Abstract
A critical point of nasogastric feeding tube placement, potentially resulting in an unsafe and/or non-effective operation of the device, is the monitoring of its proper placement into the stomach. A properly obtained and interpreted radiograph is currently recommended to confirm placement. We reported the case of a 68-year-old demented woman referred for complicated dysphagia. A nasogastric tube was blindly inserted and its placement was confirmed by the radiologist. Enteral nutrition was initiated but the patient began to vomit immediately. After reviewing the radiograph it was understood that a gastric loop in the tube and its tip pointing upwards did not allow a safe infusion of the feeding formula. It is not enough having the radiologist reporting that a nasogastric feeding tube is placed in the stomach; the inclusion in the report of specific warnings on any potential cause of malfunctioning of the device should be considered. The presence of a gastric loop should be taken into account as a cause of potential malfunctioning.

Keywords