Key messages for patients

- Please read your admission letter carefully. It is important to follow the instructions we give you about not eating or drinking or we may have to postpone or cancel your operation.

- Please read this information carefully, you and your health professional will sign it to document your consent.

- It is important that you bring the consent form with you when you are admitted for surgery. You will have an opportunity to ask any questions from the surgeon or anaesthetist when you are admitted. You may sign the consent form either before you come or when you are admitted.

- Please bring with you all of your medications and its packaging (including inhalers, injections, creams, eye drops, patches, insulin and herbal remedies), a current repeat prescription from your GP, any cards about your treatment and any information that you have been given relevant to your care in hospital, such as x rays or test results.

- Simple painkillers such as paracetamol and ibuprofen may be required after surgery. Simple bowel medication such as senna and lactulose may be required after surgery. It is suggested that you discuss with your pharmacist and have a seven day supply of these medications at home to take as you need according to the instructions.

- Take your medications as normal on the day of the procedure unless you have been specifically told not to take a drug or drugs before or on the day by a member of your medical team. Do not take any medications used to treat diabetes.

- If you have any concerns requiring urgent medical advice please call the nurse specialist during working hours on 01223 596383 or through the hospital contact centre on 01223 245151 and ask for pager 154-348. During evenings or weekends please call Upper GI Enhanced recovery unit (ward M4) via contact centre.

After the procedure we will file the consent form in your medical notes and you may take this information leaflet home with you.

Important things you need to know
Patient choice is an important part of your care. You have the right to change your mind at any time, even after you have given consent and the procedure has started (as long as it is safe and practical to do so). If you are having an anaesthetic you will have the opportunity to discuss this with the anaesthetist, unless the urgency of your treatment prevents this.
We will also only carry out the procedure on your consent form unless, in the opinion of the health professional responsible for your care, a further procedure is needed in order to save your life or prevent serious harm to your health. However, there may be procedures you do not wish us to carry out and these can be recorded on the consent form. We are unable to guarantee that a particular person will perform the procedure. However the person undertaking the procedure will have the relevant experience.

All information we hold about you is stored according to the Data Protection Act 1998.

**About laparoscopic Heller’s myotomy for achalasia**

A Heller’s myotomy is an operation to divide (cut through) the muscular fibres of the lower sphincter of the oesophagus. The aim of the surgery is to improve swallowing. Achalasia is the name given to the condition where the muscle fibres of the lower oesophagus do not relax, causing symptoms such as difficulty in swallowing, regurgitation and discomfort in the chest.

The oesophagus (gullet) is a complex muscular tube that carries food and fluid from the throat to the stomach passing through the chest. There is a muscular sphincter (opening) at each end to prevent the stomach contents from refluxing back up the oesophagus. The lowest of these sphincters is positioned at the junction between the oesophagus and the stomach (level with the diaphragm). Normally, when we swallow, the upper and lower sphincters of the oesophagus relax in a coordinated way as a wave of peristalsis (muscular contractions) passes from the throat down towards the stomach. This carries the food or liquid downwards.

In patients with achalasia the lower sphincter of the oesophagus does not relax normally during swallowing. Food, therefore, gets lodged above the sphincter and you may feel that the food has become ‘stuck’ in the gullet. Sometimes, for comfort, this food has to be regurgitated back into the mouth. Other times, the food will slowly enter the stomach after small sips of drinks are taken. The exact reason why the lower sphincter does not relax in achalasia is unknown. However, studies have shown that there is an abnormality in the nerve junctions in the muscle of the sphincter, which lead to its lack of relaxation on swallowing. As time passes a patient who has achalasia will slowly develop a dilated oesophagus and then the muscular contractions of the main body of the oesophagus fail because constantly trying to push food through an unrelaxed sphincter.

**Intended benefits**

The aim of the surgery is to divide the lower sphincter of the oesophagus and muscle in order to improve swallowing.

**Who will perform my procedure?**

This procedure will be performed by the consultant or senior surgical trainee under supervision.
Before treatment
Most patients attend a pre-admission clinic, when you will meet a member of the team. At this clinic, we will ask for details of your medical history and carry out any necessary clinical examinations and investigations. Please ask us any questions about the procedure, and feel free to discuss any concerns you might have at any time.

We will ask if you take any tablets or use any other types of medication either prescribed by a doctor or bought over the counter in a pharmacy. Please bring all your medications and any packaging (if available) with you. Please tell the ward staff about all of the medicines you use. If you wish to take your medication yourself (self-medicate), please ask your nurse. Pharmacists visit the wards regularly and can help with any medicine queries.

This procedure involves the use of anaesthesia. We explain about the different types of anaesthesia or sedation we may use at the end of this leaflet. You will see an anaesthetist before your procedure.

You will normally be admitted on the day of surgery and stay in hospital overnight. Most patients go home the following day if all is well.

During the surgery
Laparoscopic (keyhole surgery) uses long thin cameras and instruments to work inside the abdominal cavity through a number of small incisions (ports) rather than through a traditional large incision. The surgeon sees the pictures from the camera on a television monitor. The advantage of this approach is much less pain after the operation and a quicker recovery.

We use five 0.5-2 cm incisions across the top of the abdomen, to inflate the abdominal cavity with carbon dioxide gas and then insert the cameras and instruments. We then lift the liver out of the way with a special retractor and identify the junction between the oesophagus and stomach. We then carefully divide a 8-10 cm segment of the lower sphincter of the oesophagus and oesophageal muscle. At this stage it is important that the lining (mucosa) is not damaged. To check this and ensure that all the lower sphincter muscle has been adequately divided, we usually pass an endoscope down into the oesophagus from the mouth to examine it. The operation is completed by doing a procedure called a hemi fundoplication. This involves stitching part of the top of the stomach across the front of the junction of the oesophagus and stomach as it passes through the diaphragm and where the lower sphincter muscle has been divided. This helps to reduce the risk of acid reflux after this operation.

All the small incisions in the abdomen are injected with local anaesthetic before you wake up and, therefore should only cause mild discomfort at first. It might, however, be necessary to have some stronger pain control (for example, Morphine) later in the day, depending on how much pain you are experiencing.
We do not routinely use nasogastric tubes which are tubes passing down through the nose and into the stomach, but sometimes this is necessary if the operation has been very difficult and we want to be sure that the stomach is kept empty for the first 24 hours. You will have an intravenous drip in the back of your hand to give you fluids immediately after surgery.

You will be allowed to drink soon after your surgery if all has gone well. If drinking is well tolerated most patients start some soft food the day after their operation and often go home later that day. Some patients do stay longer.

The dressings on your wounds are transparent and waterproof or skin glue. You can have a shower while they are in place, but we ask you to refrain from having a bath for five days. After five days, you can remove the dressings yourself and leave the wounds open to the air and if you have glue, it will start to come off after two weeks. They will still be soreness for a week or two and you will probably need to take some regular pain killers.

After treatment
Once your surgery is completed you will usually be transferred to the recovery ward where you will be looked after by specially trained nurses, under the direction of your anaesthetist. The nurses will monitor you closely until the effects of any general anaesthetic have adequately worn off and you are conscious. The team will monitor your heart rate, blood pressure and oxygen levels too. You may be given oxygen via a facemask, fluids via your drip and appropriate pain relief until you are comfortable enough to return to your ward.

Sometimes, people feel sick after an operation, especially after a general anaesthetic, and might vomit. If you feel sick, please tell a nurse and you will be offered medicine to make you more comfortable.

If there is not a bed in the necessary unit on the day of your operation, your operation may be postponed as it is important that you have the correct level of care after major surgery.

Eating and drinking. After this procedure, you should not have anything to eat or drink until your medical team considers it to be safe - this is usually when you are fully awake following your operation.

Getting about after the procedure. Generally, it is best to get out of bed as soon as you feel you can. If, on the first day you cannot get out of bed, you will be encouraged to move your legs in bed to prevent blood clots forming. If you have an mobility problems, we can arrange nursing or physiotherapy help.

Leaving hospital. Most people who have had this type of procedure will be able to leave hospital after one day. The actual time that you stay in hospital will depend on your general health, how quickly you recover from the procedure and your doctor’s opinion. We will give you a copy of your discharge summary when you are discharged from hospital.
**Resuming normal activities including work.** Most people who have had this procedure can resume normal activities after about two weeks. You might need to wait a little longer before resuming more vigorous activity (four to six weeks). When you will be ready to return to work will depend on your usual health, how fast you recover and what type of work you do. Please ask your doctor for his/her opinion.

**Special measures after the procedure.**

- The procedure aims to improve your ability to swallow. However, the oesophagus still does not work normally. You will therefore, need to modify your diet significantly compared to what is considered a “normal” diet. You are likely to need to eat softer and more liquid foods. You will be given more detailed information about any special measures you need to take after the procedure.

- **Results:** Generally results of dividing the lower oesophageal sphincter with a keyhole operation are very good. The obstruction in the oesophagus is relieved and food therefore passes more normally into the stomach. The effects should be felt almost immediately after the operation. Sometimes the normal contractions of the oesophagus have been damaged by the unrelaxing lower oesophageal sphincter and you may continue to have poor swallowing. However, your swallowing should be much better than before the operation. Many patients notice some reflux symptoms such as heartburn despite the anti-reflux procedure built into this procedure. This is an unavoidable problem when the lower oesophageal sphincter is divided. Whether you will or will not be affected by this is impossible to predict. If it is troublesome then a simple pill once a day to reduce stomach acid is often effective.

**Follow up.** You will be seen in clinic between around six weeks after surgery for a postoperative check. We will then see you at around three months to make sure that the improvements continue and you are gaining weight. If you are doing well at this stage, you will be discharged from our care.

**Significant, unavoidable or frequently occurring risks of this procedure**

Keyhole (laparoscopic) surgery for achalasia is a safe procedure. However, there are potential risks involved in any form of surgery and we believe that it is important that you are aware of these risks.

**Damage to the lining of the oesophagus (the mucosa):** Such damage can occur with this operation. If we detect this at the time of surgery, a suture (stitch) is placed in the damaged area and at times a nasogastric tube inserted through your nose and down the oesophagus into the stomach. This will keep the stomach empty while the area heals. If this happens, you will not be able to drink until a special contrast X-ray has been performed, which is usually takes place around three to five days. This checks that there is no leakage of fluid from the damaged area. If this happens, you may be in hospital for longer rather than the usual one
day. Assuming that there is no leakage from the repaired lining, this complication should not have a major impact on your recovery, other than keeping you in hospital for a little longer. If there is damage to the mucosa and we do not detect it at the time of surgery then leakage can occur from the oesophagus, which can be very serious. However, because we usually use an endoscope during the operation to check carefully for damage, it is very unlikely that we would not detect any injury to the lining and be able to repair it during the operation and before leakage occurs.

**Damage to the spleen:** During part of the operation discussed earlier, the small blood vessels between the spleen and the upper part of the stomach (fundus) sometimes need to be cut using special instruments that seal the blood vessels before they are divided. However, very rarely damage to the spleen can occur. Frequently this can be controlled simply using the keyhole method, however, if the spleen were to sustain a more severe injury this may require conversion to an open cut operation with the potential of removal of the spleen.

**Wound infection:** These are rare with keyhole surgery and if they do occur can be treated simply with antibiotics and at times draining the infection.

**Damage to other organs inside your abdomen:** This is a rare complication of keyhole surgery but it has been recognised that during the insertion of instruments into the abdominal cavity damage can occur to any other intra-abdominal organs, including the intestine, liver and blood vessels. If this were to occur then it is likely that the approach to the operation would have to be changed from a keyhole approach to an open approach.

**Deep vein thrombosis (DVT) and pulmonary embolus:** All surgery carries varying degrees of risks of thrombosis (clots) in the deep veins of your leg. In the worst case a clot in the leg can break off and travel to the lung (pulmonary embolism). This can significantly impair your breathing. To prevent these problems around the time of your operation and following your operation we give you some special injections to ‘thin’ the blood. We also ask you to wear compression stockings on your legs before and after surgery and also sometimes use a special device to massage the calves during the surgery. Moving about as much as you can, including pumping your calf muscles in bed or sitting out of bed as soon as possible reduces the risk of these complications.

**Conversion to an open operation:** We always warn people who are undergoing a keyhole procedure that there is a small risk that if the operation is technically not possible to complete through a keyhole technique we will make an open cut. If this is necessary, it will result in a larger scar and more post-operative discomfort and, inevitably, a longer stay in hospital.

**Scarring:** Any surgical procedure that involves making a skin incision carries a risk of scar formation. A scar is the body’s way of healing and sealing the cut. It is highly variable between different people. All surgical incisions are closed with the utmost care, usually involving several layers of sutures. The sutures are almost always dissolvable and do not
have to be removed. The larger an incision the more prominent it will be. Despite our best intentions, there is no guarantee that any incision (even those only 0.5-2 cm in length) will not cause a scar that is somewhat unsightly or prominent. Scars are usually most prominent in the first few months following surgery, however, tend to fade in colour and become less noticeable after a year or so.

**Requirement for re-operation:** It is unlikely, although possible, that some time after the operation you may need a further procedure related to the Heller’s myotomy. This is because it possible that other muscle fibres, separate to those that were divided cause problems in the future. Also, sometimes there can be a build up of scar tissue around the site of operation that needs to be released with another operation.

**Reaction to surgical material:** There is a very small chance of developing reaction/allergy to surgical material and glue and if you develop redness, itchiness or discharge please let us or your GP know.

**Other complications:** We have tried to describe the most common and serious complications that may occur following this surgery. It is not possible to detail every possible complication that may occur following any operation. If another complication that you have not been warned about occurs, we will treat it as required and inform you as best we can at the time. If there is anything that is unclear or risks that you are particularly concerned about, please ask.

**Alternative procedures that are available**

There are a few ways of approaching the treatment of achalasia:

1. The muscular sphincter can be stretched with a balloon placed inside the oesophagus through the mouth. This balloon is then inflated and tears the muscle of the sphincter but leaves the internal lining of the oesophagus intact. There is a risk of damage to the lining which can lead to a large tear requiring emergency surgery.
2. Another alternative is to inject botulism toxin (‘Botox’) using an endoscope into the muscle to paralyse it and allow it to relax. This is quick and relatively easy to perform but is only temporary and will have to be repeated sometimes every few months.
3. Another option is perform endoscopic myotomy through the endoscope. (POEM).
4. The fourth way is the operation described in this document. (Heller’s myotomy).
5. If the achalasia is long standing with extensive oesophageal involvement your surgeon will also discuss whether oesophagectomy (removing most of the gullet) is indicated.
6. There is always the option of not doing any medical or surgical treatment and also consider feeding via feeding tubes.

Results from laparoscopic surgery are very durable and most patients make a rapid recovery.
You should bear this in mind all the options when deciding what treatment to have.

**Anaesthesia**

Anaesthesia means ‘loss of sensation’. There are three types of anaesthesia: general, regional and local. **The type of anaesthesia chosen by your anaesthetist depends on the nature of your surgery as well as your health and fitness.** Sometimes different types of anaesthesia are used together.

**Before your operation**

Before your operation you will meet an anaesthetist who will discuss with you the most appropriate type of anaesthetic for your operation, and pain relief after your surgery. To inform this decision, he/she will need to know about:

- your general health, including previous and current health problems
- whether you or anyone in your family has had problems with anaesthetics
- any medicines or drugs you use
- whether you smoke
- whether you have had any abnormal reactions to any drugs or have any other allergies
- your teeth, whether you wear dentures, or have caps or crowns.

Your anaesthetist may need to listen to your heart and lungs, ask you to open your mouth and move your neck and will review your test results.

**Pre-medicine**

You may be prescribed a ‘premed’ prior to your operation. This is a drug or combination of drugs which may be used to make you sleepy and relaxed before surgery, provide pain relief, reduce the risk of you being sick, or have effects specific for the procedure that you are going to have or for any medical conditions that you may have. Not all patients will be given a premed or will require one and the anaesthetist will often use drugs in the operating theatre to produce the same effects.

**Moving to the operating room or theatre**

You will usually change into a gown before your operation and we will take you to the operating suite. When you arrive in the theatre or anaesthetic room and **before starting your anaesthesia, the medical team will perform a check of your name, personal details and confirm the operation you are expecting.**

Once that is complete, monitoring devices may be attached to you, such as a blood pressure cuff, heart monitor (ECG) and a monitor to check your oxygen levels (a pulse oximeter). An intravenous line (drip) may be inserted. If a regional anaesthetic is going to be performed, this may be performed at this stage. If you are to have a general anaesthetic, you may be asked to breathe oxygen through a face mask.

**General anaesthesia**

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During general anaesthesia you are put into a state of unconsciousness and you will be unaware of anything during the time of your operation. Your anaesthetist achieves this by giving you a combination of drugs.

While you are unconscious and unaware your anaesthetist remains with you at all times. He or she monitors your condition and administers the right amount of anaesthetic drugs to maintain you at the correct level of unconsciousness for the period of the surgery. Your anaesthetist will be monitoring such factors as heart rate, blood pressure, heart rhythm, body temperature and breathing. He or she will also constantly watch your need for fluid or blood replacement.

**Regional anaesthesia**

Regional anaesthesia includes epidurals, spinals, caudals or local anaesthetic blocks of the nerves to the limbs or other areas of the body. Local anaesthetic is injected near to nerves, numbing the relevant area and possibly making the affected part of the body difficult or impossible to move for a period of time. Regional anaesthesia may be performed as the sole anaesthetic for your operation, with or without sedation, or with a general anaesthetic. Regional anaesthesia may also be used to provide pain relief after your surgery for hours or even days. Your anaesthetist will discuss the procedure, benefits and risks with you and, if you are to have a general anaesthetic as well, whether the regional anaesthesia will be performed before you are given the general anaesthetic.

**Local anaesthesia**

In local anaesthesia the local anaesthetic drug is injected into the skin and tissues at the site of the operation. The area of numbness will be restricted and some sensation of pressure may be present, but there should be no pain. Local anaesthesia is used for minor operations such as stitching a cut, but may also be injected around the surgical site to help with pain relief. Usually a local anaesthetic will be given by the doctor doing the operation.

**Sedation**

Sedation is the use of small amounts of anaesthetic or similar drugs to produce a ‘sleepy-like’ state. Sedation may be used as well as a local or regional anaesthetic. The anaesthesia prevents you from feeling pain, the sedation makes you drowsy. Sedation also makes you physically and mentally relaxed during an investigation or procedure which may be unpleasant or painful (such as an endoscopy) but where your co-operation is needed. You may remember a little about what happened but often you will remember nothing. Sedation may be used by other professionals as well as anaesthetists.

**What will I feel like afterwards?**

How you will feel will depend on the type of anaesthetic and operation you have had, how much pain relieving medicine you need and your general health.

Most people will feel fine after their operation. Some people may feel dizzy, sick or have general aches and pains. Others may experience some blurred vision, drowsiness, a sore throat, headache or breathing difficulties.

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You may have fewer of these effects after local or regional anaesthesia although when the effects of the anaesthesia wear off you may need pain relieving medicines.

**What are the risks of anaesthesia?**

In modern anaesthesia, serious problems are uncommon. Risks cannot be removed completely, but modern equipment, training and drugs have made it a much safer procedure in recent years. The risk to you as an individual will depend on whether you have any other illness, personal factors (such as smoking or being overweight) or surgery which is complicated, long or performed in an emergency.

**Very common (1 in 10 people) and common side effects (1 in 100 people)**
- Feeling sick and vomiting after surgery
- Sore throat
- Dizziness, blurred vision
- Headache
- Bladder problems
- Damage to lips or tongue (usually minor)
- Itching
- Aches, pains and backache
- Pain during injection of drugs
- Bruising and soreness
- Confusion or memory loss

**Uncommon side effects and complications (1 in 1000 people)**
- Chest infection
- Muscle pains
- Slow breathing (depressed respiration)
- Damage to teeth
- An existing medical condition getting worse
- Awareness (becoming conscious during your operation)

**Rare (1 in 10,000 people) and very rare (1 in 100,000 people) complications**
- Damage to the eyes
- Heart attack or stroke
- Serious allergy to drugs
- Nerve damage
- Death
- Equipment failure

Deaths caused by anaesthesia are very rare. There are probably about five deaths for every million anaesthetics in the UK. For more information about anaesthesia, please visit the Royal College of Anaesthetists’ website: [www.rcoa.ac.uk](http://www.rcoa.ac.uk)
Information about important questions on the consent form

1  Creutzfeldt Jakob Disease (‘CJD’)

We must take special measures with hospital instruments if there is a possibility you have been at risk of CJD or variant CJD disease. We therefore ask all patients undergoing any surgical procedure if they have been told that they are at increased risk of either of these forms of CJD. This helps prevent the spread of CJD to the wider public. A positive answer will not stop your procedure taking place, but enables us to plan your operation to minimise any risk of transmission to other patients.

2  Photography, Audio or Visual Recordings

As a leading teaching hospital we take great pride in our research and staff training. We ask for your permission to use images and recordings for your diagnosis and treatment, they will form part of your medical record. We also ask for your permission to use these images for audit and in training medical and other healthcare staff and UK medical students; you do not have to agree and if you prefer not to, this will not affect the care and treatment we provide. We will ask for your separate written permission to use any images or recordings in publications or research.

3  Students in training

Training doctors and other health professionals is essential to the NHS. Your treatment may provide an important opportunity for such training, where necessary under the careful supervision of a registered professional. You may, however, prefer not to take part in the formal training of medical and other students without this affecting your care and treatment.

4  Use of Tissue

As a leading bio-medical research centre and teaching hospital, we may be able to use tissue not needed for your treatment or diagnosis to carry out research, for quality control or to train medical staff for the future. Any such research, or storage or disposal of tissue, will be carried out in accordance with ethical, legal and professional standards. In order to carry out such research we need your consent. Any research will only be carried out if it has received ethical approval from a Research Ethics Committee. You do not have to agree and if you prefer not to, this will not in any way affect the care and treatment we provide. The leaflet ‘Donating tissue or cells for research’ gives more detailed information. Please ask for a copy.

If you wish to withdraw your consent on the use of tissue (including blood) for research, please contact our Patient Advice and Liaison Service (PALS), on 01223 216756.
Patient Information

Information and support
We may give you some additional patient information before or after the procedure, for example: leaflets that explain what to do after the procedure and what problems to look out for. If you have any questions or anxieties, please feel free to ask a member of staff including your surgeon or one of the senior trainees.

To contact one of the consultants please call 01223 217421 or 01223 358024.

Privacy & Dignity
Same sex bays and bathrooms are offered in all wards except critical care and theatre recovery areas where the use of high-tech equipment and/or specialist one to one care is required.

We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site.

For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:
If you would like this information in another language or audio, please contact Interpreting services on telephone: 01223 348043, or email: interpreting@addenbrookes.nhs.uk For Large Print information please contact the patient information team: patient.information@addenbrookes.nhs.uk.

Document history
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Laparoscopic heller’s myotomy for achalasia 100932, V2. September 2018
Laparoscopic Heller’s myotomy for achalasia +/- Fundoplication +/- Gastroscopy

| Patient’s side | left / right | or | N/A |

Consultant or other responsible health professional

Name and job title: 

☐ Any special needs of the patient (e.g. help with communication)? 

Please use ‘Procedure completed’ stamp here on completion: 

Statement of health professional (details of treatment, risks and benefits)

1 I confirm I am a health professional with an appropriate knowledge of the proposed procedure, as specified in the hospital’s consent policy. I have explained the procedure to the patient. In particular, I have explained:

a) the intended benefits of the procedure (please state)

To relief symptoms of achalasia

b) the possible risks involved. Addenbrooke’s always ensures any risks are minimised. However all procedures carry some risk and I have set out below any significant, unavoidable or frequently occurring risks including those specific to the patient

Full details are set out in the patient information and include:

haemorrhage, infection, mucosal breach, re-operation, vascular or intestinal injury, splenic injury.

c) what the treatment or procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient:
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Laparoscopic Heller’s myotomy for achalasia +/- Fundoplication +/- Gastroscopy

1) any extra procedures that might become necessary during the procedure such as:
   □ Blood transfusion    □ Other procedure (please state)
   Conversion to open procedure

2) The following information leaflet has been provided:

   
   Laparoscopic Heller’s myotomy for achalasia +/- Fundoplication +/- Gastroscopy

   Version, reference and date: Version 2, 100932, September 2018

   or □ I have offered the patient information about the procedure but this has been declined.

3) This procedure will involve:
   □ General and/or regional anaesthesia    □ Local anaesthesia    □ Sedation    □ None

Signed (Health professional): ........................................ Date: D.M.Y.Y.Y.Y.

Name (PRINT): ...................................................... Time (24hr): H.H.H.H.M.M.

Designation: ........................................................ Contact/bleep no: ........................................

C Consent of patient / person with parental responsibility

I confirm that the risks, benefits and alternatives of this procedure have been discussed
with me and that my questions have been answered to my satisfaction and understanding.

Important: please read the patient information about this procedure and then put a
tick in the relevant boxes for the following questions:

1) Creutzfeldt Jakob disease (CJD)
   Have you ever been notified that you are at risk of CJD or variant CJD
   for public health purposes? If yes, please inform your health professional. □ Yes □ No

2) Photography, Audio or Visual Recording
   a) I agree to the use of any of the above type of recordings for the purpose
      of diagnosis and treatment. □ Yes □ No
   b) I agree to unidentified versions of any of the above recordings being used
      for audit and medical teaching in a healthcare setting. □ Yes □ No

3) Students in training
   I agree to the involvement of medical and other students as part
   of their formal training. □ Yes □ No

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File: in the procedures and consents section of the casenotes

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Laparoscopic heller’s myotomy for achalasia 100932, V2, September 2018
Consent Form

Laparoscopic Heller’s myotomy for achalasia +/- Fundoplication +/- Gastroscopy

4 Use of Tissue

a) I agree that tissue (including blood) not needed for my own diagnosis or treatment can be used and stored for ethically approved research which may include ethically approved genetic research.

☐ Yes ☐ No

b) Where additional clinical information is needed for the purposes of ethically approved research, I agree that relevant sections of my medical record may be looked at by researchers or by relevant regulatory authorities. I give permission for these individuals to have access to my records.

☐ Yes ☐ No

I have listed below any procedures that I do not wish to be carried out without further discussion.

I have read and understood the Patient Information about this procedure and the above additional information. I agree to the procedure or treatment.

Signed (Patient): .................................................. Date: __/__/YYYY

Name of patient (PRINT): ...........................................................

If signing for a child or young person; delete if not applicable.

I confirm I am a person with parental responsibility for the patient named on this form.

Signed: .......................................................... Date: __/__/YYYY

Relationship to patient:

If the patient is unable to sign but has indicated his/her consent, a witness should sign below.

Signed (Witness): .................................................. Date: __/__/YYYY

Name of witness (PRINT): ...........................................................

Address:

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**Consent Form**

Laparoscopic Heller’s myotomy for achalasia +/- Fundoplication +/- Gastroscopy

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**D  Confirmation of consent**

**Confirmation of consent** (where the treatment/procedure has been discussed in advance)

On behalf of the team treating the patient, I have confirmed with the patient that she/he has no further questions and wishes the treatment/procedure to go ahead.

Signed (Health professional): ................................. Date: .................................

Name (PRINT): ................................. Job title: .................................

Please initial to confirm all sections have been completed:

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**E  Interpreter’s statement** (if appropriate)

I have interpreted the information to the best of my ability, and in a way in which I believe the patient can understand:

Signed (Interpreter): ................................. Date: .................................

Name (PRINT): .................................

Or, please note the language line reference ID number:

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**F  Withdrawal of patient consent**

☐ The patient has withdrawn consent (ask patient to sign and date here)

Signed (Patient): ................................. Date: .................................

Signed (Health professional): ................................. Date: .................................

Name (PRINT): ................................. Job title: .................................

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Patient safety – at the heart of all we do

Addenbrooke’s Hospital | Rosie Hospital

Laparoscopic heller’s myotomy for achalasia 100932, V2, September 2018

File in the procedures and consents section of the case notes.