Percutaneous endoscopic gastrojejunalostomy (PEGJ) tube placement is a technically simple procedure that is the most commonly used method of endoscopic jejunalostomy. However, it only allows the placement of jejunalostomy tubes with a diameter of 3–4 mm (9–12 Fr), which are prone to luminal occlusion and migration [1–3]. In addition, it has been reported that PEGJ tubes may not prevent aspiration resulting from frequent retrograde tube migration into the stomach and reflux of intestinal contents [1–3]. Direct percutaneous endoscopic jejunalostomy (DPEJ) appears to be a better alternative to PEGJ, as it allows placement of the larger-diameter DPEJ tube in the proximal jejunum and is associated with a reduced risk of pulmonary aspiration. However, the smaller lumen, mobility, active peristalsis of the jejunal loop, and difficulty in transillumination make this procedure much more difficult than PEGJ tube placement. To overcome the above challenges, we anchored the jejunum against the abdominal wall with a 21-gauge finder needle before passing the needle and trochar (Figures 1, 2). In addition to stabilizing the jejunum, the finder needle penetrates the soft tissue easily and is less likely to cause visceral trauma. We carried out DPEJ tube placement using this method in 21 patients for the indications listed in Table 1. The method was successful and resulted in proper placement of DPEJ tubes in 17 patients (a success rate of 81%). In four patients, DPEJ tube placement could not be completed due to an inability to achieve adequate transillumination. No significant or major complications were associated with the procedure. Minor complications in two patients included cellulitis and cutaneous leakage of enteral contents. On the basis of this experience, it appears that DPEJ tube placement with this method is a safe and effective means of providing prolonged jejunal nutrition. Similar observations have been reported by other investigators [4,5]. We believe that the application of this modified technique could lead to wider acceptance of DPEJ tube placement in clinical gastroenterology.

References


Corresponding author

S. K. Dutta, M.D.
Division of Gastroenterology, Dept. of Medicine, Hoffberger Professional Center 2435 W. Belvedere Ave., Suite 51, Baltimore, Maryland 21215-5271, USA
Fax: +1-410-601-5757
E-mail: sudhirdupta@hotmail.com

DOI: 10.1055/s-2006-925159