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PEJ PLACEMENT: A NEW STEERABLE CATHETER TECHNIQUE. William Baskin, M.D., F.A.C.G., University of Illinois College of Medicine at Rockford, Rockford, Illinois.

A new technique was developed allowing rapid placement of percutaneous endoscopic jejunostomy (PEJ) feeding tubes via an established PEG lumen. Twenty-four patients were studied to evaluate the success of the new technique. PEJ feeding was recommended for selected patients with reflux-induced aspiration pneumonia, not tolerating PEG feeding. Using standard Ponsky endoscopic pull-technique, a 28 FR PEG (Superior Biosystems Super PEG 85000) was placed. A Microvasive steerable small bowel biopsy catheter (SC) was modified by removing cutting blade and drilling end-hole in capsule. Using fluoroscopy, SC was advanced through PEG and easily steered through pylorus to ligament of Treitz. A .035 gauge guide wire (Wilson-Cook, THSF 35-480) was inserted through SC lumen beyond capsule, then SC was removed, leaving guide wire in place. This allowed rapid placement over wire of an open-ended flow-through PEJ tube (Superior Biosystem 88001) with double-lumen Y-adapter for simultaneous jejunal feeding and gastric decompression. PEJ placement was successful in 23/24 patients, with procedure time 10-15 minutes. PEJ can now be done without re-endoscopy, using fluoroscopy, SC, and flow-through tube. This technique also allows single out-patient PEJ replacement over wire.

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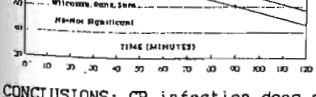
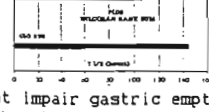
CAMPYLOBACTER PYLORI (CP) GASTRITIS DOES NOT SLOW SOLID PHASE Tc99 GASTRIC EMPTYING. Stephen H. Caldwell MD, Gregg Valenzuela MD, Barry J.Marshall MD, Susie R. Hoffman RN, Michael W. Plankey CNMT, Richard W. McCallum MD. University of Virginia, Charlottesville, Va.

INTRODUCTION: CP causes histologic gastritis. It has been implicated as a possible cause of essential (non-ulcer) dyspepsia. Previous studies have suggested that 50% of essential dyspeptics are infected with CP.An effect on GE by CP might offer an explanation for the possible role of CP in causing symptoms. PURPOSE: We examined the rate of solid phase gastric emptying in a group of CP infected dyspeptics and compared the results to a group of CP negative healthy volunteers with no history of dyspepsia. METHODS: Of 30 consecutive CP+ patients (biopsy proven) evaluated for dyspepsia, 19 (12 females, age = 38 ±9) agreed to undergo gastric emptying studies. After an overnight fast, Tc99 labeled chicken liver was ingested and % isotope retained over a two hour period was measured by continous gamma camera monitering. Results were compared to 16 asymptomatic volunteers (11 females, age 24 ± 4,) who were CP- by breath test (>90% sensitive). RESULTS: Gastric emptying was faster in CP+ at 30 and 60 (p<.05) and not different after 90 and 120 minutes:



T 1/2 was significantly shorter in CLO Positive:



CONCLUSIONS: CP infection does not impair gastric emptying of solids. On the contrary, though of questionable clinical significance, CP+ dyspeptics emptied more rapidly than controls during the early phase of GE. This was observed despite a younger mean age (P=.001) among the CP negative group. If CP infection plays a role in dyspepsia the mechanism does not involve impaired gastric motility.

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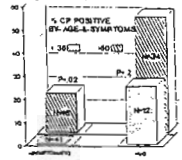
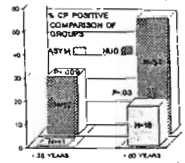
CAMPYLOBACTER PYLORI (CP) INFECTION IS RELATIVELY UNCOMMON AMONG VOLUNTEERS WHEN "ASYMPTOMATIC" IS STRICTLY DEFINED. Stephen H. Caldwell MD, Barry J. Marshall MD, Kevin R. Dye MD, Susie R. Hoffman RN, Cheryl L. Boyd, Richard W. McCallum MD. University of Virginia, Charlottesville, Va.

INTRODUCTION: CP is a common infection and its prevalence is age related. The association of CP with symptoms in non-ulcer dyspepsia (NUD) has been questioned in part because of the high prevalence of CP infection in asympotatic controls (reportedly as high as 50%).Symptoms of NUD are subject to interpretation however and tend to fluctuate over time. PURPOSE: We sought to determine the prevalence of CP in a carefully screened group of asymptomatic volunteers compared to a consecutive group of patients undergoing EGD for NUD. METHODS: Of 129 caucasion volunteers (ASYM), 59 were either younger than 35 (N=41, 32 male) or older than 50 (N=18, 11 male) and met criteria for being asymptomatic: symptoms of "dyspepsia" less than once per month, and no history of EGD, UGI, or prior antacid or H2 blocker use. Too few ASYMs between ages 35 and 50 qualified by symptoms to allow analysis.CP was detected by C14-urea breath test (>90% sensitive and specific). The results were compared to CLO Test (urease slide test, >90% sensitive and specific) results in 46 consecutive NUD patients (12 ≤ 35 years and 34 ≥ 50 years). RESULTS: All statistics were by Fisher's Test (2 Tailed). Among ASYMs none of 41 ≤ age 35 were CP+. 3 of 18 ≥ 50 were CP+ (0% vs 17%, P=.02). Among NUDs ≤ 35, 3 of 12 were CP+ and for ≥ 50 years, 17 of 34 were CP+ (25% vs 50%, P=.2):





CONCLUSIONS: CP is uncommon among young adult and older adult asymptomatic caucasions but does significantly increase with age. In comparison, CP is significantly more common among similar aged NUD patients.

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IS THERE A NEED FOR O_2 THERAPY DURING EMERGENT UPPER ENDOSCOPY IN THE ICU PATIENT? Federico Cerrone, M.D., Bennett Lipper, M.D., Douglas Simon, M.D., and Cathy Martin, CGC, Bronx Municipal Hospital Center, Albert Einstein College of Medicine, Bronx, New York.

UGI endoscopy (EGD) is associated with hypoxemia and hypoxemic complications including arrythmias and death. The purpose of this study was to evaluate O_2 saturation (SO_2) by pulse oximetry during emergent EGD and to determine if supplemental O_2 can prevent desaturation.

Twenty-six consecutive patients with active and severe upper gastrointestinal bleeding underwent EGD in the ICU with pulse oximetry monitoring before, during, and after the procedure. Fourteen examinations were done without supplemental O_2 (Group I) and 12 with supplemental O_2 (Group II). O_2 was given by nasal cannula in 6 patients and by ET tube in 6 patients. All patients were medicated with topical anaesthetic spray and usual doses of demerol and diazepam. EGD was done with left lateral decubitus position. The duration of EGD ranged from 9-25 minutes.

Groups I and II were similar in terms of causes and degree of bleeding. One patient in each group had cardiopulmonary disease. Baseline SO_2 in Group I was 97%. In 9 of the 14 patients, SO_2 <90%, and in 4 of the 9, SO_2 <80%. One of the 9 had SO_2 <90% resulting from pre-medication alone. In all cases, O_2 therapy immediately relieved the hypoxemia. In Group II, baseline SO_2 was 99% and no one desaturated.

Oxygen desaturation commonly occurs during emergent EGD in actively bleeding patients even without clinical evidence of pre-existing cardiopulmonary disease. Supplemental O_2 prevents oxygen desaturation during EGD and may decrease the incidence of hypoxemic complications.

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