Upper Endoscopy / Biopsy / Esophageal Dilation

Description of Procedure:
You will lie on your left side. A flexible tube with a small camera (called an endoscope) will be passed through your mouth and into your esophagus (swallowing tube). You will still be able to breathe normally. This will allow your doctor to see the inside of your esophagus, stomach, and the beginning of your small intestines. Photos may be taken as considered advisable or necessary by the doctor. Your doctor may take a small sample of tissue or remove abnormal growths (called polyps) for testing. Polyps are removed because they may contain cancer or pre-cancerous cells. Any tissues that are removed may be reviewed by a pathologist.

Esophageal dilation is a procedure that allows your doctor to dilate, or stretch, a narrowed area of your esophagus. If the doctor thinks dilation is necessary, (s)he may use various methods for the procedure, such as:

1) Bougies: weighted, cone-shaped tubes that are inserted into the esophagus.
2) Balloon dilator: a tiny, empty balloon that is inserted into the esophagus and slowly filled with air.
3) A guided wire dilator: the guidewire is passed through the esophagus, then a series of plastic stretchers (called dilators) are passed over the wire.

Sedation:
I consent to the administration of moderate or deep sedation/anesthetics (by mouth or through a needle placed in a vein in my arm or hand) as considered necessary or advisable by the physician, certified registered nurse anesthetist, and/or registered nurse under supervision of the physician. I understand the alternatives, the risks involved, and possible complications of sedation.

Potential Risks:

- Irritation of veins (5%)
- Excessive sedation (1%)
- Allergic reaction to medication (<1%)
- Aspiration (If you vomit and it gets into your lungs, pneumonia can occur) (<1%)
- Perforation (a hole or tear in the esophagus)
  - Risk increases to 1% if polyps are removed.
  - Rarely, blood transfusions or surgery may be required to treat these conditions.
- GI Bleeding (<1%)
  - Risk increases to 1% if polyps are removed or if patient is currently taking a blood thinning medication.
  - Rarely, blood transfusions or surgery may be required to treat this condition.
- Teeth in poor condition and dental prosthetics may become loose, broken, or dislodged during endoscopy and/or during the protective procedures related to anesthetic. While every effort is made to protect teeth, such damage is a recognized risk. Gastroenterology Associates of the Piedmont will not accept responsibility for damage to teeth or dental prosthetics.
- Infection
- Death
- Risks may increase if patient uses steroids or has significant respiratory, liver, kidney or brain impairment.

After the Procedure:

- I understand that if I am scheduled for a procedure with sedation, I must have an adult (age 18+) available to accompany me home. This adult may be given my discharge instructions.
- I agree not to drive/operate machinery for eight hours after leaving this facility.
- I agree not to drink alcohol, take tranquilizers or sedatives for eight hours after leaving this facility.
- After the procedure, I will be able to swallow once any numbness at the back of my throat has worn off. My throat might be sore for a few days.

Additional Information:

- Procedures that are presently unknown may be performed that are different from or in addition to those planned in the case that the doctor or his/her associates or assistants consider them advisable or necessary.
- Doctors in training may be present and participate during the procedure(s).
- We do not honor living wills or Do Not Resuscitate Orders (DNR) at this facility due to the fact that a terminal, incurable, vegetative state is not anticipated in this outpatient setting.
- Gastrointestinal endoscopy is generally a safe and effective way to examine the gastrointestinal tract. It is not 100 percent accurate in diagnosis. No guarantee has been given by anyone as to the result of the procedure(s). Other options are available, including (but not limited to) radiologic studies, surgery and medical treatment.

The nature and purpose of the procedure(s) along with its potential risks, potential complications and alternatives have been explained to me.

My known allergies and medications have been reviewed with clinical staff and/or my physician prior to having this procedure.

All of my questions have been answered to my satisfaction. I understand the information I have been given and voluntarily consent to the proposed procedure(s).

I request that Dr. _____ perform an upper endoscopy / biopsy / esophageal dilation procedure on me as described in this form.

Signature of Patient *(or person authorized to consent)*: _____

Relationship: ☐ Patient ☐ Other: _____

Witness Signature: _____

Physician Signature: _____

Date: _____ Time: _____ AM / PM