

Think 'Inside The Loop' : A Novel Method for Repositioning A Migrated G-J Tube

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Introduction

Gastrojejunostomy tube (G-J tube) migration is common in patients requiring long term percutaneous enteral feeding. These patients often present with forceful vomiting and decreased PO intake.

Case Presentation

- A 26-year-old female with a history of cystic fibrosis (CF), chronic malnutrition requiring enteral feeds, CF-related liver disease and variceal bleeding presented with 5 days of abdominal pain and multiple episodes of coffee ground emesis.
- Physical exam was notable for epigastric tenderness without peritoneal signs. Bright red blood was visible in the emesis bag. The skin around the G-J tube insertion site was non-tender with no signs of infection.
- CT of the abdomen revealed gastrosplenic varices and appropriate positioning of the enteral tube. There was no evidence of GI perforation or obstruction.
- The patient's tube feeds were held and IV fluids and Zofran were administered.
- An EGD performed demonstrated a patent gastrostomy tube in the gastric body with jejunal tail displacement. There were blood clots in the body of the stomach but no evidence of active bleeding.
- Given the suspicion that the migrated feeding tube was the cause of the patient's symptoms, a decision was made to reposition it.
- The patient's symptoms resolved after the EGD and she was discharged in stable condition with a functional G-J tube.

EGD Imaging

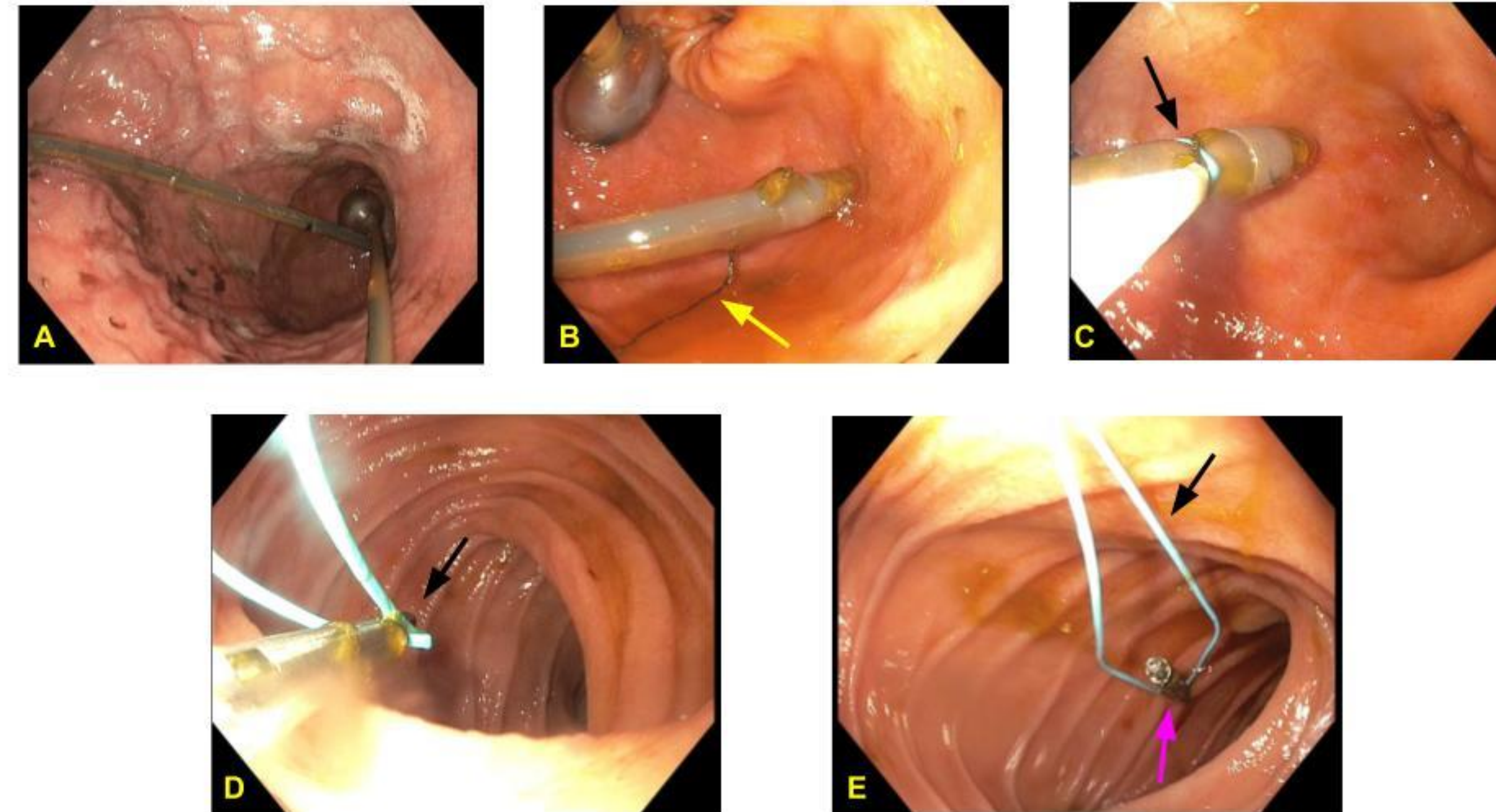


Figure 1. Upper Endoscopy:

- Intact gastrostomy with a patent G-J tube present in the gastric body. The jejunal tail is coiled up in the lumen of the stomach.
- The tip of the G-J tube with surrounding trauma to the body of the stomach characterized by edema, erythema, and inflammation. The thread at the tip of the G-J tube had degraded (yellow arrow).
- An endoloop was tied at the neck of the tip of the G-J tube (black arrow) to serve as a substitute for the suture.
- A cold snare was used to secure the endoloop (black arrow) and drag the tip of the G-J tube into the jejunum.
- The endoloop (black arrow) attached to the tip of the G-J tube was secured to the wall of the jejunum using a Resolution Clip (pink arrow).

Discussion

Migration of a G-J tube is commonly associated with severe motility disorders such as cystic fibrosis. Oftentimes the tube will loop inside the stomach or continue toward the esophagus. The tube itself can cause gastric outlet obstruction, leading to gastric distention, nausea, and vomiting. These patients are an aspiration risk and should be initially managed with IV hydration, antiemetics, and stopping tube feeds. It is important to assess for complications such as sepsis, hemorrhage, buried bumper, or perforation of the GI tract. If the feeding tube is patent, it is reasonable to have it repositioned based on clinical judgment and provider expertise.