flurouracil. The dose of radiation was 50.4Gy/ 28 fractions which was given 5 days/week for 5.5 weeks. A follow up PET-CT after completion of chemoradiotherapy showed hypermetabolic hypodense liver lesions and an FDG-avid nodular lesion in the right lung. The patient was then started on palliative chemotherapy with gemcitabine and cisplatin but was lost to follow up.

Discussion

Carcinosarcoma of the gall bladder is very difficult as imaging studies cannot differentiate it from carcinoma.[1-3] The diagnosis of carcinosarcoma requires histopathology and immunohistochemical staining. Microscopically, the diagnosis requires the presence of both a malignant epithelial and a mesenchymal component. Currently, there are no recommended treatment guidelines for carcinosarcoma. It is treated in the same way as carcinoma gall bladder. No optimal post-operative adjuvant therapy has been established. Previous studies have reported that there is no clear advantage of chemo- radiotherapy after surgery. The overall prognosis is very poor.[3,4] The prognostic factors are size of the tumor and invasion of surrounding tissues by the tumor. Patients with tumors smaller than 5 cm have a longer survival. The 5-year survival rate after a curative resection of carcinosarcoma gall bladder is 88.9 % when the invasion is restricted to the muscularis propria.[3,4]

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References

1. Yan W, Xiaodong G, Zhenyang L, Jianbin X, Zongyou C. Gallbladder carcinosarcoma accompanied with bile duct tumor thrombi: A case report. *Oncol Lett*. 2013;5:1809-12
2. Sung BP, Yang HK, Hye LR, Gi BC, Seong KH. Primary carcinosarcoma of the gallbladder. *J*

Korean Surg Soc. 2012;82:54-58
3. Al-Sheneber IF, Jaber T, Huttner I, Arseneau J, Loutfi A. Carcinosarcoma of the gallbladder: A case report and review of literature. *Saudi J Gastroenterol* 2002;8:22-4
4. Huguet KL, Hughes CB, Hewitt WR. Gallbladder carcinosarcoma : a case report and literature review. *J Gastrointest Surg*. 2005;9:818-21

Initial Placement of a Percutaneous Balloon-Retained Gastrostomy using a transgastrostomic endoscope.

Introduction

The first percutaneous endoscopic gastrostomy (PEG) placement in our country, Algeria was reported seven years earlier by our team. Since that first report, only one hundred PEG have been performed. All PEG have been performed with the pull method reported by Gauderer and Ponsky in 1980.[1] The Balloon PEG (BPEG), a balloon-retained tube is often placed as a replacement for PEG. However, they can be placed as an initial tube feeding under endoscopic guidance by the introducer-type PEG technique first described by Russell et al. in 1984.[2] This method utilizes the Seldinger technique and requires a specific kit (trocar with peel-away sheet catheter). Recently, given the lack of both pull PEG kits and the peel-away sheet catheter despite the increasing demand, we attempted an initial placement of a BPEG, the only available PEG type. Without a peel-away sheet catheter, we had two challenges: the first one was to create the gastrocutaneous stoma and the second one was to dilate the stoma to introduce our BPEG tube. Necessary equipment for this procedure included a syringe with a small-gauge needle, a scalpel, local anesthetic, a large-gauge puncture needle sheath catheter, a wire, polypectomy snare or foreign body forceps, a reusable 24 Fr pull type PEG tube without external bumper, Savary-Gilliard guide wire, an 18 Fr BPEG (Wilson COOK) and a small caliber endoscope (GIF XP–260; Olympus Optical Co., Ltd., Tokyo, Japan).

Case Report

First, a gastrocutaneous tract was created with the classic pull method. The procedure was performed after prior fasting of at least 6 h, under strict aseptic conditions, and antibiotic prophylaxis. The patient was positioned supine, under mild sedation. Two operators were required to create the gastrocutaneous stoma: one performed the endoscopy while the second worked from the abdominal site. After maximal air insufflations, the exact site of the PEG insertion was determined by gastroscopic transillumination using the small caliber endoscope orally inserted and with finger indentation.

The abdominal wall was cleaned with disinfectant and an incision was made under local anesthesia. The puncture needle was inserted through the incision into the stomach cavity under endoscopic guidance. Next, a wire was inserted into the stomach through the outer sheath of the puncture needle, grasped by a snare or a foreign body forceps, and pulled out by the endoscope through the mouth. The endoscope was than embedded in the pull type PEG tube without external bumper **(Figure 1A)**. The whole PEG tube and the embedded endoscope was attached to the wire and pulled out through the gastrocutaneous tract creating and dilating the gastrocutaneous stoma **(Figure 1B)**. Then the transgastrostomic endoscope was dis-embedded from the PEG tube. A Savary-Gilliard guide wire was then pushed through the scope to the cutaneous side and inserted in a BPEG. Simultaneously, the whole endoscope and BPEG tube on the metallic guide wire was pushed from the cutaneous side and pulled out through the mouth. Under direct endoscopic view, the BPEG was introduced into the stomach **(Figure 1C)** and the internal retention balloon inflated with the prefilled syringe (20 cc) (Figure 1D). Finally, the endoscope and the Savary-Gilliard guide wire were pulled out.

A total of 4 procedures of initial placement of BPEG tube were successfully performed in 4 patients. The classic introducer-type PEG technique requires smaller diameter feeding tubes, resulting in more frequent occlusion and dislodgement which may be reduced by