



1. Identification and description of the procedure

It is an image diagnosis technique which utilizes a radioactive tracer, Technetium-99m, to detect if stomach mucous exists out of its proper location.

Technique: after a fasting period of at least 6 hours before the exploration and during it, the patient is injected intravenously with the radioactive tracer. After this, images are obtained continuously in different positions and for up to two hours.

Previously, upon carrying out the exploration, the corresponding Nuclear Medicine Service personnel will inform you of the procedure and will answer your questions regarding it.

2. Purpose of the procedure and benefits that are expected to be achieved

Diagnosis of the existence of ectopic gastric mucous as the cause of gastrointestinal bleeding. To achieve a precise diagnosis utilizing a simple procedure, easy to perform, sensitive, without discomforts to the patient and that carries a low radiation dose, very inferior to other radiological techniques.

3. Reasonable alternatives to this procedure

Other image explorations are complementary (endoscopy, contrast radiological studies, etc.) even though they can produce more discomfort or more radiation to the patient.

4. Foreseeable consequences of its performance

To contribute to the diagnosis and adequate treatment of the patient.

5. Foreseeable consequences of its non performance

Delayed diagnosis.
Delayed therapeutic decisions.
Obtainment of an incomplete or incorrect diagnosis.

6. Frequent risks

Not described.

7. Infrequent risks.

Not described.

8. Risks depending on the patient's clinical situation

The exploration is not advised for pregnant women, even though in exceptional circumstances the risk/benefit will be evaluated.

In case of performing the exploration on a woman during lactation, she must interrupt it during a short time period.

During the day of the exploration close contact with small children and pregnant must be avoided.

Gammagraphy for the detection of gastric ectopic mucous

Declaration of consent

Mr./Mrs./Miss. aged , with home address at.....
..... , National Identity No. and SIP number
.....

Mr./Mrs./Miss. aged..... , with home address at.....
..... acting in the capacity of (the patient's legal representative, relative or close
friend) , with National Identity No.

Hereby declare:

That the Doctor has explained to me that it is advisable/necessary in my
situation to perform a
.....
and that I have adequately understood the information he/she has given me.

In on , 2

Signed: Mr./Mrs./Miss. With National Identity Card No

Signed: Dr. With National Identity Card No

Associate number

Revocation of the consent

I hereby revoke the consent granted on the date of , 2 and I do not wish
to carry on with the treatment that I hereby terminate on this date.

In on , 2

Signed: The Doctor

Signed: The patient

Associate number:



SPECIALITY IN NUCLEAR MEDICINE