



UNDERSTANDING GASTROSCOPY



Advanced Medicine Exceptional Care

WHAT IS A GASTROSCOPY?

A gastroscopy is a procedure that allows the doctor to look directly at the lining of the oesophagus (gullet), the stomach and first part of the intestine. It is performed using a thin tube (gastroscope) with a camera and a light on the tip to look at the area being examined. The procedure lasts 10 minutes and is not painful, but can feel a little uncomfortable.

GETTING READY FOR THE PROCEDURE, PATIENTS RESPONSIBILITIES

You will need to fast from food for six hours prior to having the procedure to ensure your stomach is empty. You can drink clear fluids up to four hours before your appointment time. When you arrive in the unit, it is important to tell the doctor and nurse about any medications (prescription or non-prescription) or antibiotics you are taking, and also about any allergies or reactions you may have had in the past by recording it on the medication section of this form. If you are a diabetic you must inform your doctor pre-admission.

If you are taking aspirin please continue to take as prescribed.

IF YOU ARE TAKING ANTIPLATELET DRUGS SUCH AS CLOPIDOGREL (PLAVIX) OR OTHER ANTICOAGULANT BLOOD THINNING DRUGS, for e.g. WARFARIN, PLEASE CHECK WITH YOUR CARDIOLOGIST/CONSULTANT IF THESE NEED TO BE CONTINUED OR DISCONTINUED PRIOR TO YOUR PROCEDURE.

If you are on any medications (apart from tablets for diabetes) these should be taken as normal on the morning of your procedure.

- Please complete Medication History List on page 4 before you come into the hospital.
- Diabetic patients taking insulin or oral diabetic medication must follow the instructions provided by their doctor.
- Remove make-up prior to your admission.
- You are asked to bring this signed consent form agreeing that you understand the procedure and its implications, and that any questions you may have had have been answered.
- We ask that you bring a dressing gown and slippers with you on the day, and you should wear comfortable clothing.

- Please leave any jewellery and valuable items at home.
- If you have any infections in the past eg. Methicillin-Resistant Staphylococcus Aureus (MRSA), Vancomycin-Resistant Enterococci (VRE) or other Multi-drug Resistant Organisms (MDRO) please inform your consultant or nursing staff prior to admission.
- Please tell your nurse if you have any loose teeth, crowns or dental bridge work.

- **Please ensure you bring this fully signed and completed form with you on the day of your procedure.**

SEDATION

There are two options available to you:

1. No sedation option: you will be given a local anaesthetic spray to the back of your throat that will numb the area to reduce any discomfort. This numbness will last for up to an hour after the procedure during which time you will remain fasting. You will be fully aware of the procedure which most patients find acceptable and not too unpleasant. You can leave as soon as your procedure has been completed and you have spoken to your doctor.

2. Sedation option: Sedation is the use of a small amount of medication to produce a 'sleepy like' state. It is given in to a vein through a needle in your hand. It makes you physically and mentally relaxed during the procedure which may be uncomfortable at times but where your cooperation is needed. You will purposefully respond to verbal commands either alone or

accompanied as 'conscious sedation'. **(This is not a general anaesthetic).**

Some patients will recall the test but the aim of conscious sedation is that the majority of patients will not remember it as an unpleasant experience. You may remember a little about what has happened during the procedure. If you take relaxation drugs or sleeping tablets regularly these may influence the effectiveness of your sedation.

In the event that you are unable to tolerate the procedure being done under sedation you can request to stop the procedure. You may be given oxygen through your nose.

DURING THE PROCEDURE

Prior to your procedure any queries you may have will be answered. In the procedure room, you will be asked to remove your glasses and dentures if applicable and made comfortable lying on your left side. The doctor will give your preferred option of sedation or no sedation. A plastic mouth guard will be placed gently between your teeth to keep your mouth open during the procedure. A nurse will remain with you to monitor your blood pressure and pulse. As the doctor passes the gastroscope through your mouth you may gag slightly which is quite a normal reaction. This may make you burp and/or belch a little which some people may find a little unpleasant. Routine biopsies are taken. When the procedure is finished the gastroscope is removed.

POTENTIAL PROBLEMS

Diagnostic gastroscopy procedures carry a very small risk (1 in 10,000 cases) of haemorrhage (bleeding) or perforation (tear) of the oesophagus following which surgery may be necessary. If intervention is required such as dilatation, injection the above complications are increased 10 times. There may be a slight risk to loose teeth, crowns or dental bridgework. Other rare complications include aspiration pneumonia (inflammation of the lungs caused by inhaling or choking on vomit) or an adverse reaction to the intravenous sedative drugs.

All hospital admissions carry a small risk of infection.

FOLLOWING YOUR PROCEDURE

You will remain fasting for approximately 1 hour after your procedure. The consultant will meet with you to discuss your test and follow up care, prior to discharge. When you are sufficiently awake, you may go home. Please note the following advice following sedation:

- You must have someone to accompany you home and remain with you overnight
- You must not drive or operate machinery for 24 hours
- You must not consume alcohol for 24 hours
- You should not make any vital decisions or sign any legal documents for 48 hours
- You should not take any medication not prescribed by your doctor

- If you have hearing aids, please check that you have your hearing aids with you prior to leaving the hospital.

Following your procedure your consultant will either discuss your follow up care or review results in consulting rooms at a future date. You may experience a mild sore throat for a day or so after your procedure but this will pass.

If you experience any of the following symptoms after your procedure, you should seek medical advice:

- Chest or tummy pain that is more severe or different to the pain you usually have
- Breathing difficulties
- Fever
- Vomiting blood or black fluid
- Passing blood from your back passage

PLEASE NOTE THAT FOLLOWING A SEDATED PROCEDURE YOU WILL NOT BE PERMITTED TO LEAVE THE HOSPITAL UNACCOMPANIED. WE THEREFORE ASK THAT YOU MAKE ARRANGEMENTS TO HAVE A RELATIVE COLLECT YOU AND SIGN YOU OUT. IT IS NECESSARY TO HAVE A RESPONSIBLE ADULT STAY WITH YOU OVERNIGHT.

A report of this diagnostic procedure will be sent to your General Practitioner or referring consultant.

Please ensure you sign below to confirm you understand the information on this form and hand this completed form to your nurse on admission to the day ward.

If you have any questions about the procedure, your consultant or nurse will only be too pleased to answer them.

You can call the Endoscopy Department in the Bons Secours Hospital Cork on **021-4801693** from 8:00am – 18:00pm Monday to Friday. After 18:00pm, patients can contact the hospital directly on **021-4542807** and ask for the Assistant Director of Nursing on duty. 24 hours post your procedure, contact your GP (General Practitioner) if you have any concerns/problem.

I confirm that I have read and understand the information on this form and the potential problems associated with this procedure.

Signature of patient/authorised decision maker:

Date: _____

Affix Patient Label here

PATIENT CONSENT

In this section your consent for the procedure will be obtained. You must fully read this patient 'Understanding Gastroscopy' patient information leaflet prior to completing your consent form.

You may complete this form prior to coming to the Hospital if you wish. If there are any further questions or clarifications that you require, please do not sign this consent form until you have spoken to your doctor in the Endoscopy Unit.

TO BE COMPLETED BY PATIENT

I understand why I am having this procedure and that I can change my mind at any time and not undergo this procedure.

I understand that biopsies may be taken during the procedure. I understand that there is no guarantee that this procedure will improve my condition. I understand that I have the choice to receive sedation for this procedure.

I confirm that I have read and understood the information on this form and the potential problems that are associated with this procedure, which is being carried out by

Dr/Mr _____

Signature of Patient / Authorised Decision Maker: _____ Date: _____

DOCTOR STATEMENT

I have spoken to this Patient and am satisfied that he / she fully understands the procedure.

Doctor Signature: _____ Medical Council Registration Number: _____

Date: _____ Time: _____

CURRENT MEDICATIONS

Name _____

Date of Birth _____

Affix Patient Label here

CURRENT MEDICATIONS

Allergies (medication, dye, food, latex): _____

Pharmacy Name & Telephone No: _____

If you are not taking medication at home please tick here

CURRENT MEDICATION HISTORY LIST				List any other medication which you have taken within the last 4 weeks not included in the list above.
	Name of Medication	Dose	Frequency	
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____
6	_____	_____	_____	_____
7	_____	_____	_____	_____
8	_____	_____	_____	_____
9	_____	_____	_____	_____
10	_____	_____	_____	_____
11	_____	_____	_____	_____
12	_____	_____	_____	_____

Signature of patient/carer or relative: _____

Date: _____

Do you have or have you had any of the following in the past:

	Yes	No		Yes	No
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnoea	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Family History of Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker / Implantable Cardiac Device	<input type="checkbox"/>	<input type="checkbox"/>	Vancomycin Resistant Enterococci (VRE)	<input type="checkbox"/>	<input type="checkbox"/>
Methicillin Resistant Staphylococcus Aureus (MRSA)	<input type="checkbox"/>	<input type="checkbox"/>	Previous Bowel Polyps	<input type="checkbox"/>	<input type="checkbox"/>
Previous Bowel/Abdonimal Surgery	<input type="checkbox"/>	<input type="checkbox"/>			

Name and contact phone number of person who will escort you home:

Name _____ Contact Number: _____

Admission Nurse Signature below indicates all details on the above medication history list have been reviewed.

Nurse's Signature: _____ Date: _____