Taichung Armed Forces General Hospital Voiding Cystourethrography Instructions

膀胱尿道造影說明書

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

Introduction to voiding cystourethrography (VCUG)

Voiding cystoureterography (VCUG) is primarily used to diagnose bladder-ureteral reflux or kidney reflux. It can also assess the bladder's capacity, function, residual urine volume, and any abnormalities in the urethra, especially differences in urethral diameter and the presence of valves.

Precautions before examination

- For young children, it is best to fast for 2-3 hours before the examination to prevent choking due to vomiting caused by crying, which is dangerous.
- Please read the instructions carefully and complete the Voiding Cystourethrography Consent Form and the Contrast Agent Injection Consent Form.

Precautions during examination

During the procedure, the doctor will insert a catheter to inject the contrast agent into the bladder. For young children, around 50 cc will be injected, and for adults or older children, the volume of contrast injected will depend on their tolerance. Images will be taken of the bladder from the front and at an angle. Then, you will be asked to void your bladder while X-ray fluoroscopy monitors the condition of the urethra and whether there is any reflux between the bladder and the ureters, which will be captured in the imaging.

You may feel mild discomfort while the catheter is inserted. Please relax your body as much as possible. The examination typically takes about 15-20 minutes.

Precautions after examination

- You may feel discomfort due to the catheter insertion.
- You may experience a sensation of fullness or discomfort due to the contrast injection.
- If you experience noticeable urethral discomfort or pain, please seek medical attention promptly at the outpatient clinic.

Possible complications

Urethral discomfort or pain; allergic reactions to the drug, such as nausea, vomiting, abdominal pain, night sweating, generalized discomfort, feverish sensations, generalized itching due to hives, and breathing difficulties. Severe allergic reactions leading to shock or sudden death are extremely rare.

Alternative options

Nuclear medicine imaging (such as radionuclide cystography or RNC) can only diagnose reflux and kidney damage but cannot reveal abnormalities in the urethra or bladder.

※If you wish to cancel the examination, please call the registration desk of the Radiology Department promptly at 04-23934191, extension: 525414, 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

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Taichung Armed Forces General Hospital
Voiding Cystourethrography Consent Form

(Please review the examination instructions carefully and wait for the physician 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 planned (provide brief explanation if not familiar with the medical terms)

1. Disease name:
2. Name of examination recommended:

   Voiding cystourethrography (VCUG)
3. Reason for the recommended examination:

II. Physician statement

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

☐ Reason why the examination must be performed, method and site of the examination, and risks of the examination.

☐ Examination 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 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 physician has explained to me and I have understood the information relate to the necessity, steps, and risks of the examination.
2. The physician has explained to me and I have understood the possible prognosis of the examination and risks if the examination is not performed.
3. The physician has explained to me that situations that are immediately life-threatening, if any, during the examination will be treated according to appropriate steps.
4. I understand that this examination may be the best option now. Based on the above statement, I hereby give my consent to this examination.

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. Possible complications

Urethral discomfort or pain; allergic reactions to the drug, such as nausea, vomiting, abdominal pain, night sweating, generalized discomfort, feverish sensations, generalized itching due to hives, and breathing difficulties. Severe drug allergies leading to shock or sudden death are extremely rare.

V. Alternative options

Nuclear medicine imaging (such as radionuclide cystography, RNC) can only diagnose reflux and kidney damage but cannot reveal abnormalities in the urethra or bladder.

Radiology Department of Taichung Armed Forces General Hospital Contrast Agent Injection Consent Form

Examinations involving the intravenous injection of a contrast agent utilize the contrast effect on the area to be examined to enhance and improve the visibility of the organs or lesions under examination to reach the diagnostic effect. Conventional ionic iodine-based contrast agents may cause allergic reactions in a small number of patients (the incidence of allergic reactions is 10%). Symptoms include nausea, vomiting, skin rashes, itching, and in a few severe cases, shock or even sudden death (the reported mortality rate is approximately 1 in 100,000, according to international statistics). However, if you have any of the following conditions, you will have a significantly increased risk of allergy.

□ 1. Heart, lung, and vascular diseases (impaired cardiac function, hypertension, arteriosclerosis and emphysema).

□ 2. Cirrhosis, poor liver function.

□ 3. Kidney dysfunction, uremia.

□ 4. Asthma.

□ 5. Diabetes mellitus for five years or longer.

□ 6. History of allergies (including reactions caused by the injection of iodine-based contrast agents, and allergies to food, other medications, pollen, or other allergens).

□ 7. A senior age with poor physical condition (72 years or above).

□ 8. A young age (infants or small children of 2 years or younger).

□ 9. Critically ill patients.

If you have any of the above conditions, please indicate a ˇ in the corresponding ☐

Signature of patient or family:_____

If the patient is a minor, a legal representative should sign the consent form.

※Please read these instructions before deciding to sign the examination consent form※

Date: YYYY MM DD Time: hh mm

Name:_____
ID No.:_____

Date of birth:__YYYY__MM__DD

Radiology Department of Taichung Armed Forces General Hospital

Pre-Contrast Injection Risk Assessment Form

※ **Please read the following questions first and complete the known ones. The remaining questions will be completed by the physician in the examination room.**

Have you ever had a history of allergies in the past? Allergy

☐ Nil

☐ Previous allergy to a contrast agent injected, and the type of allergy is:_____

☐ Allergy to food, drug or others, and the type is:_____

☐ Unknown

Contraindication

☐ Nil

☐ Severe hyperthyroidism

☐ Severe de-compensated heart failure

☐ Severe hepato-renal dysfunction

☐ Oliguria or anuria

Assessment of high risk conditions

☐ Nil

☐ Asthma, allergy constitution

☐ Renal dysfunction

☐ Cardiovascular disease

☐ Pulmonary hypertension

☐ Cerebral disease

☐ Thyroid disease

☐ Pheochromocytoma

☐ On metformin for diabetes mellitus

Cre values in last three months:_____(mg/dL)__

Evaluation physician:_____ Date: YYYY MM 日 hh mm