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Response:

We read with interest the comments by Samiullah et al regarding similarities between the endoscopic appearance of duodenal mucosa in visceral leishmaniasis and in Whipple’s disease.

Obviously any condition that involves diffuse infiltration of duodenal mucosa results in an endoscopically/macroscopically comparable appearance with engorged and flattened villi and massive yellowish or greenish coloration caused by impaired absorption of bile, as noted in our original report. A very similar appearance of mucosa may be seen in a diffuse infiltration of the duodenum by lymphoma, as observed by the authors in several patients.

Although leishmaniasis is endemic in the Mediterranean basin, the disease itself is extremely rare in Bosnia and Herzegovina and practically nonexistent in northern parts of the country because vector insects (Phlebotomus) are not present that far north. Duodenal leishmaniasis is not very common and is recognized as an important problem in patients with acquired immunodeficiency.

The clinical presentation of visceral leishmaniasis is similar in immunocompetent and immunodeficient patients, although in immunodeficient (HIV-infected) patients, splenomegaly occurs less frequently. Nevertheless, the classic pentad of fever, weight loss, hepatosplenomegaly, pancytopenia, and hypergammaglobulinemia is usually present. As an important note, endoscopy may show a normal mucosal appearance in as many as one half of cases.

Whipple’s disease, on the other hand, is characteristically a wasting illness caused by prominent malabsorption with substantial weight loss, diarrhea, steatorrhea, and arthralgia/ arthritis. To complicate things even further, patients with lymphoma may have clinical features that resemble both diseases.

Therefore, we do agree that described appearance of duodenal mucosa should always raise suspicion of a serious condition and that all important clinical and epidemiological features need to be considered, but what we believe is most important is to obtain generous mucosal biopsy specimens.

Apparently, this is one of those situations when our pathologist friends indeed do have a decisive word in establishing the diagnosis.

DISCLOSURE

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A technique for skin-level gastrostomy tube placement after gastrostomy tube dislodgement

To the Editor:

Dislodgement of feeding tubes can be a frustrating occurrence, especially when this occurs multiple times in the same patient. Accidental dislodgment of gastrostomy tubes is a common and often serious adverse event. Stomal patency is sometimes preserved by replacing the dislodged tube, or placing a temporary alternative such as a bladder catheter. Too often, this does not occur promptly, the stoma closes, and an endoscopy is required to restore stomal patency. In these cases, the usual approach is to place a standard gastrostomy tube and, after several weeks of tract maturation, to replace the gastrostomy tube with a skin-level gastrostomy (SLG) tube that may be more difficult to dislodge.

Although SLG tubes have a role in breaking this dangerous cycle of dislodgement, the rates of tract disruption during SLG tube placement have been reported as high as 20%.2,3 sometimes resulting in peritonitis and death. For this reason, SLG tubes are usually placed several weeks or months after the initial gastrostomy to allow the original gastrostomy tract time to thoroughly mature. It would be clinically useful, however, if SLG tubes could be placed immediately after gastrostomy tube dislodgement. Toward this end, we have developed
a new, over-the-wire technique for SLG tube placement during a single, same-day endoscopic procedure.

First, we identify the existing fistula between the skin and the gastric body. We gently probe the gastrostomy tract and establish it with a guidewire under direct endoscopic vision. We grasp the guidewire with an endoscopic snare and withdraw it through the mouth in a standard manner. Second, we pass a stoma measuring device over the wire to measure the tract length. This is a vital step because tracts can elongate over time, and the true tract length can differ from the initial marking at the external bolster. After measurement, we remove and discard the stoma measuring device. Third, we insert a push-type gastrostomy tube over the oral side of the guidewire to dilate the tract, dragging the push-type gastrostomy tube only so far that the internal bolster remains at the patient’s mouth. We then cut the dilating plastic portion of the push gastrostomy tube at an appropriate spot, taking care not to damage the guidewire within. After discarding the dilating portion of the tube, we pass the SLG tube over the wire and engage it over the cut plastic end of the push gastrostomy tube (Fig. 1A). Fourth, we apply traction on both the wire and the internal bolster while simultaneously feeding the SLG tube through the tract into place in the patient’s abdomen (Fig. 1B). Grasping the external portion of the SLG tube, we use simultaneous gentle traction on the extraoral portion of the push gastrostomy tube and the SLG tube to disengage the push gastrostomy tube from the SLG tube (Fig. 1C). Finally, we remove the wire and inflate the internal balloon of the SLG tube, which may be done under direct endoscopic vision or followed by repeat endoscopy to confirm final positioning.

Other clinicians may find this method useful for patients who have accidentally dislodged a recent gastrostomy tube and are thought to be at risk for repeated dislodgements. We have now used this technique 8 times, and in all 8 cases we were able to reestablish the tract and place the SLG tube without excessive difficulty. The patients received prophylactic antibiotics as they would for an initial gastrostomy tube placement, and there were no cases of peritonitis, SLG tube dislodgement, or other significant adverse events.

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Cyanoacrylate injection to treat recurrent bleeding from Dieulafoy’s lesion

To the Editor:

Dieulafoy’s lesions are associated with GI hemorrhage that frequently recurs in spite of repeated endoscopic therapy. A 41-year old-woman, with a previous episode of GI...