A disrupted fistulous tract is a rare complication associated with the replacement of a gastrostomy or jejunostomy tube [1]. It is important to confirm that the replacement tube is accurately positioned in the same site as the previous one. Although adverse events following fistula disruption have been reported [2, 3], little is known about how the fistula can be successfully recanalized.

We have encountered disruption of the tract in six cases with a gastrocutaneous fistula and two cases with a jejunocutaneous fistula. The disruption was identified on a fistulogram by the extravasation of Gastrografin (arrowhead) (● Fig. 1). We first attempted to insert a guide or loop wire into the gastrointestinal tract from the original skin incision under fluoroscopic guidance. However, the wire failed to pass into the gastrointestinal lumen in five of the eight patients (● Fig. 2). In these five patients, we then inserted an ultrathin endoscope (GIF XP-260 or XP-260N, Olympus Optical Co., Ltd., Tokyo, Japan) into the gastric or jejunal lumen from the site of the skin incision, as described previously [4, 5]. The endoscope was retrogradely passed upward toward the oral cavity via the esophagus (● Fig. 4), and then a loop wire was passed out though the mouth via the biopsy channel (● Fig. 5). A new feeding tube was positioned in the recanalized gastrocutaneous tract, using the pull-through technique (● Fig. 6).
tract using the pull-through technique (Fig. 6).

Percutaneous endoscopic gastrostomy is usually carried out again after the closure of a disrupted gastrocutaneous tract when a guide wire cannot pass through the disrupted tract. An endoscopic approach through the original skin incision facilitates the search for a route into the gastrointestinal tract. This technique is useful for the recanalization of the fistula and continuation of enteral feeding.

References
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S. Nishiwaki¹, H. Araki², J. Takada¹, N. Watanabe¹, T. Asano¹, M. Iwashita¹, A. Tagami¹, H. Hatakeyama¹, T. Hayashi¹, T. Maeda³, K. Saitoh¹
¹ Department of Internal Medicine, Nishimino Kosei Hospital, Yoro-cho, Yoro-gun, Gifu, Japan
² Department of Gastroenterology, Graduate School of Medicine, Gifu University, Gifu, Japan

Corresponding author
S. Nishiwaki, MD
Department of Internal Medicine
Nishimino Kosei Hospital
986 Oshikoshi Yoro-cho
Yoro-gun Gifu 503-1394
Japan
Fax: +81-584-32-2856
wakky@nishimino.gfkosei.or.jp

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