# ERCP

## GENERAL INFORMATION

ERCP (**E**ndoscopic **R**etrograde **C**holangio-**P**ancreatography) is a procedure that uses a flexible "scope" (a tube about the width of a finger, with a camera lens and light on the tip) to examine the first section of the small intestine, the bile ducts, and the pancreatic ducts. The procedure usually takes 30-90 minutes and is performed under deep sedation.

During the procedure, you will be lying flat on your abdomen with your head turned to your right side. After deep sedation is given, the scope is inserted in the mouth and gently advanced to the small intestine. In the small intestine, the "papilla" (a small projection where the bile duct and pancreatic duct secretions drain) is located, and a small catheter is gently inserted into the appropriate duct. Contrast dye is injected into the ducts and X-rays are used to determine the anatomy of the ducts and detect any abnormalities. In addition,

- Tissue samples ("biopsies" or "brushings") may be taken.
- A bile duct stricture may be dilated (stretched) or held open with a stent (a small plastic tube).
- If gallstones are found in the bile ducts, the opening to the bile duct may be cut and made larger. Then, surgical instruments may be inserted into the bile duct to remove the stones.
- If the bile duct has a leak, a stent may be inserted to seal the leak.

## ERCP COMPLICATIONS ARE UNUSUAL, BUT CAN OCCUR:

- After the procedure, you may feel abdominal pressure or bloating. Also, your throat may be slightly sore, but you should be able to eat a regular diet.
- **Minor or major bleeding,** possibly requiring hospitalization, blood transfusions, repeat endoscopy, or surgery.
- **Perforation of internal organs,** requiring hospitalization and emergency surgery.
- **Pancreatitis** (inflammation of the pancreas) may occur between 5-25% of the time. This is often mild, but can sometimes lead to low blood pressure, severe abdominal pain, organ failure, and death.
- **Infection** into the bile ducts or liver (called "cholangitis").
- **Adverse reactions to medications,** possibly resulting in low blood pressure, irregular heart rhythms, difficulty breathing, or inflammation at the injection site.

## ERCP PREPARATION

- Continue all prescription medicines, unless directed by your doctor.
- **If you take Aspirin, Plavix (clopidogrel), Coumadin (warfarin), or Pradaxa (dabigatran etexilate mesylate), please discuss with your doctor.**
- If you have **DIABETES**, take only half of your usual dose of diabetes medicine on the day of your endoscopy. If you have questions, please discuss this with your doctor.
- ***STOP EATING 8 HOURS BEFORE THE PROCEDURE.*** Drinking clear liquids is okay until 4 hours before the procedure.
  *Nothing by mouth after _____.

## PLEASE PREARRANGE FOR A RESPONSIBLE ADULT TO DRIVE YOU HOME.

Because of the sedation, you are not permitted to drive, operate machinery, drink alcohol, or sign legal documents for at least 12 hours after the procedure. Use of a taxi or public transport service will not be permitted without an accompanying adult. You can plan on being discharged approximately one hour after the start of your procedure.

# ERCP

**Your ERCP is scheduled**

with Dr._____at _____ on _____ (mo/d/yr), at:

☐ Sentara Medical Center 2300 Opitz Blvd, Main Hospital Entrance,1st Floor, Woodbridge
☐ Alexandria Hospital 4320 Seminary Road, Alexandria, Endoscopy Services to the left of Visitor's Entrance

****** PLEASE ARRIVE AT _____ ON THE DAY OF YOUR PROCEDURE. ******

**Have questions?** Please call the Woodbridge office: **703-580-0181,** Manassas office: **703-365-9085**, or the Mt. Vernon office: **703-360-0594**, Alexandria office: **703-823-3750.**
If it is after normal office hours, and you have an urgent question that cannot wait until the following business day, you may call the office and be connected to the physician on call.
**IF YOU NEED TO CANCEL YOUR PROCEDURE**, we require a 7-business day notice. Failure to inform us by _____ will result in a **two hundred-dollar ($200) charge.**

_____ I understand the potential benefits and risks of the procedure;
_____ I am responsible for charges related to my deductible, co-insurance, or co-payment;
_____ I am also aware of the cancellation fee

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Print Patient Name | Date of Birth | Patient Signature | Date |