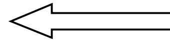
Greg S. Cohen, MD
GI Lab Address
259 East Erie Street, Lavin Family Pavilion  **go here for the procedure**
<u>16th Floor Reception Area</u>
Chicago, IL 60611 312-695-4452

Outpatient Anorectal Manometry Instructions

<u>Please read carefully</u> all the instructions TODAY and at least one week before your procedure and follow the instructions exactly. Failure to do so may result in the need to reschedule your procedure. If you have questions please call 312-926-2425 Monday – Friday, 8:00 am – 4:00 pm. **If you need to cancel, please call with at least 72 hours notice.**

ABOUT ANORECTAL MANOMETRY

Anorectal Manometry is a test used to assist your physician in the diagnosis and treatment of various rectal disorders such as incontinence and constipation. Anorectal Manometry allows your physician to measure the pressure in the rectum and in the anal sphincters to show how strong the sphincter muscles are and whether they relax as they should when having a bowel movement. It also measures the ability to perceive sensations of fullness in the rectum.

ANORECTAL MANOMETRY PREPARATION

- Before your test, the GI lab nurse will review your medical history, allergies, and current medications. Please complete the patient questionnaire which is attached to this packet and bring it with you to the GI lab on the day of your test.
- You will need to administer 2 Fleet's enemas (available without a prescription over-the-counter) 2 hours before the test. The rectum needs to be clear of stool to perform an accurate test.
- There are no eating or drinking restrictions prior to the Anorectal Manometry. However, you may wish to eat a light breakfast and/or lunch on the day of your test.

DURING THE ANORECTAL MANOMETRY

Anorectal Manometry takes about **<u>15 minutes to complete</u>.** The physician will explain the test and ask you several questions related to the symptoms that you have been experiencing. Then you will be asked to lie on your left side. The physician will perform a rectal exam before starting the Anorectal Manometry test. A thin catheter, which is a flexible plastic tube about the size of a drinking straw will be inserted into the rectum to perform the test. The Anorectal Manometry catheter has a small balloon at the tip which is filled with air. During the test, pressure measurements will be taken. The catheter may be moved around slightly to ensure proper positioning.

During the test you may experience some rectal pressure and/or a feeling of having to have a bowel movement. The physician or technician will ask you to squeeze, relax, and push during the test. During these exercises, the anal sphincter muscle pressures are measured. When squeezing, you will tighten your sphincter muscles as if trying to prevent yourself from having a bowel movement. When pushing, you will bear down as if trying to have a bowel movement. You will also be asked during these exercises if you notice any rectal sensations. In some cases a balloon expulsion test may be performed in which a small balloon at the end of the Anorectal Manometry catheter is inflated and you are asked to try to push the catheter out. Once the Anorectal Manometry is completed, the catheter will be removed and your test will be finished.

AFTER THE ANORECTAL MANOMETRY

The Anorectal Manometry test is usually well tolerated with no serious problems or side effects. Unless instructed otherwise by your physician, after the test, you may resume all normal activities. Your physician will receive the test results usually within 4 business days and will discuss the results with you.

Northwestern Memorial Hospital

GI LABORATORY
At-Home Medications List

Dear Patient,
Please complete the Allergies and Medication sections. A staff member will review this list with you if there are any questions.
If you have questions about medications NOT prescribed during today's visit, please contact your primary care physician.

ALLERGIES: ☐ None (check the box if you do not have any allergies)

Source	Reaction	Source	Reaction
Example: Penicillin	*Hives*	3.	
1.		4.	
2.		5.	

MEDICATIONS: ☐ None (check the box if you do not take any medications, vitamins, herbals, etc) Physician/Staff Use

DRUG List the medications you are taking, include all over-the-counter medicines, vitamins, herbals, minerals, and those you may have held for today's visit.	**STRENGTH** List the strength of each tablet, capsule, etc.	**DOSE/ DOSE FORM** How many tablets, units, capsules, are you taking at one time?	**FREQUENCY** How often do you take the medication? (once a day, twice a day, etc.)	**ROUTE** How are you taking this medication? (by mouth,injection, patch, etc.)	**LAST DOSE TAKEN** Indicate the date and time you last took the medication	***Physician:*** **Please check if prescribing additions or changes to chronic medications** ***Staff:*** **If checked, refer to Instructions below. If not checked, file list**
Ex. Cardizem CD	*180 mg*	*1 capsule*	*once a day*	*by mouth*	*9 pm last night*	☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐
						☐

Date:______________________________

Do not write below this line - Hospital Staff ONLY

INSTRUCTIONS:
Staff: If, during this visit, the patient was prescribed a new medication for a chronic disease/condition or a change was made to the at-home medication regimen for a chronic disease/condition, complete the patient instructions portion below, instruct the patient regarding additions and/or changes, and provide the patient with a photocopy of this document. After completion, check box below, and file.

☐ Medication instructions were reviewed with the patient. The patient received a photocopy of this medication list.

Patient: START/RE-START taking this at-home medication(s):

Condition Medication is prescribed for:	Take this Medication at this Strength:	At this Dose/Dose Form:	How often: (Frequency)	Route:	Start taking this Medication on:	Date, if any, you should **stop** taking this medication:
					___/____/____	
					___/____/____	

Patient: STOP taking this at-home medication:

STOP taking this Medication at this Strength, Dose/Dose Form, and Frequency: ______________________________

STOP taking this Medication on:_________ /______ /_________

Additional Comments: ______________________________

420610 (02/09)