**Direct percutaneous endoscopic jejunostomy tube placement using a fine needle for jejunal anchoring**

Percutaneous endoscopic gastrojejunos¬
tomy (PEGJ) tube placement is a techni¬
cally simple procedure that is the most com¬
monly used method of endoscopic jeju¬
nostomy. However, it only allows the place¬
ment of jejunostomy 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 report¬
ed that PEGJ tubes may not prevent aspira¬
tion resulting from frequent retro−
grade tube migration into the stomach and reflux of intestinal contents [1–3]. Direct percutaneous endoscopic jejunos¬
tomy (DPEJ) appears to be a better alterna¬
tive 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 peri¬
stasis of the jejunal loop, and difficulty in transillumination make this procedure much more difficult than PEGJ tube place¬
ment. To overcome the above challenges, we anchored the jejunum against the ab¬
dominal wall with a 21-gauge finder nee¬
dle 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 pa¬
tients 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 tech¬
nique could lead to wider acceptance of DPEJ tube placement in clinical gastroen¬
terology.

**References**

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2. Henderson JM, Strodel WE, Gilinsky NH. Limitations of percutaneous endoscopic jeju¬
nostomy. JPEN J Parenter Enteral Nutr 1993; 17: 546–550
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**Table 1 Indications for direct percutaneous endoscopic jejunostomy tube placement**

<table>
<thead>
<tr>
<th>Patients</th>
<th>n</th>
<th>%</th>
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<tr>
<td>Gastroesophageal regurgitation</td>
<td>12</td>
<td>57</td>
</tr>
<tr>
<td>Pulmonary aspiration</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Gastropareis</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Gastric resection</td>
<td>2</td>
<td>10</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>21</strong></td>
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