Title: **A strange case of chronic buried bumper syndrome.**

Authors: V. Clemente+, A. Eramo+, M.C. Trotta+, F.Fabiocchi+, B. Novi+, L. Vannella+, D. De Santis*, M. Barbieri*, V. De Biase*, G.M. Giorgetti+

Affiliations: + MD, Department of Clinical Nutrition, S.Eugenio Hospital, Piazzale dell'Umanesimo 10, 00144, Rome, Italy; * Nurse, Department of Clinical Nutrition, S.Eugenio Hospital, Piazzale dell'Umanesimo 10, 00144, Rome, Italy

Background and aims: Percutaneous endoscopic gastrostomy (PEG) is the preffered route of feeding in patients with a functional gastrointestinal system, who required long term enteral nutrition. Generally it is considered safe, but there is the potential risk of complications. We report the case of 81 year-old female admitted to our hospital to replacement of the first implant peg.

Methods: Patient had a history of abdominal surgery with polypropylene net placement and was affected by dementia and Parkinson's disease with dysfagia, for which she positioned PEG. After one month from PEG placement, she had a local wound infection, that was treated with systemic antibiotic therapy. Therefore replacement of the first implant peg was attempted without endoscopy using a "cut and push" technique, without result and recover of the bumper and so a new first PEG implant was made. Patient cames to our observation to perform the replacement of the new first implant peg.

Results: Patient presented to our attention in poor general conditions, with persistent local wound infection. We tried to extract the PEG with traction but without success, and so it was cut and recovered endoscopically. A first implant PEG and an ileostomy drainage bag in the site of the previous PEG were placed. The patient was hospitalized. Parenteral nutrition and systemic antibiotic therapy were initiated. An abdomen computed tomography with contrast medium showed the presence of two PEG, one with an abscess collection area, incarcerated in the abdominal wall in the site of previous surgery for the laparocele and the second that was the last one positioned by us. Surgical removal of the incarcerated PEG was not possible due to the patient's general clinical condition. Therefore we decided to replace a first implant PEG with percutaneous endoscopic jejunostomy to made both enteral nutition through the jejunal route and to have a route of further gastric drainage. Patient was discharged in better condition with enteral feeding and ileostomy bag.

Conclusion: Buried bumper syndrome can occur in tubes with an internal bumper as early as 3 week after PEG tube insertion. Excessive causes subsequently migration of the tube toward the abdominal wall. The tube becomes dislodged anywhere between the gastric wall and the skin along the PEG tract. In our case PEG was incarcerated in the polypropylene net.