

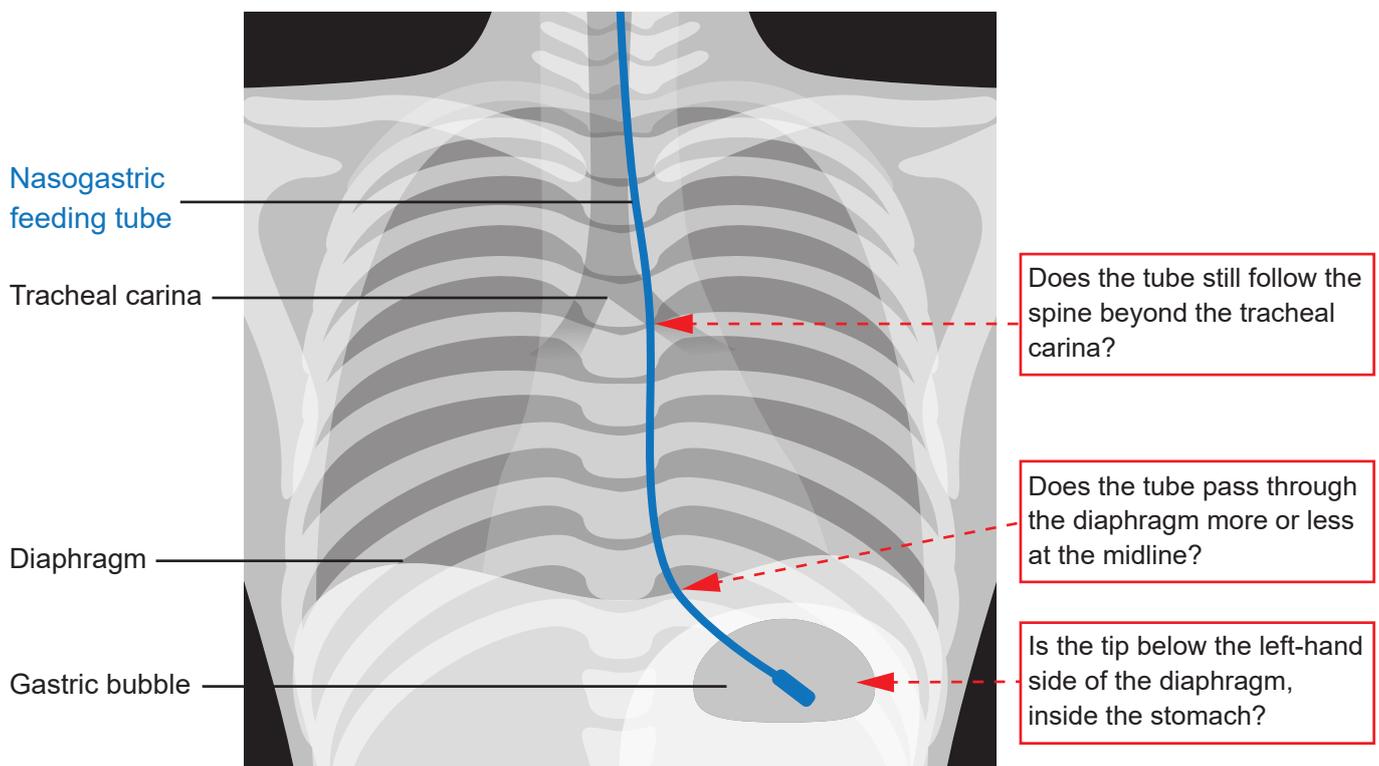
## Wrongly Inserted Nasogastric Feeding Tube Overlooked When Checking X-ray Images

**Cases have been reported in which a physician checked the placement of a nasogastric feeding tube on an X-ray image after insertion, but did not notice that it had been wrongly inserted.**

Thirty such cases were reported between January 1, 2016 and November 30, 2024. This information was compiled on the basis of the content featured in the Recurrence of Events and Occurrence of Similar Events section of the 77th Quarterly Report.

\*Please refer to the X-ray image of a wrongly inserted gastric tube shown on p.77 of the 77th Quarterly Report.

### Key points when checking the route of a nasogastric feeding tube on an X-ray image



◆ [Medical Safety Information No.121 "Wrongly Inserted Nasogastric Feeding Tube"](#) focused on cases in which a nasogastric feeding tube was inserted into the airway in error, but was judged to have entered the stomach based solely on listening for bubbling sounds (Whoosh test) and, as a consequence, enteral nutrients or oral medication were injected into it.

## Wrongly Inserted Nasogastric Feeding Tube Overlooked When Checking X-ray Images

### Case 1

Physician A replaced the nasogastric feeding tube of a patient being treated in ICU. After inserting the tube, Physician A and Physician B checked the image on the display of a portable X-ray device, but wrongly determined that the tip of the nasogastric feeding tube was inside the stomach. When the nurse injected oral medication and enteral nutrients into the tube, the patient's respiratory condition deteriorated. Physician C performed a bronchoscopy and found that the nasogastric feeding tube had been inserted into the trachea.

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### Case 2

The patient had dysphagia and was to begin receiving tube feeding, so the nurse inserted a nasogastric feeding tube. Physician A subsequently checked the X-ray image, but wrongly determined that the tip of the nasogastric feeding tube was positioned appropriately. When the nurse injected oral medication and enteral nutrients into the tube, the patient's respiratory condition deteriorated. When Physician B checked the X-ray image taken after insertion of the nasogastric feeding tube, they found that the tube had been inserted into the lung.

### Preventive measures taken at the medical institutions in which the events occurred

- The key points for checking the route of a nasogastric feeding tube on an X-ray image will be summarized and circulated to staff.
- When checking X-ray images after insertion of a nasogastric feeding tube, staff will carry out checks of not only the position of the tip, but also the tube's route, in accordance with these key points.

The measures above are examples. Please consider initiatives suitable for your own facility.

\* As part of the Project to Collect Medical Near-Miss/Adverse Event Information (a Ministry of Health, Labour and Welfare grant project), this medical safety information was prepared based on the cases collected in the Project as well as on opinions of the "Comprehensive Evaluation Panel" to prevent the occurrence and recurrence of medical adverse events. See the Project website for details.

<https://www.med-safe.jp/>

\* Accuracy of information was ensured at the time of preparation but cannot be guaranteed in the future.

\* This information is intended neither to limit the discretion of healthcare providers nor to impose certain obligations or responsibilities on them.

