and recurrent jaundice and a clinical diagnosis of biliary obstruction was made. ERCP was performed. During the examination, the 12 F stent was not visualized in the duodenum. By fluoroscopy, the distal edge of the stent was seen “stuck” in the common bile duct stricture. Conventional attempts to remove the stent with a Dormia basket failed. We therefore decided to manage this problem in an original way. We “cannulized” the stent through the papilla with a thin balloon catheter (5 F). This catheter was placed deep into the biliary stent; the balloon was then slowly inflated and “pulled out” from the stricture through the papilla until the tip of the biliary stent reached the duodenal lumen. At this point, the stent was removed conventionally and a new one was inserted. No complications were evident. After several months, a second case presented with the same complication after placement of a biliary stent and it was favorably managed in the way proposed. If biliary stents migrate, they most often lodge above the stricture and a Dormia basket is generally used for “fishing” out the stent. However, when the distal edge of the stent remains in the stricture, no space is left between the stricture and the stent in which to introduce the basket. Therefore, in these cases, we recommend the use of a thin (5 F) balloon to retrieve the biliary stent.

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Unclogging percutaneous endoscopic gastrostomy tubes

To the Editor:

I have received numerous requests to evaluate non-functioning percutaneous endoscopic gastrostomy tubes. The most frequently encountered problem is a blocked tube. An easy method of clearing these blockages uses a closed biopsy forceps. The forceps is threaded gently down the tube to a few centimeters past the bumper guard. This dislodges caked food particles easily into the stomach. Usually, attempts to clear the tube with water fail. This technique helps, however, since water is absorbed by the food particles, and facilitates clearing with the biopsy forceps.

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Replacement gastrostomy tube as a cause of gastric outlet obstruction

To the Editor:

A 57-year-old woman with Von-Hippel Lindau syndrome with a history of dysphagia was referred for percutaneous endoscopic gastrostomy in April 1989. Her history was significant for multiple central nervous system hemangiomas, renal cell carcinoma, and a pancreatic islet cell tumor. Her surgeries included multiple cranial and spinal procedures, right nephrectomy, partial left nephrectomy, and a Whipple procedure. A 14 F Sachs-Vine percutaneous endoscopic gastrostomy tube was placed just proximal to the efferent limb of her Billroth II anastomosis in a very small gastric pouch. This functioned well until March 1990, when it migrated out of the abdominal wall. An 18 F Microvasive replacement tube with a 20-ml balloon was substituted. Over the following week, copious amounts of enteral feeding formula and bile were noted to leak around the replacement G-tube, necessitating numerous changes of her clothing each day. At upper endoscopy 7 days later, enteral formula was noted to coat the stomach, despite the interruption of her feedings 3 days previously. The 20-ml retention balloon of the replacement tube was noted to completely occlude the efferent limb of the Billroth II anastomosis.

We suspect that the low profile of the 14 F Sachs-Vine G-tube internal bumper prevented obstruction. However, the much larger size of the replacement tube’s retention balloon, coupled with its proximity to the efferent limb, caused gastric outlet obstruction. This report should alert other physicians to the danger of replacing permanent G-tubes that are located adjacent to small bowel anastomoses or in the small bowel itself with replacement tubes that have large internal retention devices.

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The opinions or assertions herein are the private views of the authors and are not to be construed as reflecting the views of the Department of the Air Force or the Department of Defense.

Endoscopic removal of solitary hamartomatous polyp of the duodenum

To the Editor:

Although duodenal polyps are common in cases of Peutz-Jeghers syndrome, isolated polyps resembling Peutz-Jeghers polyps (hamartomas) are rare.1 A review of the literature reveals only one case in which a solitary hamartoma of the duodenum was endoscopically removed because of the risk of intussusception and bleeding.2 We describe two patients both of which underwent successful endoscopic removal of a solitary hamartomatous polyp of the duodenum.

Case 1 was a 41-year-old man who was referred to us for the endoscopic removal of a duodenal polyp, which had been detected by an upper gastrointestinal series. He had no subjective symptoms, and his family history proved unremarkable. Physical examinations revealed no evidence of mucocutaneous pigmentation. Radiography of the upper gastrointestinal tract revealed a 25- x 18-mm coarsely lobulated polyoid mass with a 60- x 6-mm stalk in the third portion of the duodenum (Fig. 1). Endoscopy with a long forward viewing duodenofiberscope (GIF-Q10-2000; Olympus, To-
kyo, Japan) confirmed the radiographic findings (Fig. 2). There were no other polyps in the entire gastrointestinal tract, except for two minute hyperplastic polyps in the stomach. The histological findings of the biopsy specimen showed neither adenomatous nor cancerous changes. Therefore, the tumor was polypectomized with a long duodenofiberscope. No complications such as abdominal pain or bleeding occurred either during or after the treatment. Histologically, the excised polyp was a hamartoma composed of branching cores of smooth muscle fibers in a treelike pattern covered by hyperplastic duodenal mucosa with no epithelial atypia (Fig. 3).

Case 2 was an 82-year-old woman who was evaluated for pain and swelling in her right jaw. Needle aspiration of the mass revealed metastatic papillary adenocarcinoma. She had no abdominal symptoms. An attempt to ascertain the original site of the metastatic mass failed. An upper gastrointestinal series disclosed a polypoid lesion in the upper gastric body and a 25- x 20-mm multilobulated polyp with a 53- x 4-mm stalk in the second portion of the duodenum (Fig. 4). Gastroscopy revealed a whitish elevated lesion in the upper body. The histological diagnosis of a biopsied specimen from the lesion was tubular adenoma. Endoscopy with an Olympus GIF-Q10-2000 revealed a large pedunculated polyp which appeared reddish in color. Biopsy specimens of the polyp revealed it to be benign. There were no additional polyps in the entire gastrointestinal tract, and the patient had neither mucocutaneous melanin spots nor a positive family history for Peutz-Jeghers syndrome. Endoscopic resection was attempted with a long duodenofiberscope, and a large duodenal hamartoma was removed without complication (Fig. 5).

In 1962, Gannon et al. reported 25 solitary polyps (6, duodenum; 12, jejunum; and 7, ileum) histologically hamartomatous, as seen in Peutz-Jeghers syndrome but without

![Figure 2. Case 1. Endoscopic picture showing the reddened, lobulated head of the polyp and the stalk covered by normal mucosa.](image1)

![Figure 5. Case 2. Endoscopic picture reveals a pedunculated polyp arising from the second portion of the duodenum.](image2)
mucocutaneous pigmentation and family history, and suggested that these were incomplete forms of the syndrome. A recent report gave some support to their concept by the finding of a solitary hamartoma in a resected specimen of ileum.

Paterlini et al. in 1983 succeeded in performing endoscopic polypectomy of multiple jejunal polyps in a patient with Peutz-Jeghers syndrome who had undergone surgical segmental resection of the jejunum. In the literature, there have been only two cases of hamartoma detected endoscopically in the distal duodenum. One polyp was removed by endoscopic polypectomy. Because of the difficulty of inserting the conventional duodenofiberscopes into the distal duodenum and upper jejunum, endoscopic excision of polyoid lesions in these areas has rarely been reported. We recently described the advantages of jejunal endoscopy with a long duodenofiberscope, which was successfully used for the excision of these solitary hamartomas in the distal duodenum.

REFERENCES


Variable stiffening device for colonoscopy

To the Editor:

It is apparent to most endoscopists who perform colonoscopy on a regular basis that it is sometimes difficult to perform colonoscopy where there is formation of loops in the sigmoid, transverse colon, or even the descending colon. The more redundant the colon and the less stiff the scope, the more frequent this problem would be. Some endoscopists have already used various devices such as biopsy forceps to