

Sigmoidoscopy

Explanation of Procedure

Direct visualization of the lower portion of the colon including the anus, rectum and left side of the colon up to approximately 60 cm with lighted instrument is referred to as a sigmoidoscopy. Your physician has advised you to have this type of examination. The following information is presented to help you understand the reasons for and the possible risks of these procedures.

At the time of your examination, the lining of the lower digestive tract will be inspected thoroughly and possibly photographed. If an abnormality is seen or suspected, a small portion of tissue (biopsy) may be removed or the lining may be brushed. At times, other specimens, as deemed necessary by your physician, may be collected. These samples are sent for laboratory study to determine if abnormal cells are present. Small growths (polyps), if seen, may be removed. These samples are sent for laboratory study to determine if abnormal cells are present.

Deep sedation, a type of medication to keep you comfortable, may be administered to you by an anesthesia provider.

Alternatives to Flexible Sigmoidoscopy

Although sigmoidoscopy is an extremely safe and effective means of examining the gastrointestinal tract, it is not 100 percent accurate in diagnosis. In a small percentage of cases, a failure of diagnosis or misdiagnosis may result. Other diagnostic or therapeutic procedures, such as medical treatment, x-ray and surgery are available. Another option is to choose no diagnostic studies and/or treatment. Your physician will be happy to discuss these options with you.

Flexible Sigmoidoscopy is generally a low risk procedure. However, all of the following complications are possible. Your physician will discuss their frequency with you, if you desire, with particular reference to your own indications for gastrointestinal endoscopy. *Please ask your physician if you have any questions about your test.*

- 1. Perforation:** Passage of the instrument may result in an injury to the gastrointestinal tract wall with possible leakage of gastrointestinal contents into the body cavity. If this occurs, surgery to close the leak and/or drain the region is usually required.
- 2. Bleeding:** Bleeding, if it occurs, is usually a complication of biopsy, polypectomy or dilation. Management of this complication may consist only of careful observation, or may require transfusions, repeat endoscopy to stop the bleeding or possibly a surgical operation.
- 3. Medication Phlebitis:** Medications used for sedation may irritate the vein in which they are injected. This may cause a red, painful swelling of the vein and surrounding tissue and the area could become infected. Discomfort in the area may persist for several weeks to several months.
- 4. Other Risks include but are not limited to:** Aspiration of secretions from the oral cavity or stomach resulting in cough, sore throat and rarely pneumonia; damage to teeth and dental prosthetics, corneal irritations and abrasions, Post-Polypectomy Burn Syndrome, drug reactions, and complications from other diseases you may already have. *Please inform your physician of all your medical problems, medications and allergies.* Instrument failure and death are extremely rare but remain remote possibilities.

Physician explaining procedure: _____ M.D.

Signature: _____ M.D.

Date: _____

I consent to the taking of any photographs during my procedure to assist in my care and for use in the advancement of medical education; for the presence of an observer during the procedure to provide assistance or consultation services to the physician. I certify that I understand the information regarding gastrointestinal endoscopy and deep sedation. I have been fully informed of the risks, benefits, alternatives and possible complications of my procedure/anesthesia.

I understand that I have been advised that I should not drive for twelve (12) hours following my procedure. I also understand that in the event of cardiac or respiratory arrest or other life threatening situation during my admission, the Center will perform necessary life saving measures until transferred to a hospital should such methods become necessary and that my Advance Directives will not be honored at LICDH. I give my consent for any medical treatment deemed necessary including transfer to a higher level of care.

I consent to the drawing and testing of my blood in the event that an individual is accidentally exposed to my body fluids. The results of these tests will remain strictly confidential, except as specified by law.

I consent to having a peer physician review my medical record to obtain information about the delivery of medical care.

I hereby authorize and permit _____, M.D., and whomever he/she may designate as his/her assistant to perform the following:

Flexible Sigmoidoscopy with possible biopsy, polypectomy and collection of specimens

If any unforeseen condition arises during the procedure calling for, in the physician's judgment, additional procedures, treatments, or operations, I authorize him/her to do whatever he/she deems advisable. I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me concerning the result of this procedure. If there is any question that I might be pregnant, I will allow a urine pregnancy test to be performed prior to my procedure.

Patient / Legally Authorized Representative (check one)

Relationship to Patient

Date: _____ Time: _____

Witness of Signature only: _____