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Eternal Vigilance

Feeding jejunostomy in advanced malignancy of oesophagus under combined coeliac plexus and bilateral TAP blocks - A case report

Sir,

Oesophageal carcinoma is the 8th most common cancer and the 6th leading cause of malignancy-related deaths worldwide.[1] Surgery, chemotherapy and radiotherapy are the listed treatment options in majority of individuals. In some individuals, where there are extensive metastases, with complete obstruction of the digestive tract, feeding jejunostomy is the procedure contemplated to provide nutrition.[2] As such, patients are already having extensive secondaries and there will be multiple problems which may hinder a safe and smooth anaesthetic journey. Transversus abdominis plane (TAP) block[3] is a technique of administering local anaesthetic drug in a plane between internal oblique muscle and transversus abdominis muscle usually used to counter post-operative pain after laparotomy. Coeliac plexus is the prime sympathetic chain of the abdominal viscera and hence used commonly to treat chronic pain.[4] We present here a successful conduct of such a case coming for feeding jejunostomy with combined TAP and coeliac plexus blocks.

A 55-year-old female, weighing 45 kg, was admitted with complaints of difficulty in swallowing solids for 30 days and liquids for three days, with vomiting minimal bloody streaks. She was a known case of upper oesophageal malignancy with multiple secondaries. She had a complete obstruction of the left bronchus and she had metastases of D11-D12 vertebrae. There were many enlarged lymph nodes in the abdomen. She was posted for feeding jejunostomy. The vitals were stable (pulse 100/minute, blood pressure 126/80 mmHg) with a saturation of 90%. Respiratory rate was 35-40/minute. The cardiovascular system was normal. Bilateral wheeze was present which was managed with nebulised budesonide and levosalbutamol. As general anaesthesia and neuraxial blocks were not possible,

we planned for a regional block. Visceral pain could be countered with a coeliac plexus block and somatic pain with bilateral TAP block. An ultrasound guided transgastric coeliac plexus lock was administered with 10 ml of 1% lignocaine and adrenaline [Figure 1]. A minimal but acceptable fall in systolic blood pressure was found. After a gap of 15 minutes, bilateral TAP block was given under USG guidance with 15 ml of 0.25% bupivacaine each side. The gap was allowed to dim the chances of any toxic symptoms. 25 μg of intravenous fentanyl was given. Oxygen, 4 litres/minute with a face mask was administered. Surgery i.e., feeding jejunostomy after an adhesiolysis was completed within 30 minutes with a minimal discomfort in the lateral part of the abdominal wall where the tube was taken out. There was no pain in visceral handling. A very satisfactory muscle relaxation was felt by the surgeon. There were no post-operative complications. Tachypnoea, with a saturation of around 90%, remained the same as preoperative condition. The patient was discharged after three days with feeding jejunostomy and regular feeds.

Feeding jejunostomy is one of the common palliative procedures in gastrointestinal malignancies with obstruction. The surgery involves a nociception in the midline just above and below umbilicus. Hence, a bilateral TAP lock is likely to cover the area of somatic nociceptive input. But handling the gut may cause discomfort. This can be countered by a coeliac plexus block. We did give only a minimal sedation in the form of 25 μg of fentanyl. Bharati *et al*.[4] have done feeding jejunostomy under bilateral TAP block with dexmeditomidine infusion. We did not resort to such heavy sedation as there was a significant preoperative respiratory compromise in our case. Regional anaesthesia in the form of neuraxial blockade was not feasible in our case because of multiple vertebral secondaries. Ye PE *et al*.[5] have done 5 cases of rejejunostomy under local anaesthesia. This series of 5 cases were only a rejejunostomies which involved only minimal nociception. Freeman JB *et al*.[6] have studied many cases of jejunostomy and concluded that the surgery can be done under local anaesthesia. In our case, the surgeon expected some difficulty in locating the jejunum due to a previous laparotomy. This prompted us to go ahead with a coeliac plexus block to overcome any possible surgical difficulty. Hence, we combined coeliac plexus block to tackle visceral pain and TAP block for somatic pain. This is the first such reported case in the literature. We conclude that feeding jejunostomy as a part of palliative care in advanced oesophageal malignancies can be successfully done under combined coeliac plexus and bilateral TAP blocks.

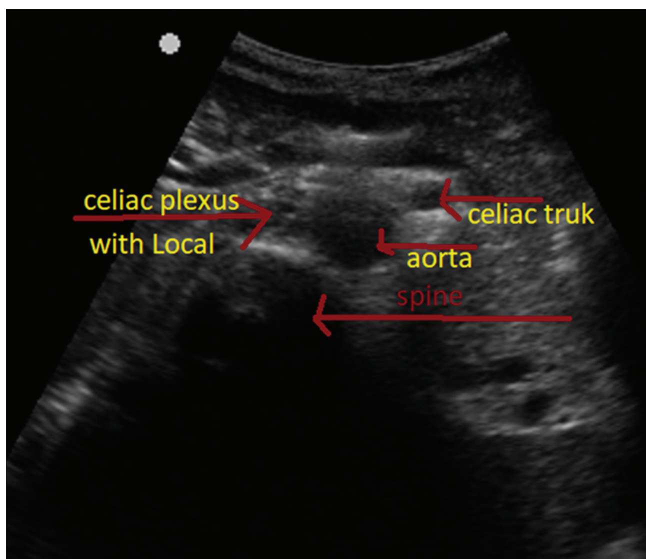

Figure 1: Showing USG guided trans gastric celiac plexus block

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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