STANDARD OPERATING PROCEDURE

OESOPHAGO-GASTRO-DUODENOSCOPY (OGD)

1. Purpose

To establish a standardized protocol for safe and effective diagnostic and therapeutic upper gastrointestinal endoscopy for surgical patients.

2. Scope

Applies to: General surgeons, endoscopy nurses and anesthesia team

3. Responsibilities

Surgeon / Endoscopist - confirm indication, risk assessment, consent, perform procedure, documentation

Endoscopy Nurse - Patient preparation, IV access, monitoring, assist procedure, recovery observation, equipment preparation, scope sterilization and image recording

Anesthesia Team (if deep sedation required) – Sedation, airway management and recovery supervision

4. Indications

Upper GI bleeding, dysphagia, GERD symptoms, epigastric pain, unexplained anemia suspected malignancy, caustic ingestion, foreign body

5. Contraindications

Absolute - Unstable patient, uncooperative patient without sedation, recent MI with instability

Relative - Severe coagulopathy, recent upper GI surgery, cervical spine instability, severe hypoxia

6. Pre-Procedure Assessment

History - Indication, Bleeding history, Liver disease
Anticoagulants, Antiplatelets, NSAID use
Previous endoscopy, Allergies

Examination- vitals, airway assessment, abdominal exam

Investigations - CBC, INR, LFT, Urea , ECG if elderly/high risk.

7. Patient Preparation

Consent - Explain: Procedure, sedation, biopsy, bleeding risk, perforation risk, aspiration risk

Fasting - Minimum: 6 hours solids, 2 hours clear fluids

Premedication- Lignocaine throat spray, Midazolam, Buscopan

8. Equipment Preparation

Endoscope system: Gastroscope, light source, monitor, suction

Accessories: Biopsy forceps, band ligator and foreign body forceps

Emergency: Oxygen, suction, ambu bag, crash trolley, adrenaline, IV fluids

9. Procedure Steps

Position Left lateral position**.** Neck slightly flexed.

Monitoring: Continuous: Pulse, BP, SpO_2

Procedure Technique

Step 1: Oral entry

Step 2: Oesophagus examination - look for: Tumor, Varices, Esophagitis, Stricture, Candida, Ulcer

Step 3: GE junction Assess: Z line, hiatus hernia, Barrett's changes

Step 4: Stomach examination - Look for: Ulcer, tumor, gastritis, bleeding, polyps

Step 5: Duodenum Look for: Duodenal ulcer, tumor, bleeding, deformity

Step 6: Therapeutic procedures (if needed) Biopsy, banding, foreign body removal

10. Documentation

Patient details, Indication, Extent examined, Findings, Intervention, Biopsy site, Complications, Photos

11. Post Procedure Care

Monitor: 30–60 minutes if sedated.

Check: vitals, bleeding, pain, conscious level

Diet: If throat spray only: start fluids after gag reflex returns.

If sedation: start when fully awake.

12. Complications

Bleeding Usually after biopsy.

Management: Observation, adrenaline injection

Perforation

Signs: Severe chest pain, subcutaneous emphysema, tachycardia

Management: Nil by mouth, IV antibiotics, CT scan, Surgical consultation

Aspiration

Management: Oxygen, suction, antibiotics if needed

Sedation complications

Management: Airway support, oxygen

Reversal: Flumazenil (benzodiazepine), Naloxone (opioid)

13. Discharge Criteria

Patient may be discharged if: stable vitals, fully conscious, no bleeding, no severe pain

Instructions: Return if: Hematemesis, melena, severe pain, fever, dysphagia

Avoid: driving 24 hours after sedation.

14. Follow Up

Depends on findings:

Normal → treat symptoms

Biopsy: review histology

15. Infection Control

Endoscope reprocessing: Pre-cleaning, leak test, manual cleaning, high level disinfection, drying, storage

16. References

ASGE guidelines
ESGE guidelines
Tokyo GI bleeding guidelines
NICE UGIB guidelines