



Double Balloon Enteroscopy

What you need to know before and after the test

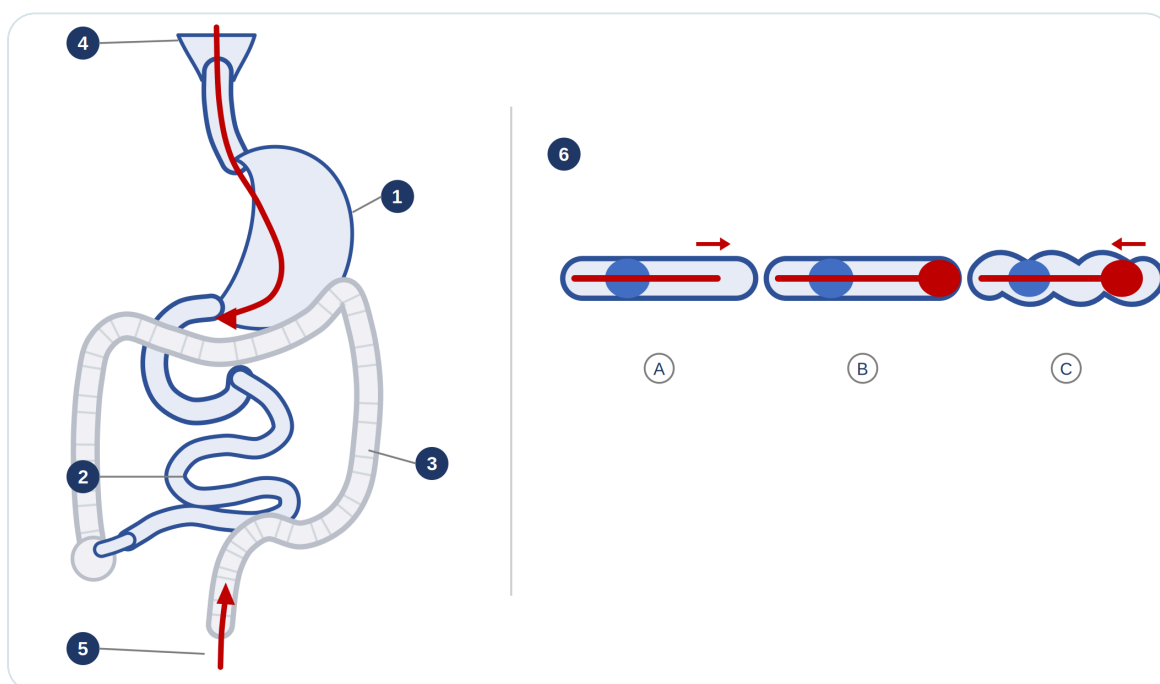
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Please read this sheet carefully before your appointment and bring it with you on the day. If anything is unclear, contact the Endoscopy Unit before your procedure rather than on the day.

What is a double balloon enteroscopy?

The small bowel is several metres long and lies in loops that an ordinary endoscope cannot reach. A double balloon enteroscopy uses a long, thin camera tube inside an outer tube, each with a soft balloon at its tip. The balloons are inflated and deflated in turn so that the bowel is gently gathered over the tube, allowing the camera to travel far deeper than a standard endoscopy. The examination can be done through the mouth or through the back passage, depending on where the problem is thought to be, and takes 60 to 90 minutes – sometimes longer. Biopsies can be taken and, where needed, bleeding points treated, polyps removed and narrowed segments stretched during the same procedure.



1 Stomach 2 Small bowel 3 Colon 4 Route through the mouth 5 Route through the back passage

6 How the balloons work: A the outer tube grips the bowel while the camera advances · B the camera tip balloon grips · C both are drawn back, gathering the bowel over the tube

Why has it been recommended for me?

The commonest reason is bleeding or iron deficiency anaemia when a gastroscopy and colonoscopy have not found the cause and a capsule endoscopy or scan has pointed to the small bowel. Other reasons include assessment or treatment of Crohn's disease of the small bowel, removal of small bowel polyps, retrieval of a capsule that has not passed, and examination of the bile duct in patients whose anatomy has been altered by previous surgery.

What are the benefits?

This is the only test that both examines the deep small bowel directly and treats what it finds, avoiding an operation in most cases. When a capsule endoscopy has already shown a lesion, an enteroscopy finds it in about three out of four patients. Bleeding points can be sealed, polyps removed and biopsies taken to confirm a diagnosis, all in one procedure.

Preparing for the test

- Through the mouth: do not eat solid food for 8 hours before your appointment, and stop all fluids including water 4 to 6 hours before, as stated in your appointment letter. These times are longer than for a routine gastroscopy, so please follow them exactly. No bowel preparation is needed.
- Through the back passage: you will be given bowel preparation to take, exactly as for a colonoscopy, along with separate written instructions on diet and timing.
- Iron tablets: stop 7 days before the test.
- Blood thinners – warfarin, aspirin, clopidogrel, ticagrelor, prasugrel, rivaroxaban, apixaban, dabigatran, edoxaban: contact the unit at least 7 days before. Whether they are continued depends on whether treatment is planned during the procedure, so the instruction must come from us. Do not stop them on your own.
- Diabetes, and weight-loss or diabetes injections (semaglutide, liraglutide, dulaglutide, tirzepatide): tell the unit in advance, as separate instructions are needed.

- Arrange for a responsible adult to take you home and stay with you. The procedure will be postponed if no escort is available.

Sedation and anaesthesia

Because the procedure is long, it is done under deep sedation or a general anaesthetic. You will be asleep or heavily sedated and will not remember it. Your breathing, heart rate, blood pressure and oxygen level are monitored throughout by a dedicated team. Most patients go home the same day, but an overnight stay is arranged if treatment was carried out during the procedure or if you have other medical conditions. For 24 hours afterwards you must not drive, travel alone, operate machinery, drink alcohol, sign legal documents, or care for young children on your own.

What are the risks?

Enteroscopy carries a higher risk than a standard gastroscopy or colonoscopy, because the examination is longer and reaches much further. Serious complications occur in fewer than 1 in 100 examinations without treatment, and in up to about 5 in 100 when treatment such as polyp removal or stretching a narrowing is carried out.

Complication	How often it happens
Perforation (a tear in the bowel wall)	About 1 in 300 to 1 in 1,000 without treatment, rising to 1 to 3 in 100 when a polyp is removed or a narrowing is stretched. Surgery may be needed. If you have had previous bowel surgery the risk is higher – for the route through the back passage it has been reported as high as 1 in 10, and this will be discussed with you.
Inflammation of the pancreas (pancreatitis)	About 1 in 300, and almost always after the route through the mouth. It causes pain and vomiting and usually settles with a short hospital stay. A temporary rise in pancreas blood tests without any symptoms is much more common and harmless.
Bleeding	About 1 in 500 without treatment, and more common after a polyp is removed. It usually stops on its own or is treated during the procedure.

Effects of sedation or anaesthesia on breathing, heart rate or blood pressure	Up to about 1 in 200. You are monitored throughout and these effects can be treated.
Sore throat, bloating and abdominal discomfort	Common – about 1 in 10. These are expected effects rather than complications and settle within 12 to 24 hours.
The whole small bowel cannot be examined	In European practice the whole small bowel is seen in roughly a quarter to a half of examinations, even when both routes are used. A second procedure from the other end is often arranged, and this is planned rather than a complication.
Death directly related to the procedure	Very rare. No deaths occurred in an international series of 2,362 procedures, although occasional deaths have been reported in larger registries, usually after a perforation or severe pancreatitis.

Are there alternatives?

Capsule endoscopy takes pictures of the small bowel but cannot take biopsies or treat anything, and the capsule occasionally becomes stuck. CT or MR enterography shows the wall and structures around the bowel but not the lining in detail, and again allows no treatment. An operation with the endoscope passed during surgery is the remaining option and is far more invasive. Choosing not to have the test is also an option; discuss with your doctor what might be missed.

After the procedure

You will recover in the ward or recovery area for a few hours. Bloating, wind and mild abdominal discomfort are expected and are relieved by walking. Eating and drinking are usually allowed once you are fully awake, unless you are told otherwise. The findings are explained before you leave and a written report is given; because of the sedation, ask for the information to be repeated or given to the person accompanying you. Biopsy results take 2 to 4 weeks and are discussed in clinic.

When to get urgent help

Go to the nearest emergency department if, within two days of the test, you develop:

- severe abdominal pain, particularly pain made worse by moving or coughing, or a swollen, hard abdomen
- pain at the tip of the shoulder
- persistent vomiting, or vomiting blood
- heavy or repeated rectal bleeding, clots, or black tarry stools
- fever of 38 °C or above, or difficulty breathing

Take this sheet with you and tell the staff that you have had a double balloon enteroscopy.

Contact

For appointments and questions, contact the endoscopy unit using the numbers it has given you. If you are seriously unwell, or it is outside working hours, go to the Emergency Department rather than waiting for a reply.

Based on ESGE small bowel endoscopy guidelines, BSG/ESGE antithrombotic guidance and published multicentre enteroscopy safety data. Supports but does not replace the discussion with your doctor and the consent process. PE-PROC-03 · Version 1.0 · October 2026 · Review due: October 2028

This leaflet is general information and does not replace advice from your own doctor.

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