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## Introduction

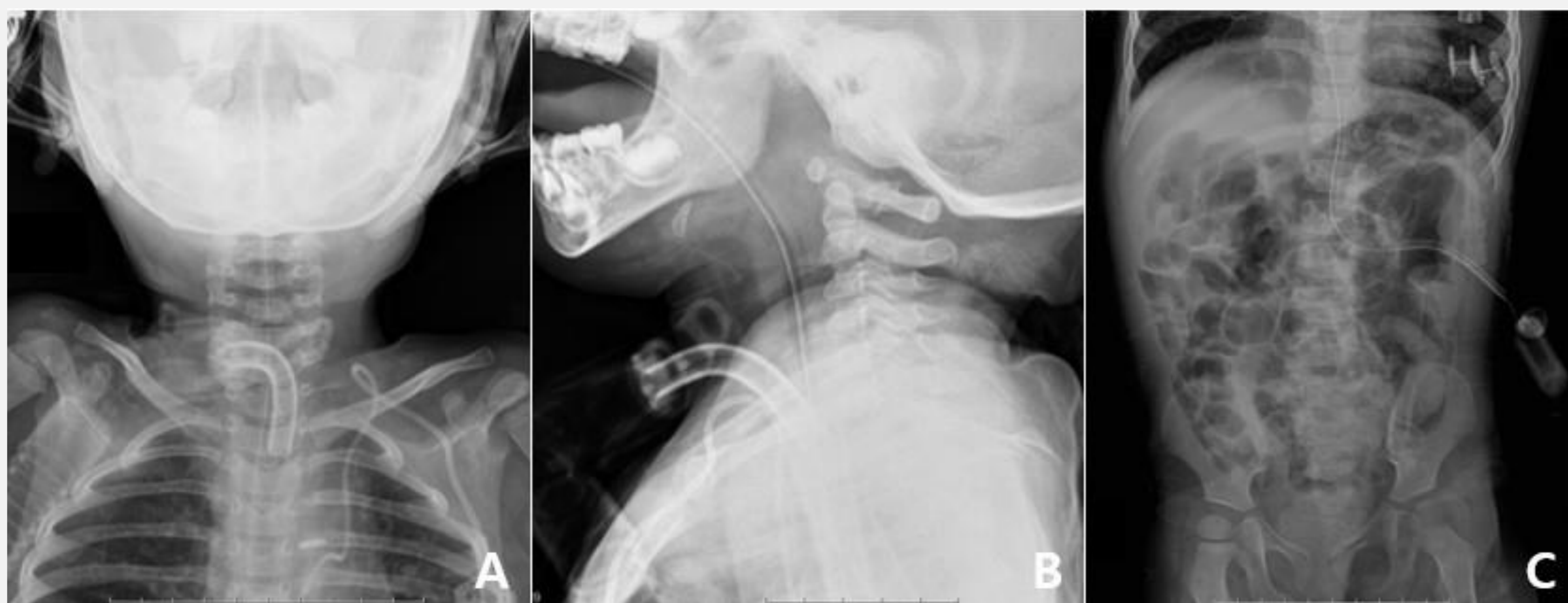
Gastrostomy tubes are widely used in children requiring long-term enteral nutrition when oral intake is insufficient to meet caloric, nutritional, or hydration needs. Gastrojejunostomy (GJ) tubes are preferred in patients at high risk of aspiration, with severe gastroesophageal reflux disease (GERD) refractory to medical or surgical therapy, gastroparesis, or when intragastric feeding is contraindicated. Despite their utility, jejunal extensions may migrate proximally, leading to complications such as retrograde dislodgement and obstruction. We report a rare pediatric case of oral retrograde extrusion of a GJ tube.

## Case Report

A 2-year-6-month-old girl, born preterm at 28+3 weeks with extremely low birth weight (920 g) via cesarean section for cord prolapse, had a complex medical history including PDA ligation, tracheostomy with 24-hour home ventilation, ASD device closure, and PEG with fundoplication. Due to persistent vomiting after fundoplication, a GJ tube was inserted and later exchanged. She presented to the emergency department with a foreign body visible in the throat after two hours of nausea and vomiting. On physical examination, a tube-like structure was observed in the oral cavity (Fig. 1). Neck radiographs and abdominal plain films confirmed retrograde migration of the jejunal limb into the esophagus and mouth (Fig. 2). The GJ tube was removed, and a temporary 12-Fr Foley catheter was placed through the gastrostomy tract (Fig. 3). During follow-up, reinsertion of a GJ tube was unsuccessful due to occlusion and dislodgement, and the device was converted to a gastrostomy tube. At 1-month follow-up, the gastrostomy functioned well, and symptoms of vomiting and reflux had resolved. Regular gastrostomy tube exchanges were scheduled at three-month intervals.



**Fig. 1.** Oral protrusion of the migrated gastrojejunostomy tube at presentation



**Fig. 2.** Radiographs obtained at arrival: (A) neck anteroposterior view, (B) neck lateral view, and (C) abdominal plain film demonstrating retrograde migration of the jejunal limb into the esophagus and oral cavity.



**Fig. 3.** Abdominal plain film following removal of the gastrojejunostomy tube and temporary gastrostomy reinsertion with a 12-Fr Foley catheter.

## Conclusion

In children with severe reflux symptoms and an indwelling GJ tube, visualization of a tube-like foreign body in the mouth should raise strong suspicion for oral retrograde extrusion. Importantly, even when the tube is not externally visible, retrograde malposition along the gastrointestinal tract may occur and increase aspiration risk. Persistent nausea or vomiting in GJ-fed children should prompt careful evaluation for tube migration.