Decompression side tube-equipped double-balloon enteroscopy extends intubation depth and reduces patient discomfort

Since the first article introducing double-balloon endoscopy (DBE) was published in 2001 [1], the technique has proven effective for deep intubation of the small bowel and is used in clinical practice worldwide. However, the intubation depth is sometimes limited by the distension of the small bowel due to air insufflation during the procedure. In a recent report [2], the total success rate using a combined (antegrade and retrograde) or antegrade-only approach in DBE was 44.0% (95% confidence interval [CI] 35.0%–53.3%). To improve intubation depth, we have developed a modified method for desufflation around the overtube of DBE using a decompression side tube.

A nasogastric tube with sideholes placed every 10 cm (Fig. 1a) is used as the decompression side tube. The proximal ends of this tube and the overtube are aligned, and the two tubes are attached to each at several points using plastic tape and film dressing tape (Fig. 1b–d). Decompression tube-equipped DBE is carried out with air insufflation. In this method, intestinal gas and fluid spontaneously drain out through the decompression tube (Fig. 2a, b). If necessary, manual aspiration is also possible. Intraluminal decompression leads to efficient insertion of the endoscope and shortening of the proximal small intestine (Fig. 2c). We have not encountered any significant complications such as intraluminal mucosal injury with this method.

Recently, usefulness of a carbon dioxide (CO₂) insufflation system during DBE has also been reported [3]. However, decompression side tube-equipped DBE extends intubation depth and reduces patient discomfort associated with over-insufflation, even in cases where CO₂ insufflation cannot be used. Total enteroscopy was successful using the antegrade-only approach and the EN-450T5 double-balloon enteroscope (Fujinon, Omiya, Japan) equipped with a decompression side tube (Fig. 3). Because this method is simple,
easily applied, and cost-effective, it may lead to a higher diagnostic and therapeutic yield via enteroscopy, while reducing patient discomfort.

Endoscopy_UCTN_Code_TTT_1AP_2AD

Competing interests: None

K. Ikeya1,2, S. Osawa1, S. Kuriyama1, Y. Hamaya1, T. Yamada1, M. Sugimoto1, T. Furuta3, K. Sugimoto1

1 First Department of Medicine, Hamamatsu University School of Medicine, Hamamatsu, Japan
2 Center for Gastroenterology and Inflammatory Bowel Disease Research, Hamamatsu South Hospital, Hamamatsu, Japan
3 Center for Clinical Research, Hamamatsu University School of Medicine, Hamamatsu, Japan

References

Bibliography
DOI http://dx.doi.org/10.1055/s-0032-1309356
Endoscopy 2012; 44: E256–E257
© Georg Thieme Verlag KG Stuttgart · New York
ISSN 0013-726X

Corresponding author
S. Osawa, MD, PhD, Senior Assistant Professor
First Department of Medicine
Hamamatsu University School of Medicine
1-20-1 Handayama
Higashi-ku
Hamamatsu 431-3192
Japan
Fax: +81-53-434-9447
sososawa@hama-med.ac.jp