

Preparing for your Pouchoscopy Procedure

Thank you for choosing the Gastroenterology Associates at Mass General Hospital for your Pouchoscopy. We want to make sure your procedure goes as smoothly as possible. **Please read all the instructions in this packet at least 1 week before your procedure.** All instructions must be followed, or your Pouchoscopy may be cancelled. If you have any other questions, call us at 617-726-7663.

MGH Gastroenterologist name and phone number:

Patient name:

Scheduled procedure:

Procedure location:

Please Note: There is more than one location for MGH endoscopy procedures. Your location is listed here.

Date and arrival time:

Please note: Your arrival time is different than the start time for your endoscopy, so you have time to get ready for your procedure.

- **Most patients are ready for discharge within 3 hours of the scheduled arrival time but occasionally unforeseen events occur that result in delays. You will be informed of any potential delays when you arrive.**
- **Your escort should be available to meet you within 30 minutes after we call.**

** Please refer to the day of procedure instructions attached with your prep for important covid pre-procedural related inquiries.*

Plan ahead

- ☐ Update your MGH registration information by calling 866-211-6588.
- ☐ If you have questions about the coverage for your procedures, please call and verify with your insurance company directly.
- ☐ Sign up for a Partners HealthCare Patient Gateway account if you do not have one. It will help with communicating with us. You will be able to see your test results in Patient Gateway within 2 weeks of the procedure.
- ☐ Arrange for an adult escort to take you home after your procedure.
- ☐ If your procedure is scheduled at Charles River Plaza (165 Cambridge St) and you use CPAP, home oxygen or have an implantable cardiac defibrillator, call so your exam can be rescheduled in the Blake Building.
- ☐ Please note that MGH policy requires that women, ages 11-55 years old have a pregnancy test prior to having any endoscopic procedure. When you arrive for your procedure, a registered nurse will screen you for the test and if needed, request that you provide a urine sample.
- ☐ Read the information about the day of your procedure in this packet. It will tell you what to bring.

It is very important that you keep this appointment. **If you must cancel, please call us at least 5 business days before your appointment** by calling 617-726-7663. Calling ahead allows us to reschedule your appointment and give that slot to another patient. **If you cancel late, we may not be able to reschedule your appointment.**

For driving directions, please visit the MGH Parking and Visitor Information website at www.massgeneral.org/visit. If you are using GPS, please make sure to use the correct zip code.

For more information and frequently asked questions, please visit our website www.massgeneral.org/endoscopy.



These instructions tell you what you will need to do to clean your bowels so that your doctor can see problems inside your J Pouch. If your bowels are not clean, you may have to reschedule your test. If you have questions about this Pouchoscopy prep, call your MGH gastroenterologist.

Items you will need to buy

☐ **Laxative Powder.** Either generic polyethylene glycol or MiraLAX®. You will need 119 grams or a 4.15-ounce bottle. Do not mix it with water until the afternoon before your procedure.

☐ **Clear liquids that are not colored red, purple or orange.** Clear liquid is any liquid that you can see through. Examples include water, tea, black coffee, clear broth, apple juice, white grape juice, sodas, sports drinks like Gatorade, and Jell-O.

Medications

- If you are taking Canagliflozin (Invokana), Canagliflozin and Metformin (Invokamet), Dapagliflozin (Farxiga), Xigduo XR Dapagliflozin and Metformin extended-release, or Empagliflozin (Jardiance), please stop it at least three days before your colonoscopy. If you are taking ertugliflozin (Steglatro, Stegujan, or Segluromet), please stop it at least four days before your scheduled colonoscopy. Make sure to contact your primary care physician or diabetes doctor about the suggested changes above and get their guidance as well.
- If you take insulin, we usually recommend that you take ½ your normal dose on the day of the procedure.
- If you take blood thinners, we recommend you take them unless your MGH gastroenterology doctor told you to stop taking them.
- Aside from the medications above, we usually recommend you take all home medications as usual with water.



Five (5) days before your procedure:

If you take vitamins, iron pills, or liquid antacids, stop taking them 5 days before your procedure.

Two (2) days before your procedure:

-Eat only well-cooked fruits and vegetables. Don't eat popcorn, seeds, nut, salad, corn, beans, peas, whole grain or whole wheat breads, raw fruits or raw vegetables.

One (1) day before your procedure:

Follow a clear liquid diet only. Clear liquid is any liquid that you can see through. Do not drink any red, purple or orange liquids. Examples of clear liquids include: Water, tea, black coffee, clear broth, apple juice, white grape juice, sodas, sports drinks like Gatorade, and Jell-O.

Remember! The day before your exam, don't drink or eat:

- solid foods
- dairy products
- alcoholic drinks

6 pm (the day before your procedure)

- Mix the entire 119-gram container of MiraLAX powder with 32 ounces of liquid. You may use water, Gatorade or Crystal Light.
- Start by drinking 8 ounces which is 1 cup of the laxative
- Repeat this drink every 10 minutes until the Laxative is gone.

Keep drinking the laxative on schedule even though you may not start moving your bowels for 2 to 3 hours.

Day of your procedure:

Take your morning pills with clear liquids. If you stopped taking vitamins, iron pills, or liquid antacids, do not take them today.

2 hours before your scheduled arrival time:

- Stop drinking all liquids.
- Do not chew gum or eat any food.
- If you drink liquids, chew gum, eat hard candy or eat food within 2 hours of your procedure, it will be postponed or cancelled.

The Day of Your Pouchoscopy Procedure

Bring these things with you to your procedure

- ☐ Your photo identification
- ☐ The name and phone number of your escort.
- ☐ You may wear your wedding rings but no other jewelry.

The day of your procedure

- The time for your appointment is earlier than the time your procedure will start so you can get ready.
- Before the procedure, we will review the procedure with you and ask you to sign a consent form. (see last page)
- Most procedures take about 3 hours. We make every effort to keep on time, but sometimes there are delays.
- We will call your escort 30 minutes before you are ready to leave.

After the procedure

- Most people need to rest at home for the remainder of the day. Don't drive or operate any machines on the day of your procedure. Avoid making any important decisions. Avoid drinking alcohol.
- You can go back to eating as you normally do right away.
- You will get a letter in the mail with your test results within 2 weeks after your procedure. If you have a Partners HealthCare Patient Gateway account, you can also see your results there.

Remember

- You cannot drive after your procedure.
- We will have to cancel your procedure if you do not have an adult escort to meet you in the endoscopy unit and bring you home.
- Your escort should be able to pick you up 30 minutes after we call them.

For any questions about this information call 617-726-7663.



CONSENT FOR PROCEDURE

Patient Identification Area
PATIENT MUST BE IDENTIFIED BY
NAME AND MEDICAL RECORD NUMBER

I hereby authorize _____ to perform the following procedure(s)

Procedure Pouchoscopy

Site: Massachusetts General Hospital

If laterality applies: ☐ Right ☐ Left ☐ Both Sides ☒ NA

I have been informed of 1) the potential risks and benefits of the procedure(s); and 2) the risks and benefits of the alternatives, including the consequences of not having the procedure(s).

I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the proposed treatment(s) or procedure(s).

Further I am aware that there are possible risks, such as loss of blood, infection or pain that may accompany any surgical, diagnostic or therapeutic procedure. The following additional risks were explained to me:

Pouchoscopy is a minimally invasive endoscopic procedure to examine an ileo-anal pouch, a replacement for the colon / rectum which is surgically created from the small intestine (ileum) as Treatment for ulcerative colitis, a preventive measure in certain genetic illnesses such as FAP or HNPCC or as a procedure in the treatment of colon cancer. Typically, a fiber optic camera on a flexible tube is passed through the anus. Although it may determine the integrity of the J-pouch (hence the name pouchoscopy).

If procedural sedation will be used during this procedure, I understand that this sedation has risks. My physician has discussed the use of procedural sedation. The risks include but are not limited to slower breathing and low blood pressure that may require treatment.

I understand that a potential risk or complication of the procedure is the loss of blood. I understand that I may require blood products during the procedure or in the post-procedure period. If I refuse blood products, I will complete a separate release for blood-free treatment form.

I understand that one or more healthcare industry professionals (technical representatives for medical equipment and device companies) or observers may be present during this procedure for advisory or observational purposes only.

The hospital may photograph, videotape, or record my procedure/surgery for educational, research, quality and other healthcare operations purposes. Any information used for these purposes will not identify me.

I understand that blood or other samples removed during this procedure may later be disposed of by Massachusetts General Hospital. These materials also may be used by Massachusetts General Hospital, its partners, or affiliates for research, education and other activities that support Massachusetts General Hospital's mission.

A team of medical professionals will work together to perform my procedure/surgery. The role and involvement of the senior attending in my procedure has been discussed with me, including that he/she may join the procedure after the opening of the surgical site or may leave during the closing of the surgical site, and may need to step away during non-critical portions of the procedure. The roles of additional practitioners involved in the procedure, indicated below, have also been explained to me. I understand that other medical professionals may be involved in the procedure who are not listed below. The name of those practitioners will be shared with me after the procedure.

Role of Practitioner (check all that apply)	Name of Practitioner if known
☐ Fellow.	
☐ Resident. Specify Year:	
☐ Physician Assistant	
☐ Advanced Practice Nurse	
☐ Other, please specify:	
☐ Other, please specify:	

I have had a chance to ask questions about the risks, benefits, side effects, likelihood of achieving the goals of this procedure, and other approaches. All my questions were answered to my satisfaction and I give permission to have the procedure.

_____	_____	_____	AM PM
Patient/Surrogate Decision Maker Signature	Printed Name if not Patient	Date	Time
_____	_____	_____	AM PM
Practitioner Obtaining Consent Signature	Printed Name	Date	Time

Attending Physician/Primary Practitioner Attestation (not required if individual obtained original consent)

I attest that I discussed all relevant aspects of this procedure/surgery, including the indications, risks, and benefits, as compared with alternative approaches with the patient or surrogate decision maker, answered their questions, and provided information regarding other medical professionals who will be present during the surgery.

_____	_____	_____	AM PM
Attending Signature	Printed Name	Date	Time

If interpreter was used please complete name or number of interpreter: _____

Telephone Consent

Date: _____ Time: _____ AM PM

Reason for Telephone Consent: _____

Surrogate Decision Maker Name: _____

Consent Received by: _____

Consent Witnessed by: _____