

PEG J tube placement with optimization of J tube insertion

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We present a case series of 5 patients who underwent placement of a PEG tube followed by a J extension tube (PEG-J). PEG-J placement is usually performed as a 2-step procedure and is used for a variety of conditions such as gastroparesis. First, the PEG tube is placed using endoscopic transillumination, followed by tube placement with the pull method, and trimming of the PEG tube to approximately 20 cm. This is followed by insertion of the J extension tube through the PEG tube; the J extension tube is grasped by an endoscope and guided through the pylorus to a position distal to the ligament of Treitz. Two

common problems related to the length of the PEG tube portion can occur when placing the J tube. A short PEG tube may not allow advancement of the J tube distal enough because of looping. On the other hand, a PEG tube that is too long can prevent adequate J tube insertion.

Although the adverse events of PEG tubes are well documented, we did not find any published literature addressing problems with the placement of J tube extensions, although it is a frequently occurring problem in our clinical practice. Therefore, we have tried to address this problem.

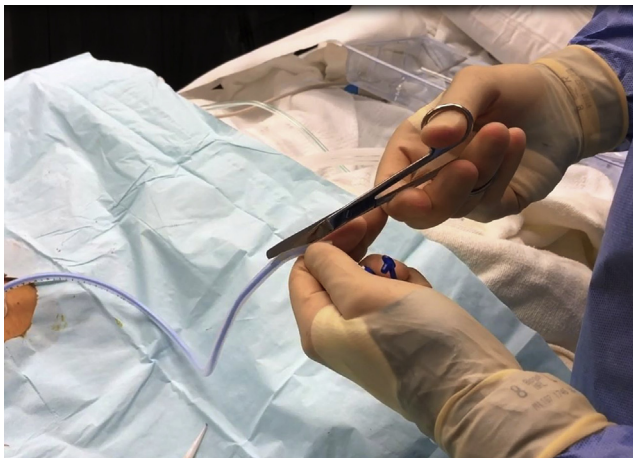


Figure 1. The silicon portion of the PEG tube is cut by using the sharp tip of the scissors provided with the PEG tube kit.

PROCEDURE

We present our technique for PEG-J tube placement, which allows optimal PEG tube length independent of the depth of J tube insertion. After PEG tube placement with the pull method, only the introducer is cut, and the entire length of the silicon PEG tube is left in situ. The tip of the J tube is lubricated and inserted into the PEG tube. In parallel, the J tube is grasped, in our cases with an endoclip, and gently maneuvered into the duodenum and eventually into the jejunum while the J tube is threaded into the PEG tube, matching the pull force from the J tube insertion by the endoscope.

We use a pediatric colonoscope to achieve deep jejunal intubation; however, either the adult colonoscope or enteroscope are adequate alternative endoscopes. Once the

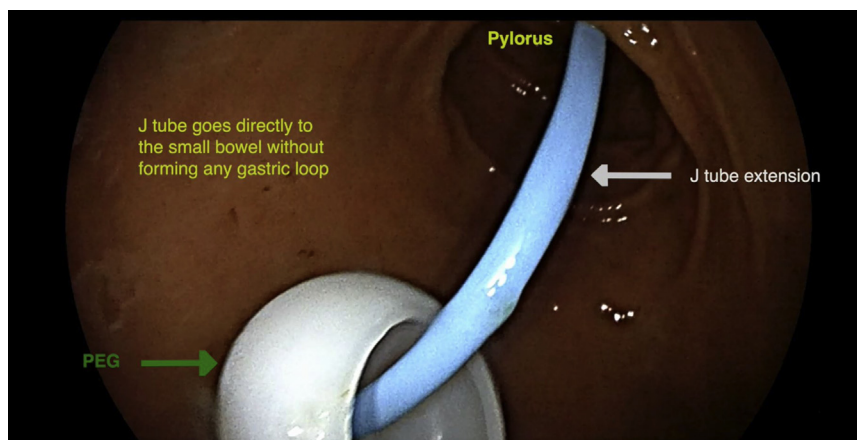


Figure 2. Optimal placement of the PEG-J tube without any looping or sharp angulation in the stomach.

J tube seal reaches the silicon portion of the PEG tube and further introduction is needed, a 5- to 10-cm portion of the silicon is cut using the sharp tip of the scissors provided with the PEG tube kit (Fig. 1). These steps of “peel and advance” are repeated until the J tube is advanced to the desired location and clipped to the jejunum mucosa.

This technique allows optimal J tube placement without gastric looping or a too-short jejunal J tube insertion (Fig. 2).

OUTCOME

We followed all patients over 4 weeks. No PEG-J tube replacement adverse events were noted. Two patients had abdominal imaging at 4 weeks documenting optimal J tube placement without J tube loops or short J tubes resulting in proximal migration of the J tube (Video 1, available online at www.giejournal.org).

DISCLOSURE

All authors disclosed no financial relationships.

Abbreviation: PEG-J, percutaneous endoscopic transgastric jejunostomy.

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