This instruction sheet shall be kept by patient (or patient's family)

Taichung Armed Forces General Hospital
Ultrasound-guided aspiration cytology instructions
超音波導引細胞穿刺說明書

Introduction to ultrasound-guided aspiration cytology

In this examination, tissue cells are removed from lesions in the sites of interest under the guidance of ultrasound to further understand the pathological changes of the lesions.

Precautions before examination:

- Generally, no fasting is required for aspiration of cells, but to remove cells from deep organs (such as kidney cysts), please fast for 4 hours.
- Please wear light clothing on the day of examination or change into an examination gown before the examination.

Precautions during examination:

- Generally, no local anesthetic injection is required for sampling by aspiration as a regular syringe is usually used under the guidance of ultrasound to target the lesion site, puncture, and extract a small amount of cells or tissue fluid to be sent for testing.
- For aspiration of deep organs, a thicker aspirating needle is required, and a local anesthetic will be administered.
- Aspiration may cause slight discomfort, and the wound after sampling is a small needle puncture. Cover it with a small piece of gauze and press for a short time.
- The duration of tissue sampling varies depending on the location and nature of the tissue, and cell aspiration typically takes 15 to 30 minutes.

Precautions after examination:

- Please make an appointment with the original outpatient clinic to view the results of the aspiration cytology seven business days (excluding the day of the procedure and holidays) after the procedure.
- Cover the sampling wound with gauze, and press it with a finger for 15-30 minutes.
- Please remove the gauze on the wound after 24 hours.
- You may take a shower on the day of the procedure. However, please keep the wound dry for 24 hours.
- For excessive bleeding or infection of the wound, or any discomfort, please immediately go to the emergency department for management.

Possible side effects:

- Wound infection and bleeding.
- Common side effects include localized pain and hematoma, while bleeding in the abdominal cavity or retroperitoneal space, and injury to major blood vessels are very rare.

* Note: If you wish to cancel the examination, please call the registration desk of the Radiology Department promptly at 04-23934191, extension 525415 to pass the opportunity of undergoing this examination to someone who needs it.

Reviewed and approved by the Medical Records Management Committee on May 4, 2023 No.: MR18-RAD-6 Version 04

Taichung Armed Forces General Hospital

Invasive Diagnostic/Therapeutic Examination (Procedure or Treatment) Consent Form

(Please review the examination instructions carefully and wait for the doctor to explain the examination to you before signing the consent form)

* Basic Information

Patient Name_____

Patient Date of Birth____YYYY_____MM_____DD

Patient Medical Record No._____

Name of Attending Physician_____

I. Examination (procedure or treatment) planned (provide brief explanation if not familiar with the medical terms)

1. Disease name:

2. Name of examination (procedure or treatment) planned:

□ Ultrasound-guided aspiration cytology □ CT-guided aspiration cytology

□ Mammography-guided fine needle aspiration □ Other

3. Reason for planned examination (procedure or treatment)

II. Physician statement

1. I have explained the examination (procedure or treatment) to the patient in ways as comprehensible as possible to provide the patient with the relevant information, particularly the following:

□ Reason why the examination (procedure or treatment) must be performed, method and site of the examination (procedure or treatment), and risks of the examination (procedure or treatment)

□ Examination (procedure or treatment) complications and possible management methods.

□ I have given the patient any other information available related to the treatment.

2. I have provided the patient with adequate time to ask the following questions about the examination (procedure or treatment) and I have answered the questions:

(1) ---

(2) ---

(3) ---

Signature of attending physician: Date: YYYY MM DD

Time: hh mm

III. Patient statement

1. The doctor has explained to me and I have understood the information related to the necessity, steps, and risks of the examination (procedure or treatment).
2. The doctor has explained to me and I have understood the possible prognosis of the examination (procedure or treatment) and risks if the examination is not performed.
3. I understand that during the examination (procedure or treatment), if an organ or tissue is removed for the purpose of the examination (procedure or treatment), the hospital may retain it for a period of time for examination and reporting, and will subsequently handle it carefully in accordance with the law.
4. I understand that this examination (procedure or treatment) may be the best option now.

Based on the above statement, I hereby give my consent to this examination (procedure or treatment).

Consenter Signature: Relationship to patient:

Address: Telephone:

Date: YYYY MM DD Time: hh mm

Witness: Signature:

Date: YYYY MM DD Time: hh mm

Notes: I. If the consenter is not the patient, the relationship to the patient should be indicated in the "Relationship to patient" field. II. The fields for the witness may be left blank if no witness is available. III. If the patient is a minor, a legal representative should sign the consent form.

IV. Risks of examination/procedure

1. Wound infection and bleeding.
2. Common side effects include localized pain and hematoma, while bleeding in the abdominal cavity or retroperitoneal space, and injury to major blood vessels are very rare.