

A 73-year-old Hispanic male with a history of stage IV chronic kidney disease and three-vessel coronary artery disease was admitted for coronary artery bypass graft surgery and mitral valve repair.

On post-operative day two, the patient developed cardiac tamponade and subsequently progressed to a cardiac arrest while temporary pacing wires were being removed.

Advanced cardiovascular life support and emergent exploratory sternotomy were performed, and the patient was transferred to the intensive care unit (ICU) for further care.

During the patient's ICU admission, his renal failure progressed, requiring hemodialysis.

A nasogastric tube was placed on post-operative day two for establishing early enteral nutrition.

PEG tube insertion was suggested given his cognitive impairment and poor swallowing function on the Modified Barium Swallow test.

His coagulation profile prior to the procedure revealed an international normalized ratio of 1.04 and partial thromboplastin time of 36 seconds.

A complete blood count showed a hemoglobin of 11.6 grams per deciliter, a hematocrit of 34.9%, and 281×10^3 platelets per microliter.

His blood urea nitrogen was 55 milligrams/deciliter, and his serum creatinine was 5.22 milligrams/deciliter.

The patient was taking aspirin 81 mg per day due to recent cardiac surgery, but was not on any anticoagulant agents.

He also did not have a history of coagulopathy.

PEG tube insertion was performed on post-operative day eight under intravenous anesthesia.

The esophagogastroduodenoscopy (EGD) was accomplished without difficulty, revealing diffuse moderately erythematous mucosa without bleeding in the gastric antrum.

While attempting PEG tube placement, a rapidly expanding hematoma (Figure 1) developed at the needle insertion site.

The procedure was stopped and the patient was sent back to the ICU with a nasogastric tube.

A single dose of intravenous desmopressin (0.3 microgram/kilogram) was administered under the suspicion of uremic bleeding.

No further gastrointestinal bleeding events were noted.

To assess platelet function, a platelet function assay (PFA) was ordered after desmopressin injection.

PFA collagen/epinephrine closure time was 195 seconds (normal <174 seconds), and collagen/ADP closure time was 76 seconds (normal <120 seconds), indicating platelet dysfunction due to either aspirin or uremia.

Aspirin was discontinued, and he was monitored with a daily complete blood count and metabolic panel.

Three days later the patient underwent a second attempt at PEG tube placement.

PFA collagen/epinephrine closure time prior to this procedure had gone down to 141 seconds, possibly due to withholding aspirin and an improvement in renal function.

EGD showed an area of flat, bluish gastric submucosal bruising at the site of the previous hematoma (Figure 2).

The PEG tube was placed successfully at an adjacent site.

Over the course of the following month, the patient continued to undergo feeding through the PEG tube with no adverse events.