

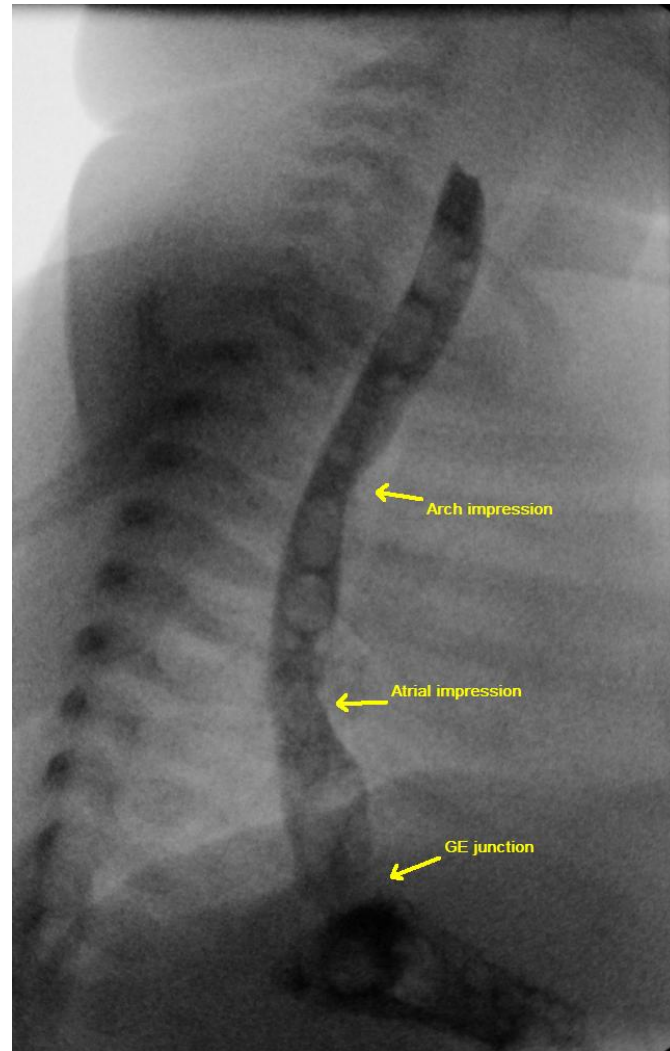
Caveats

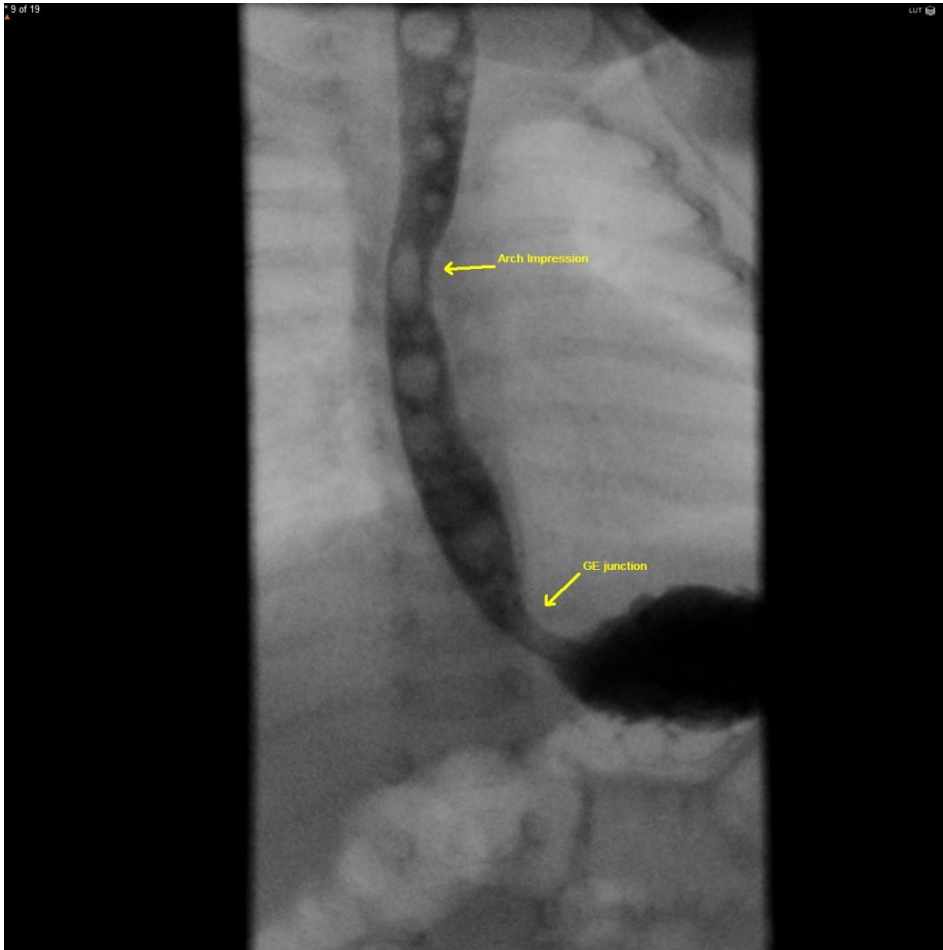
- This document is still a work in progress
- If you have nice cases to add, please contact Dr Naheedy
- Each attending has different preferences on how fluoroscopic procedures should be done. These are just meant as a general guideline.
- It is recommended to do at least one of each procedure with an attending before performing on your own.
- If you have questions, please do not hesitate to ask your attending or our experienced techs

Esophagram

- Barium preferred (unless post-operative patient)
- Single contrast almost always adequate
 - Double contrast technique may be useful in cooperative teens with appropriate history (e.g. concern for ulcer, mucosal abnormality)
- Fluoro store images (last image hold) are preferred, unless an abnormality is noted
- Need at least AP and Lateral

Normal Esophagram



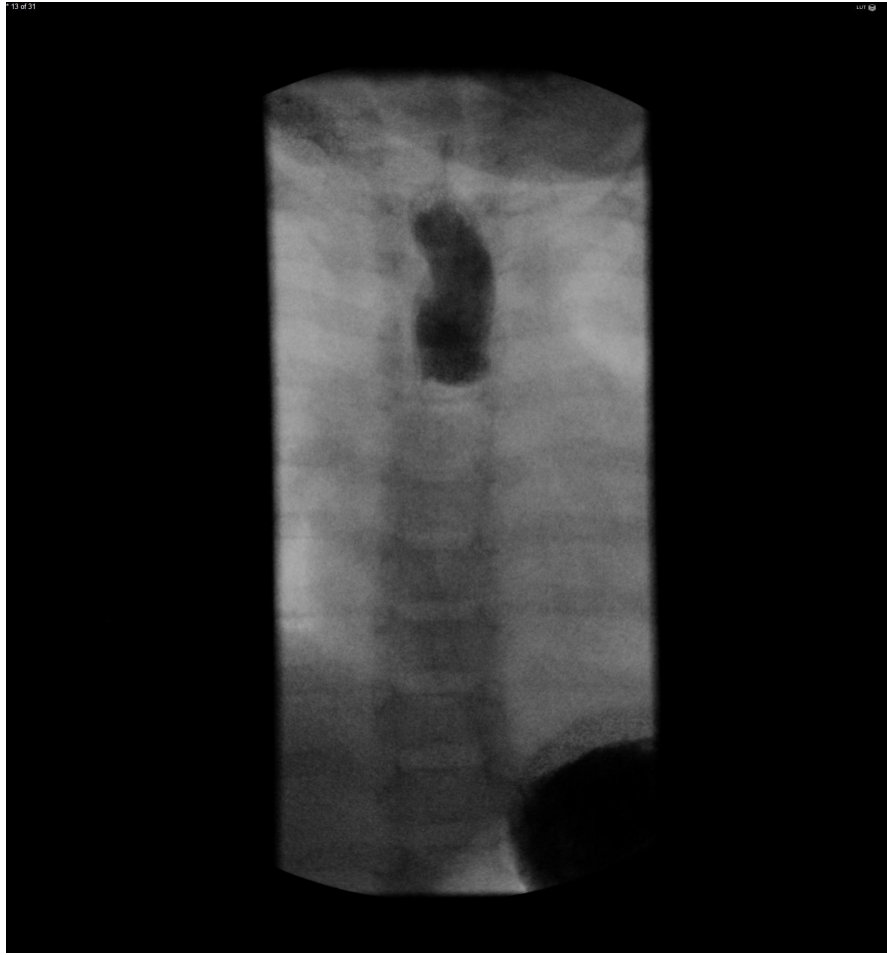


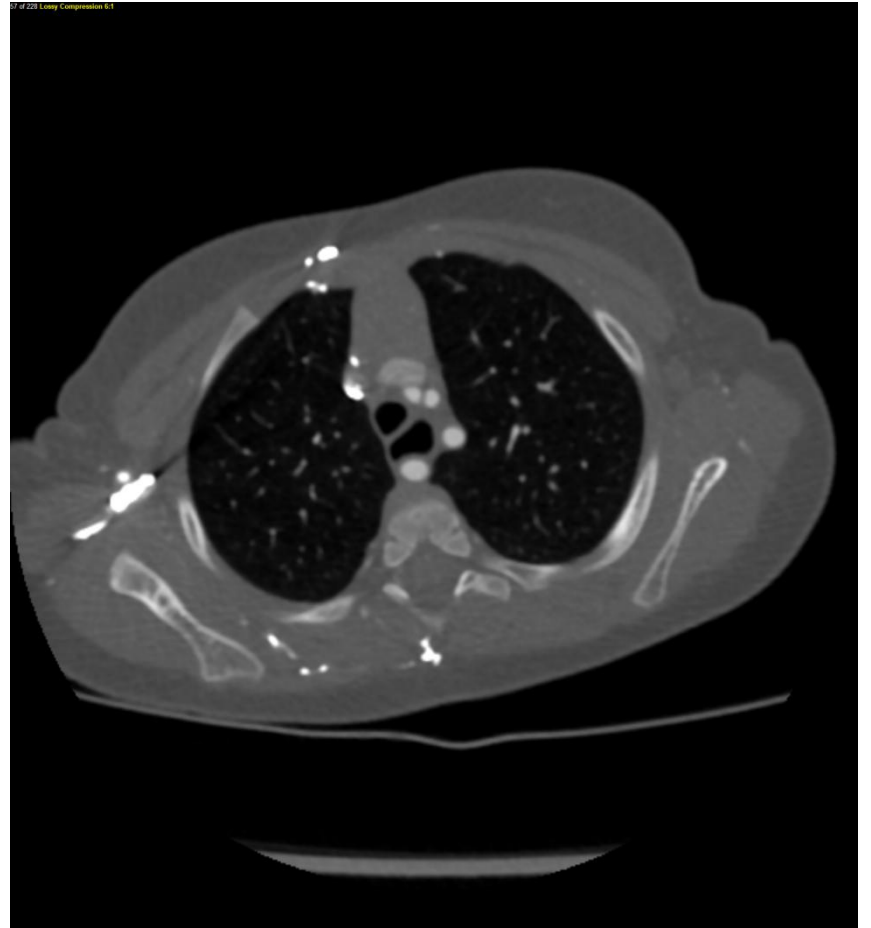
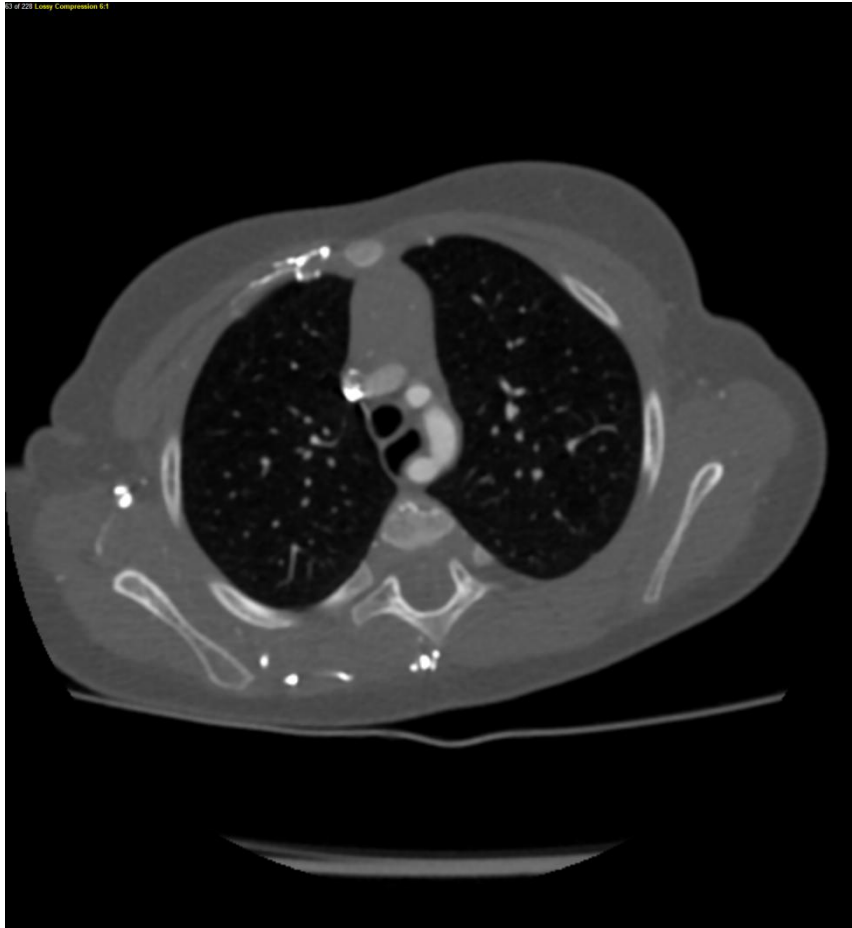
Abnormal Esophagram











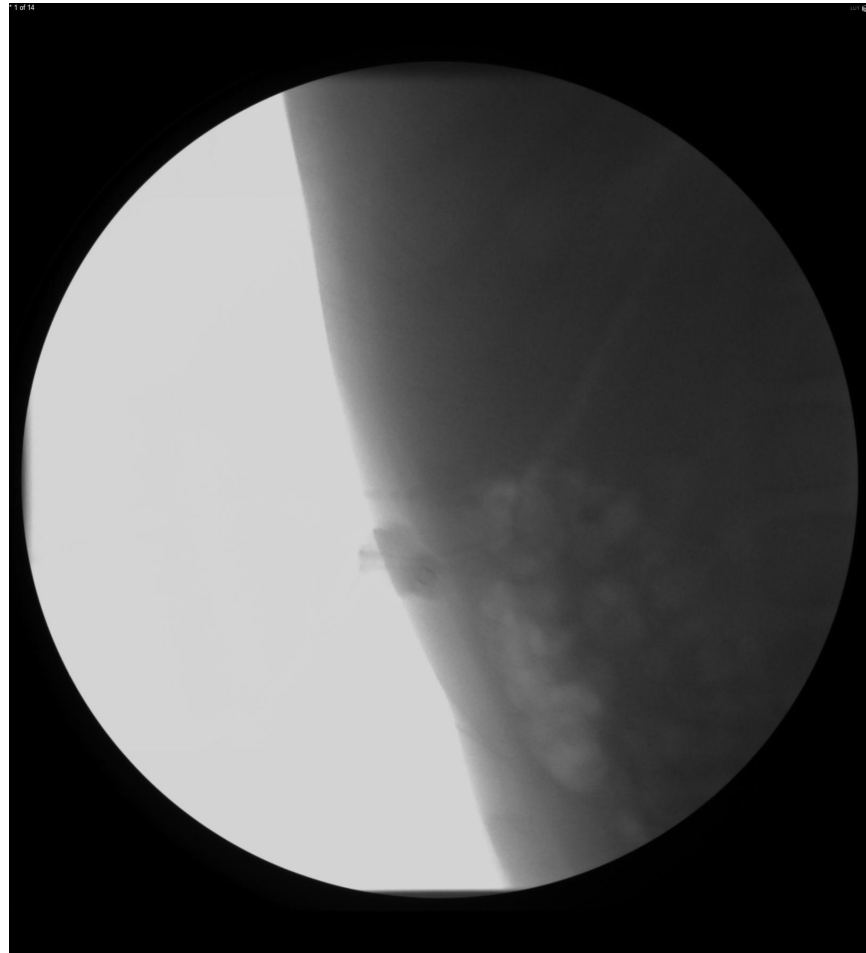
Aberrant R SCA

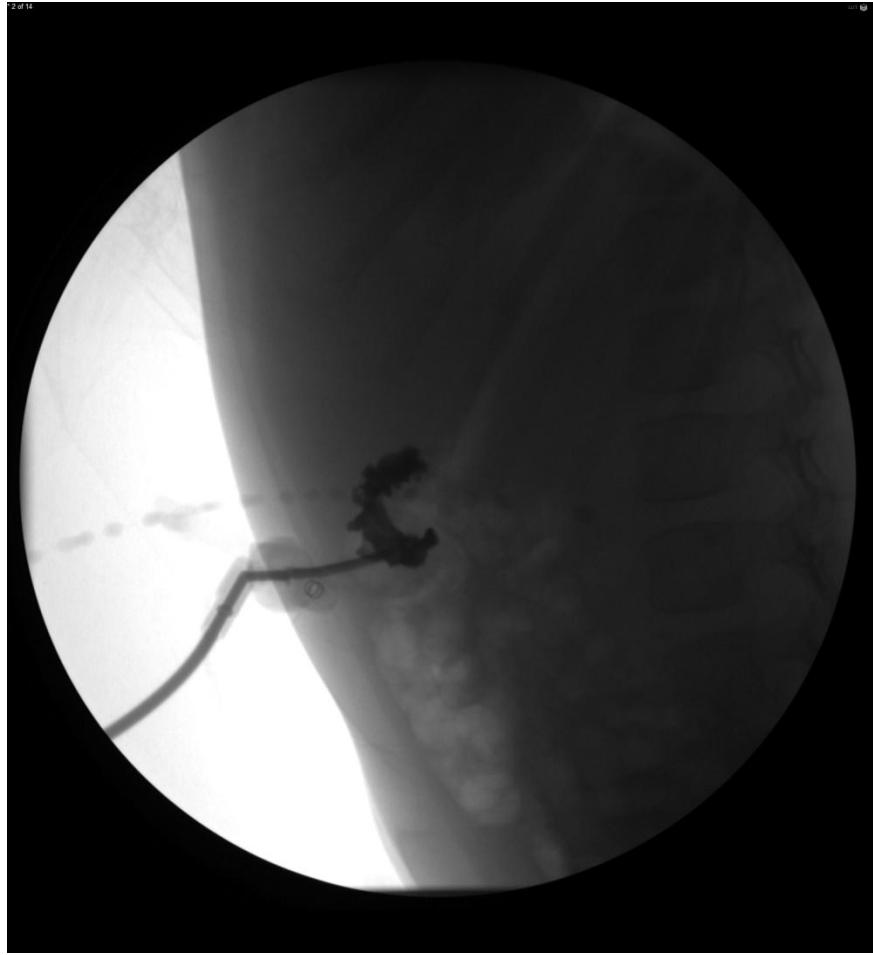


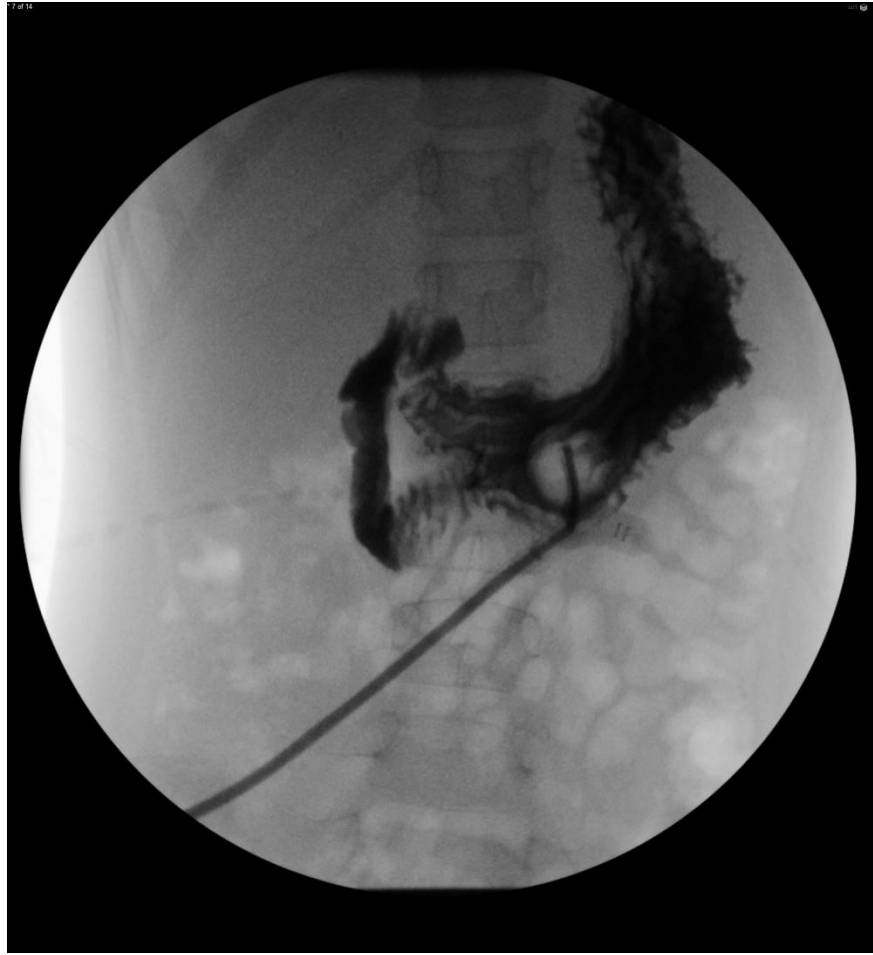
G-tube check

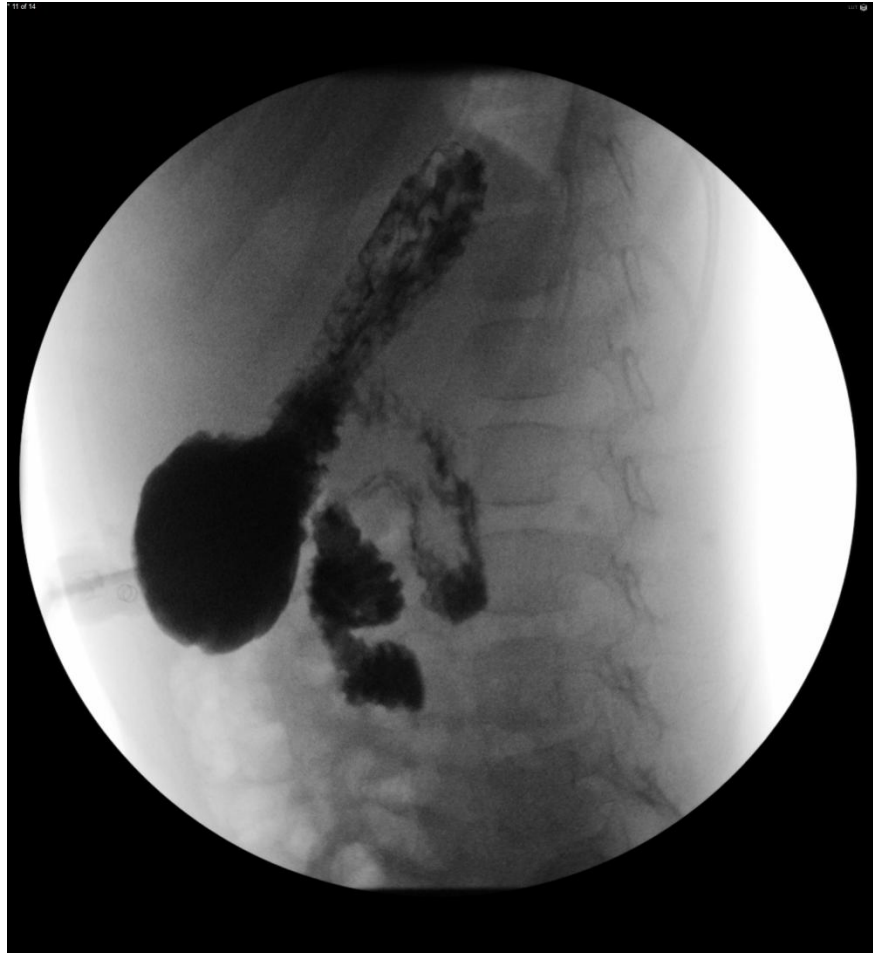
- Always water soluble contrast, since exam is often ordered for G-tube malfunction or recent replacement.
- Please check with attending first if planning to use Barium for this exam
- Start lateral (tangential) to G-tube entry site

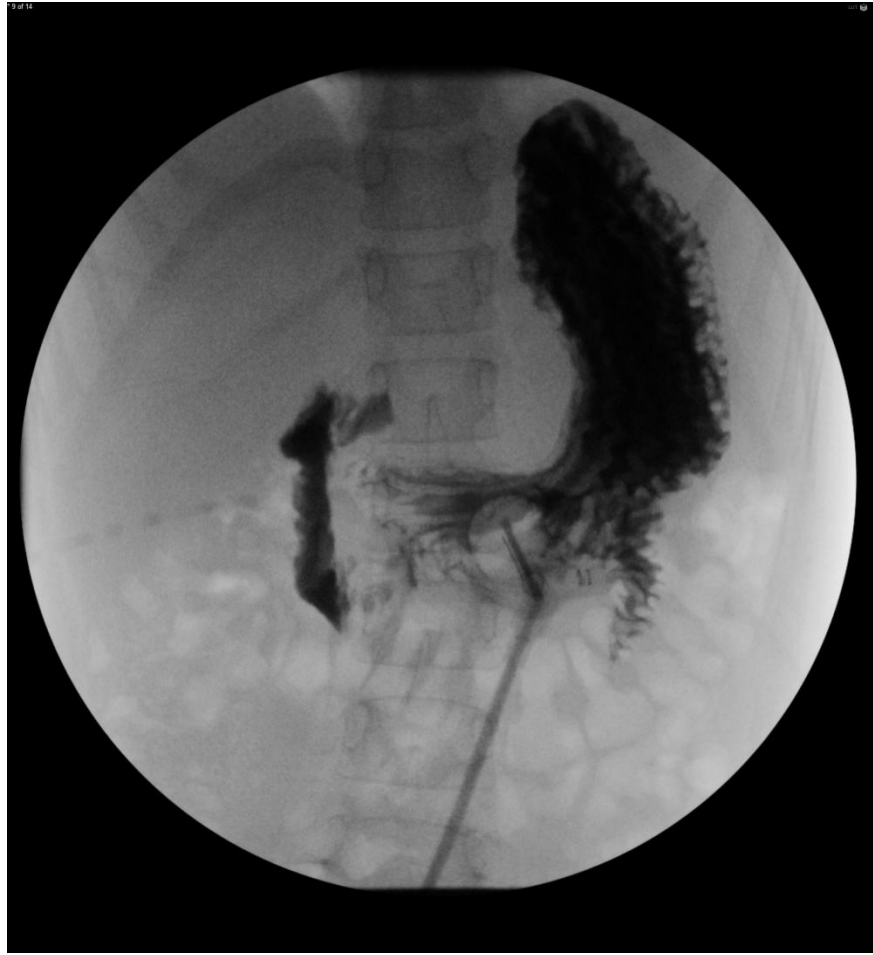
Normal G-tube check



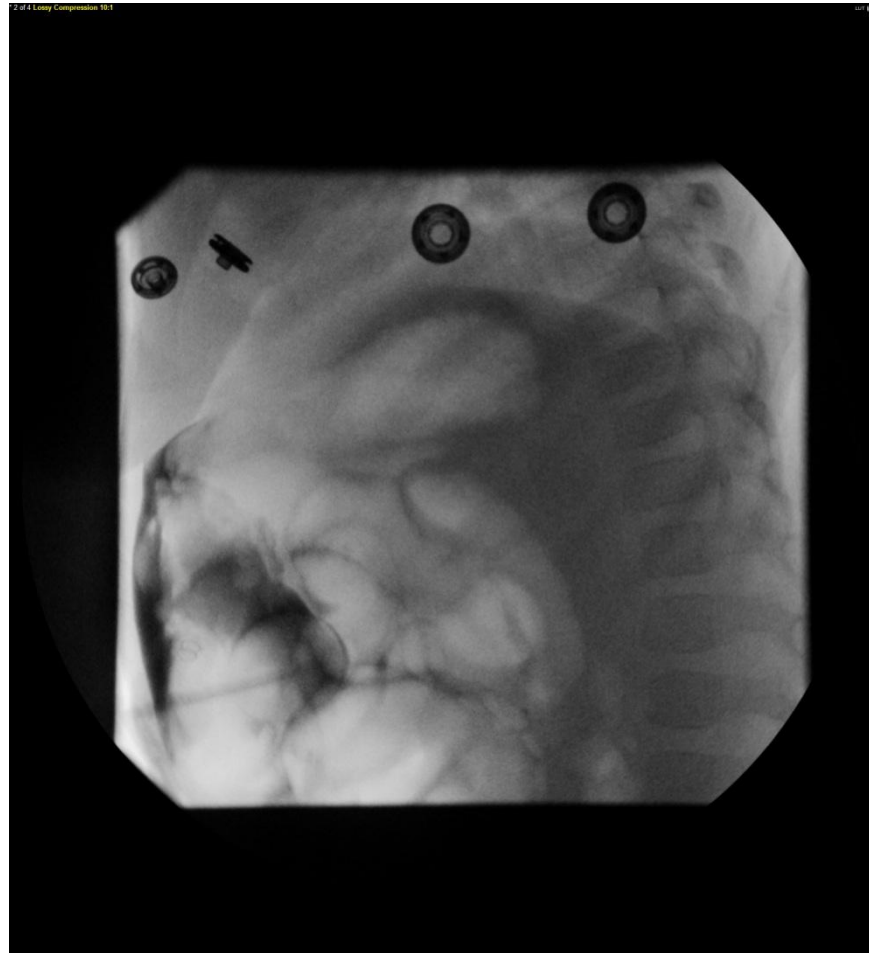


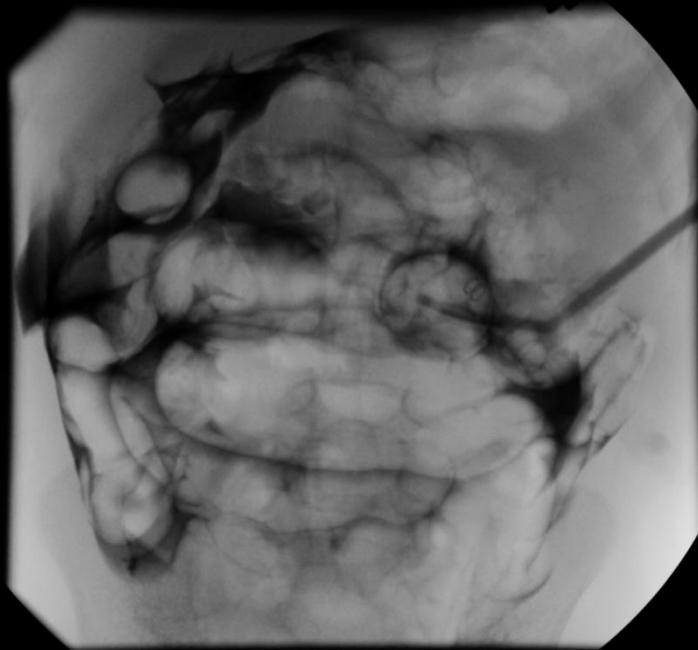






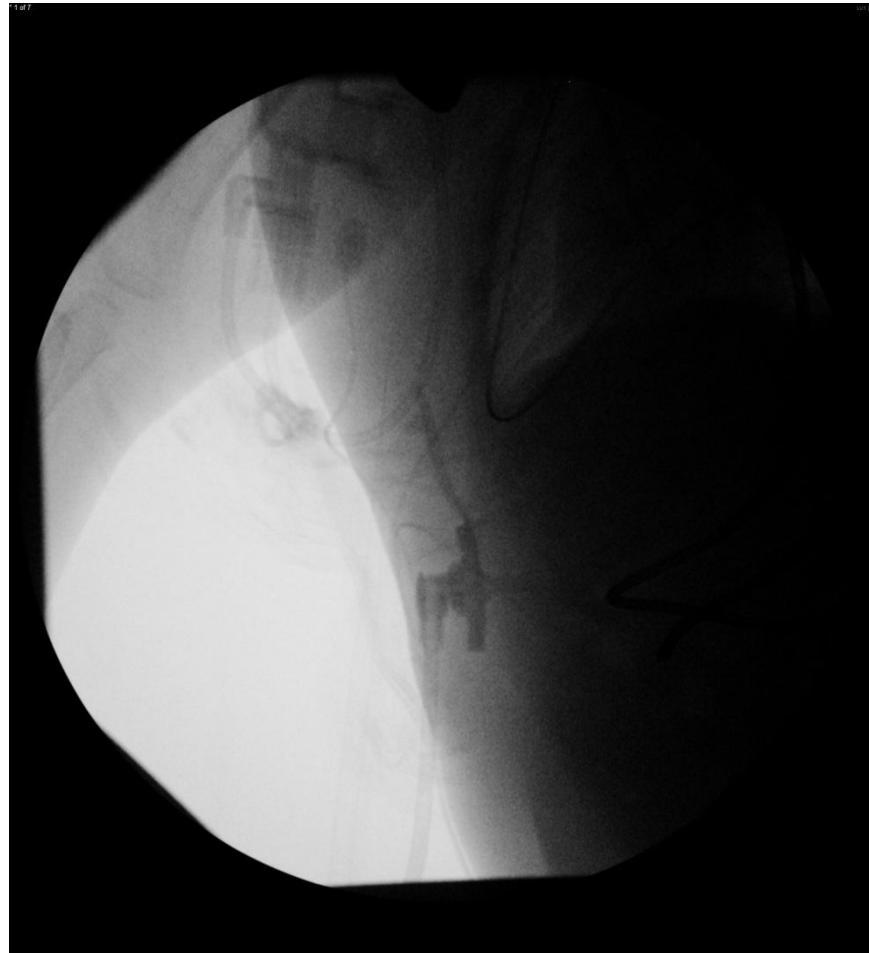
Example of malpositioned G-tube

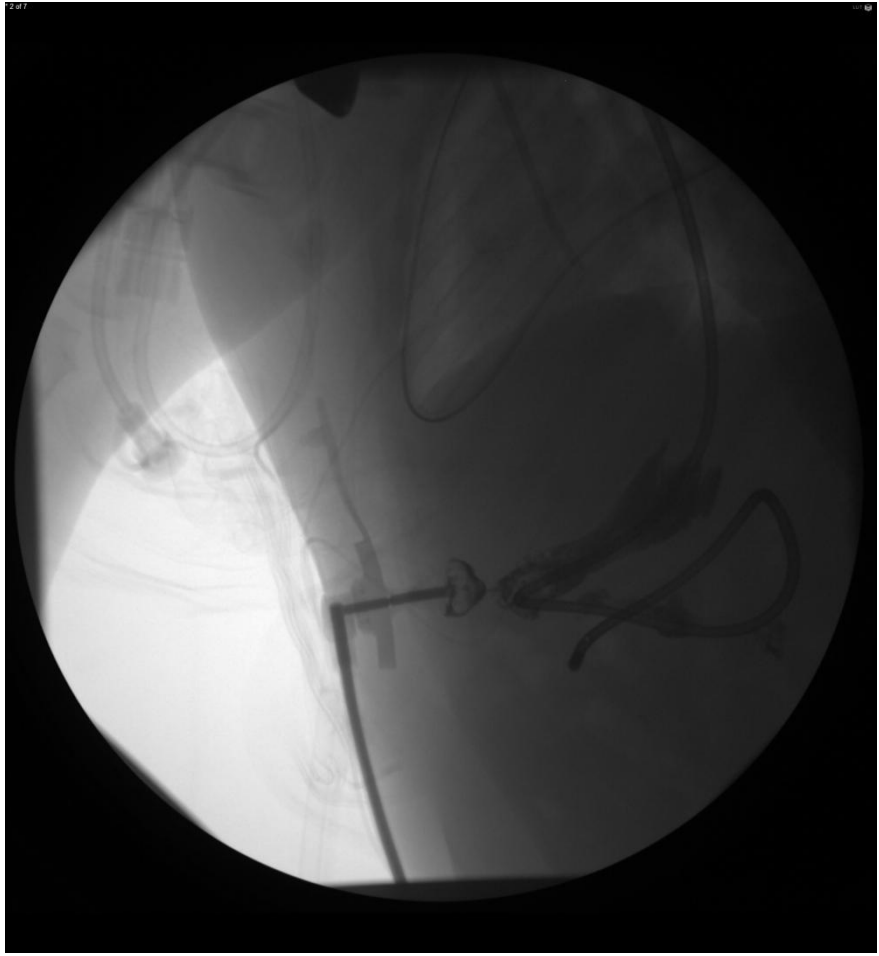


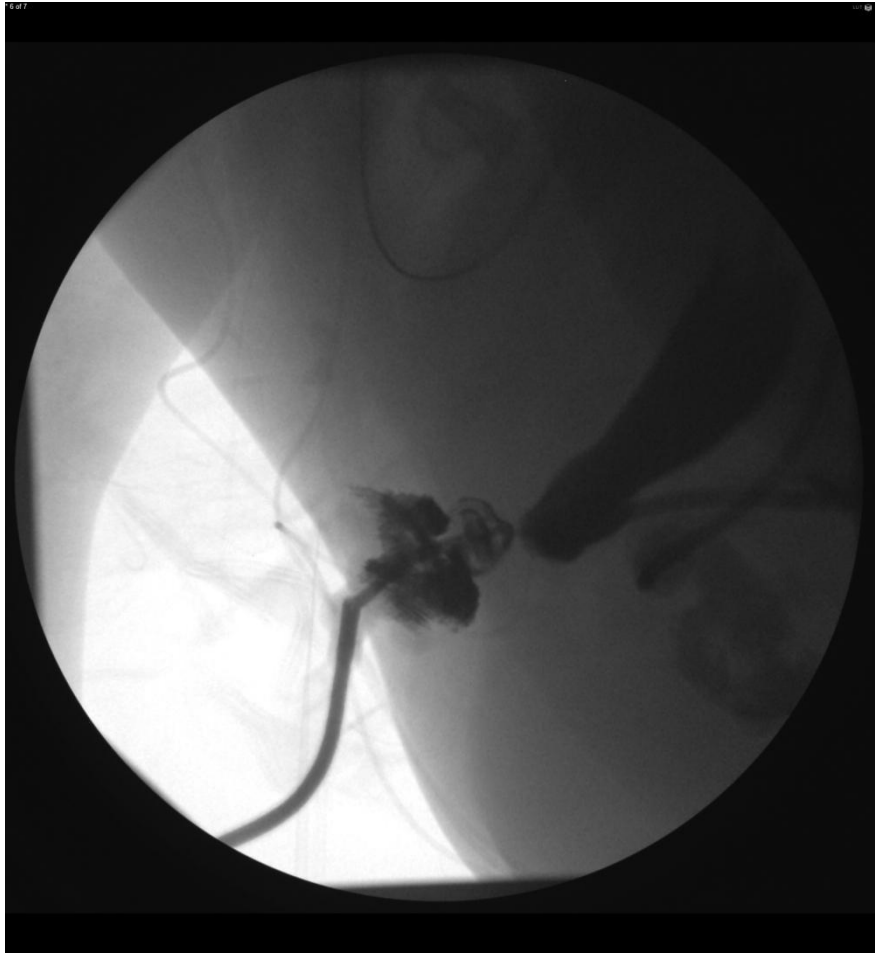




Another malpositioned tube

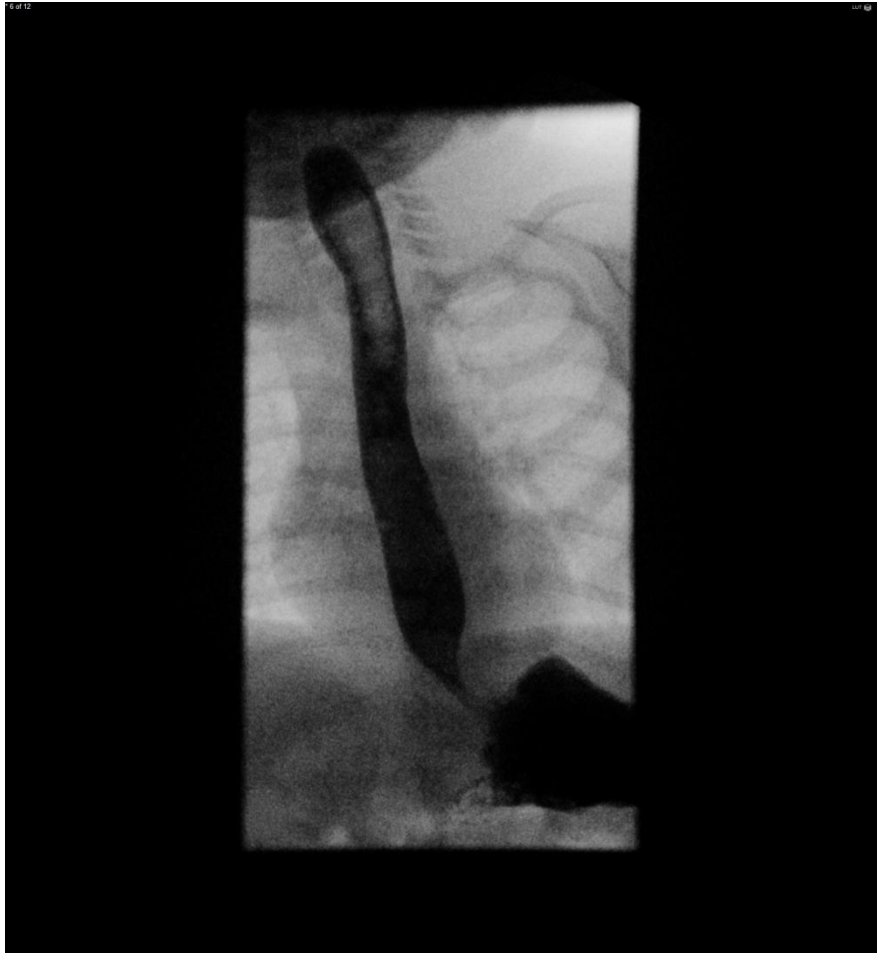


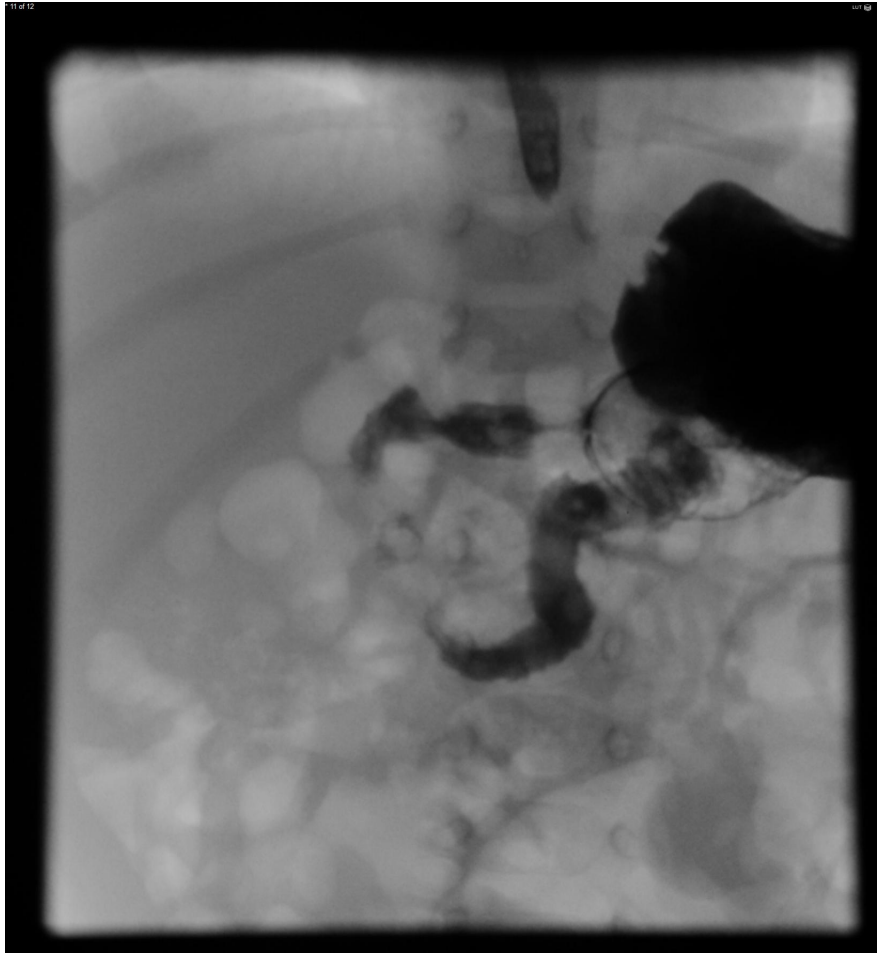




Normal Upper GI



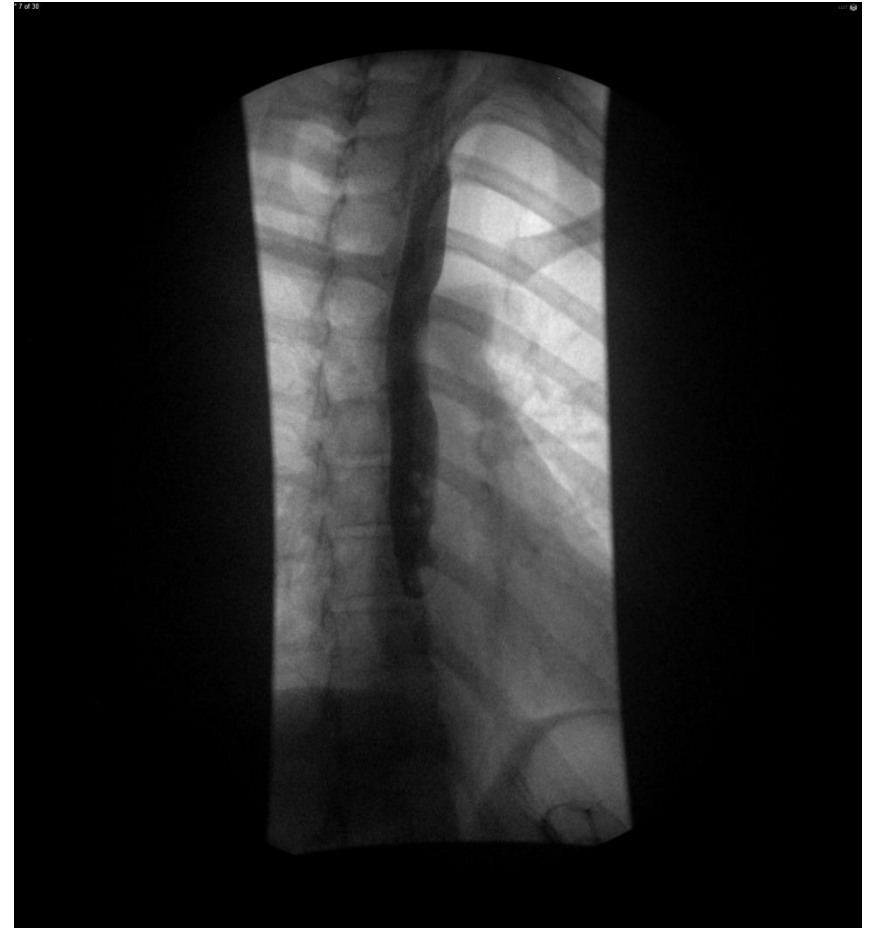


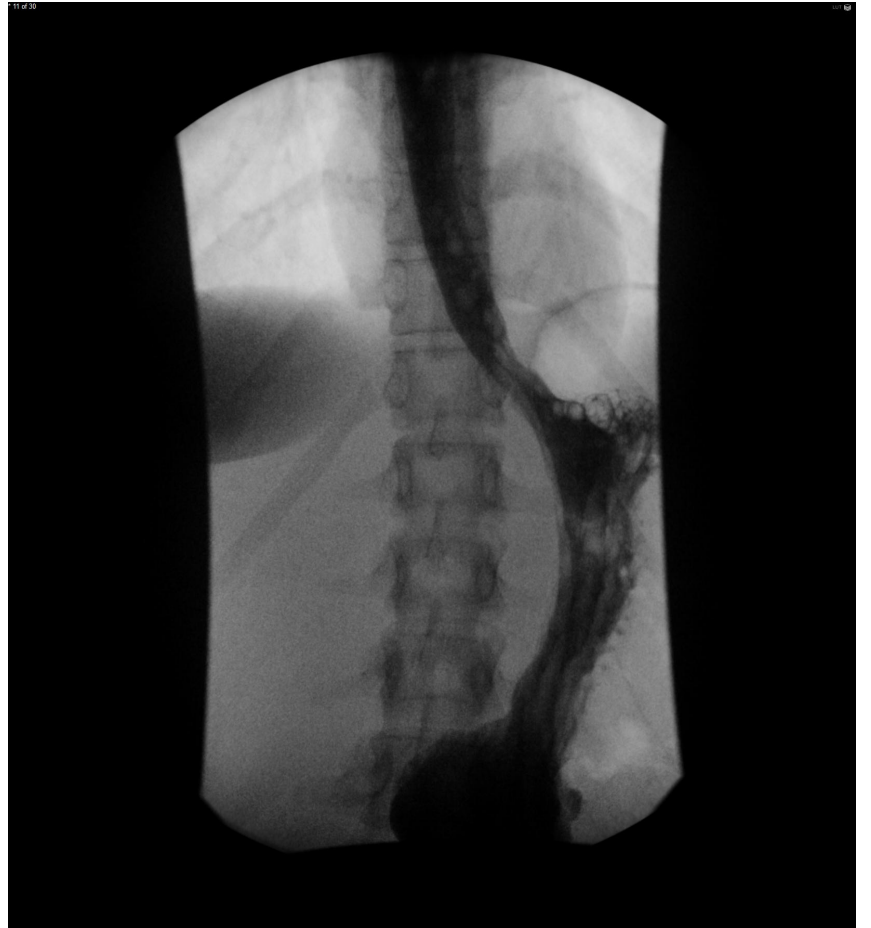
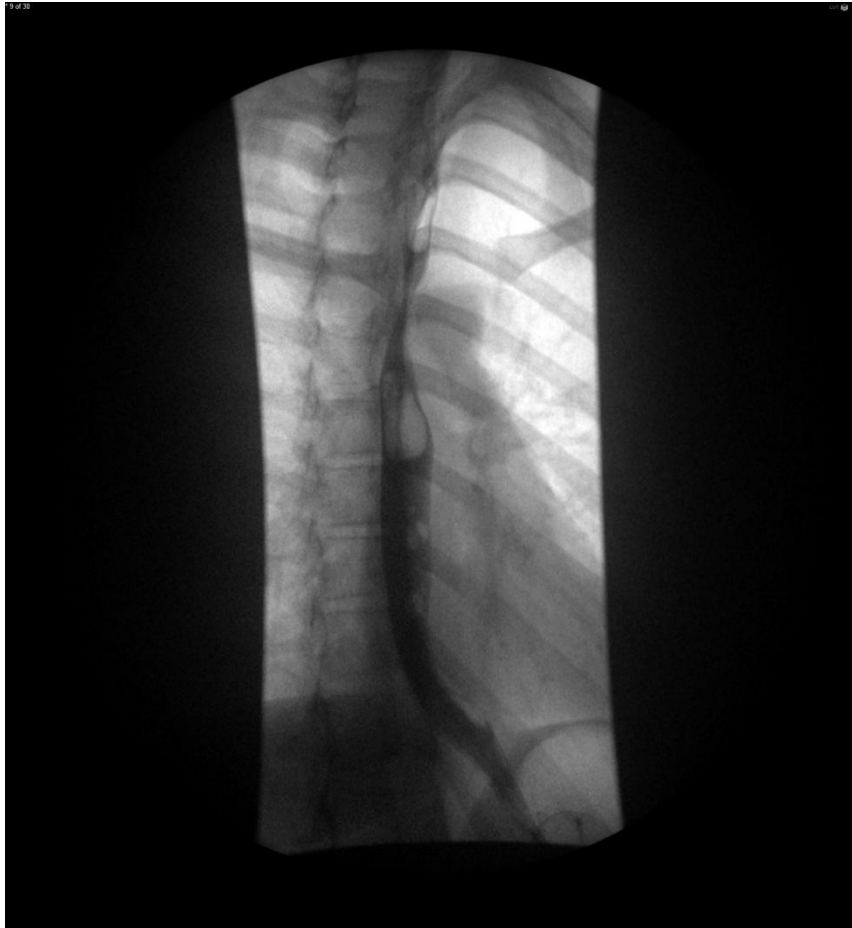


Upper GI

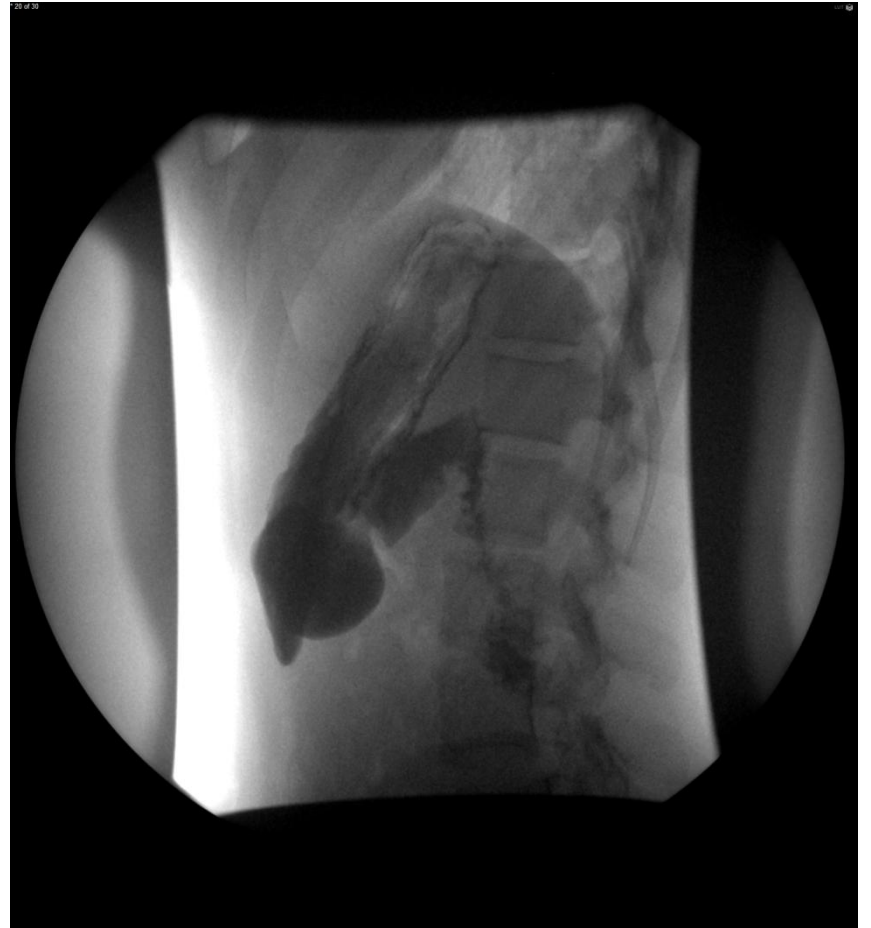
- Esophagram + Upper intestinal anatomy (through the ligament of Trietz)
- Keys
 - Show normal esophagus and gastric anatomy
 - Show the 2nd and 3rd portions of the duodenum to be retroperitoneal
 - Lateral views during opacification of C-sweep are crucial
 - Show the ligament in the correct anatomic position
 - Lateral to the left pedicle at same level of duodenal bulb

Normal Upper GI

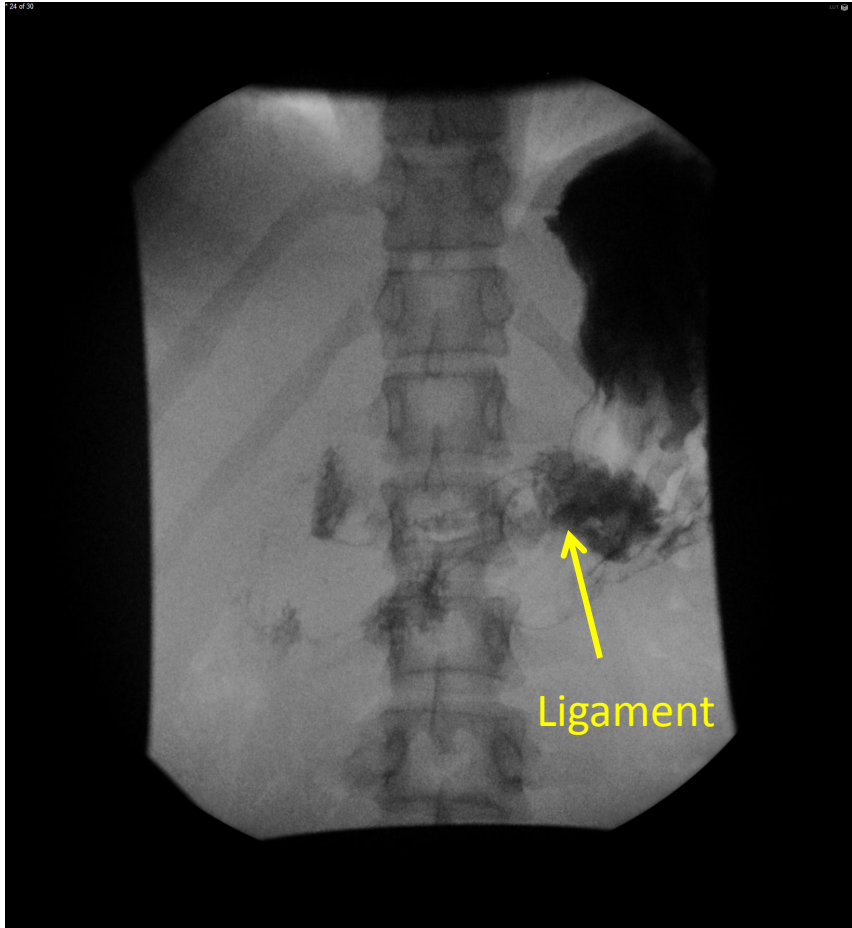








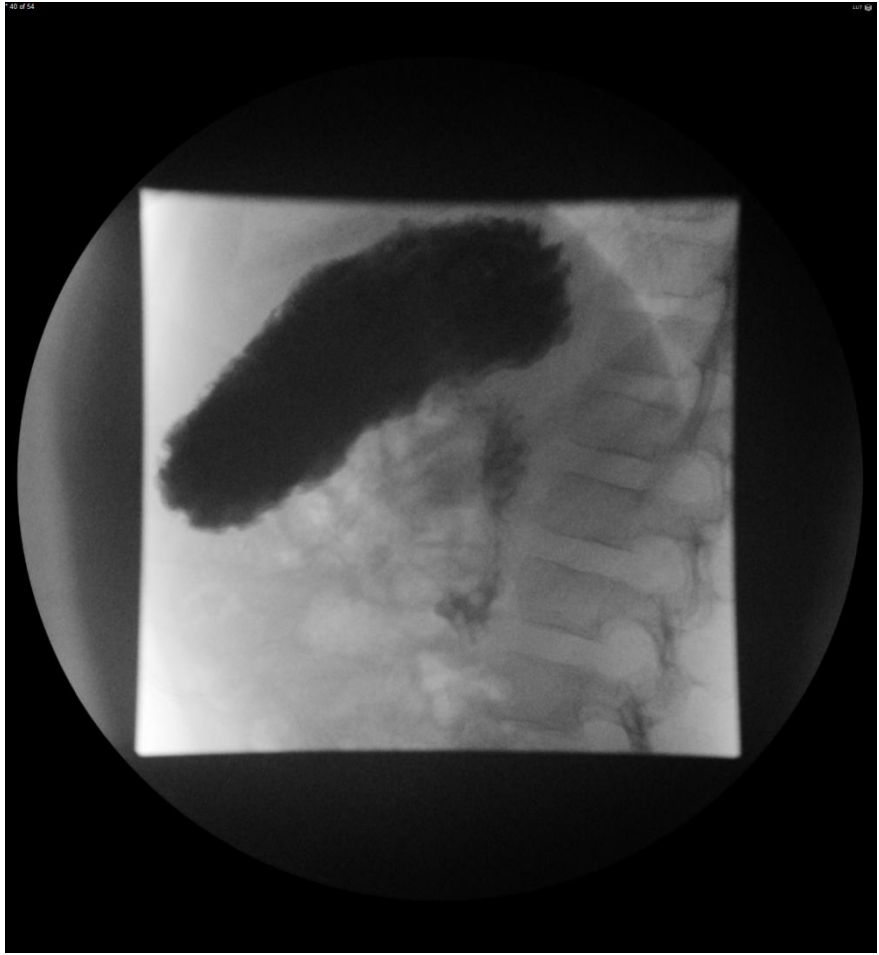


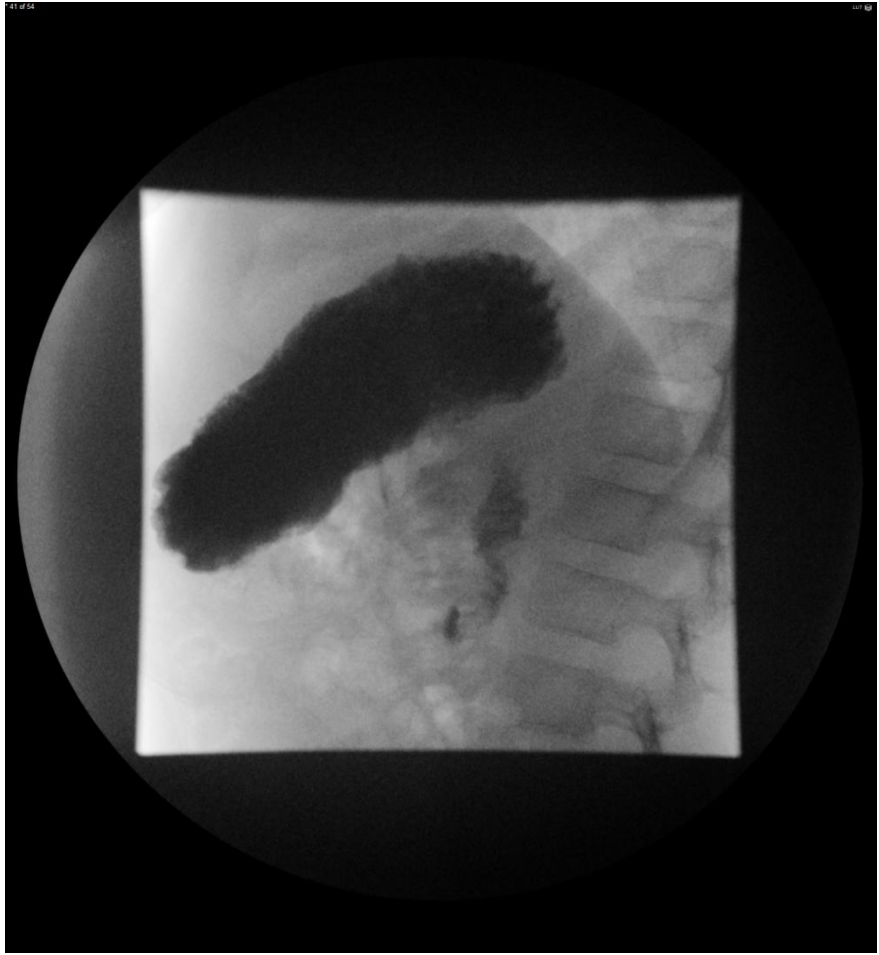


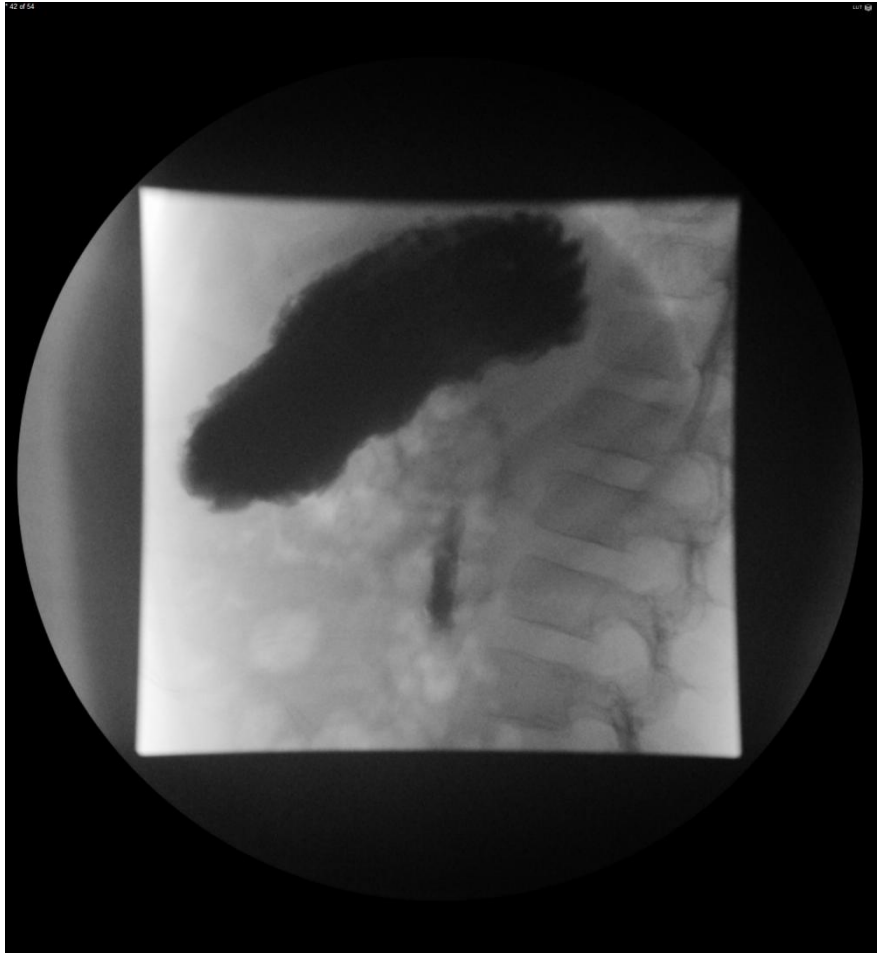
Another Normal Upper GI

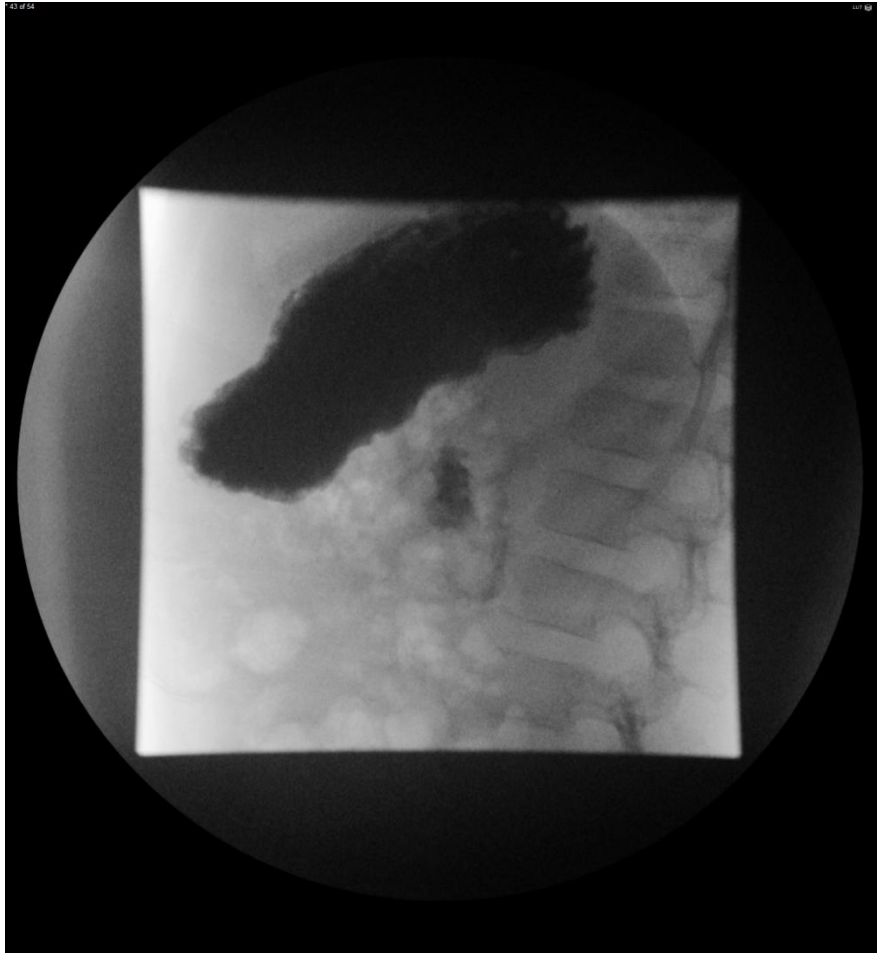
(with attention to the duodenal C-sweep)

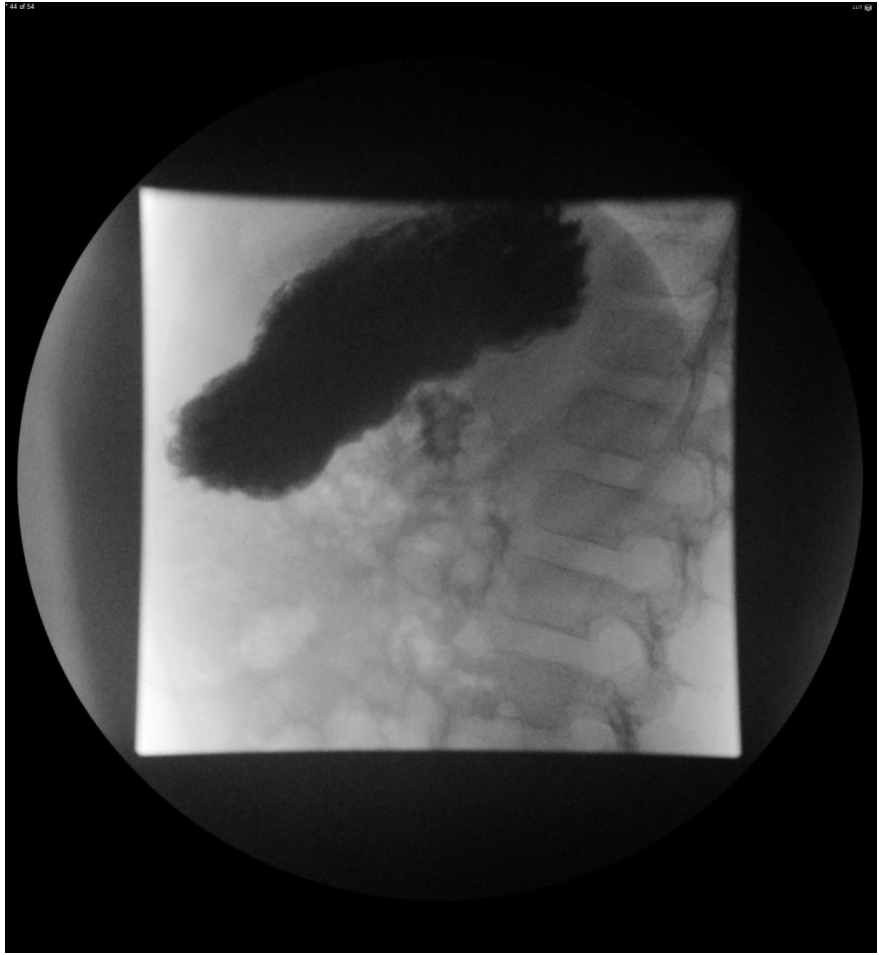


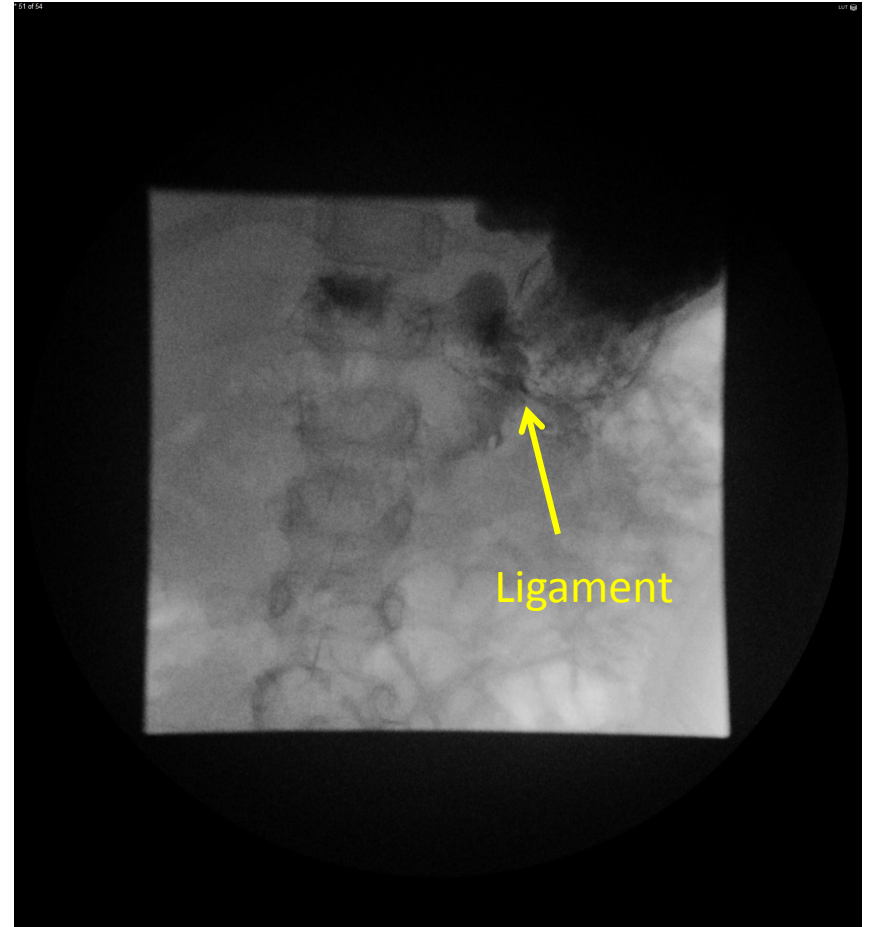




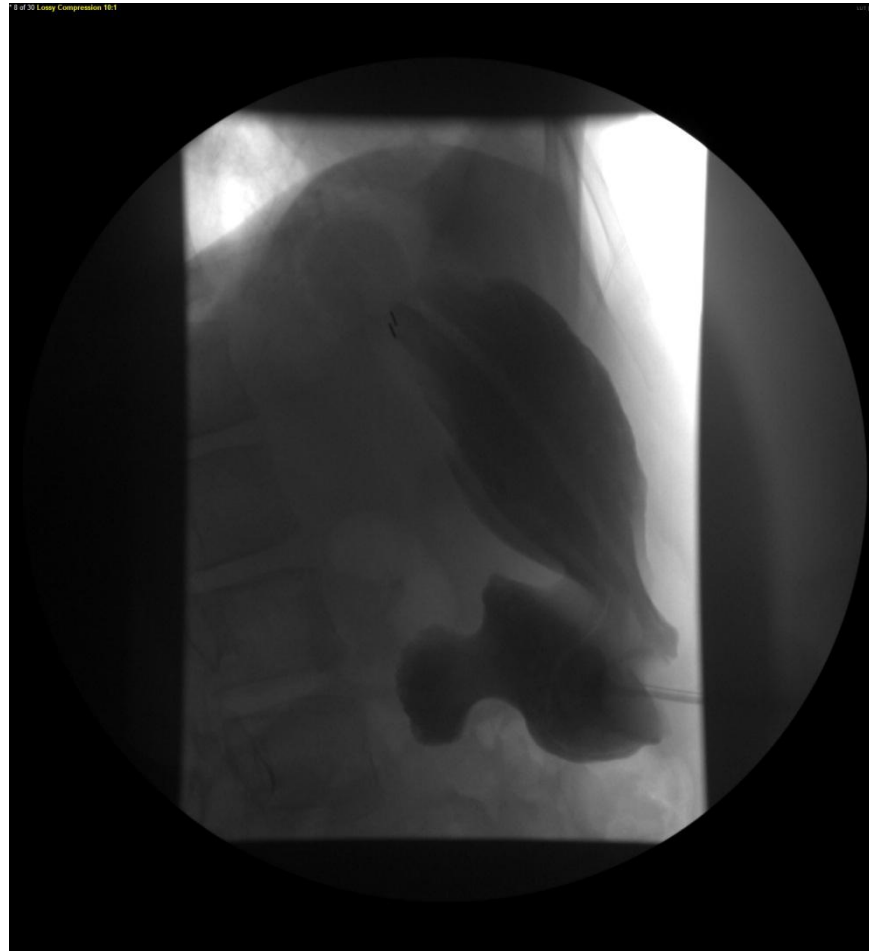


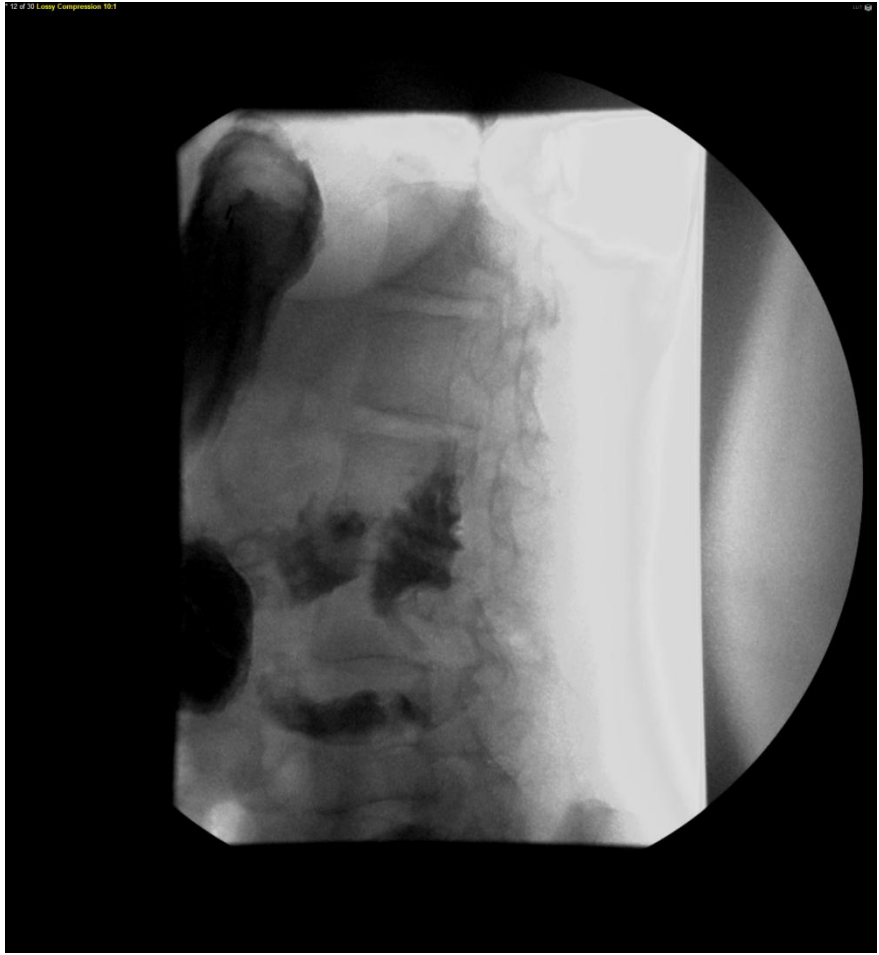




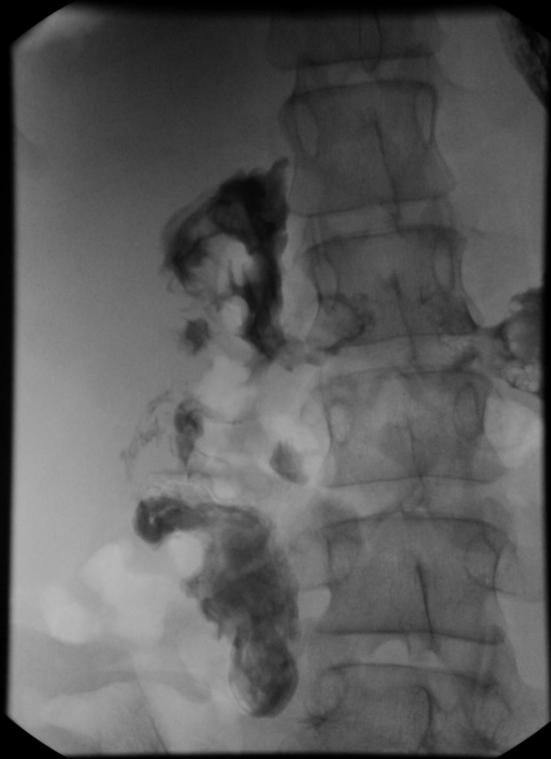


Abnormal Upper GI (through G-tube)











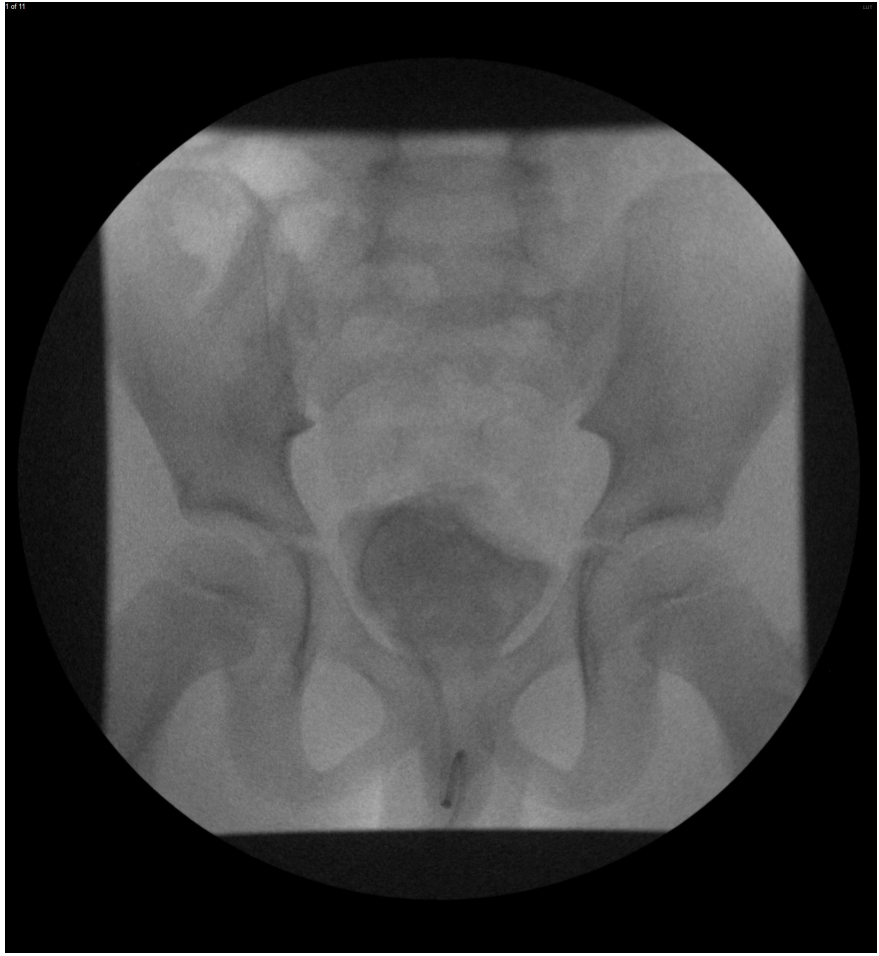


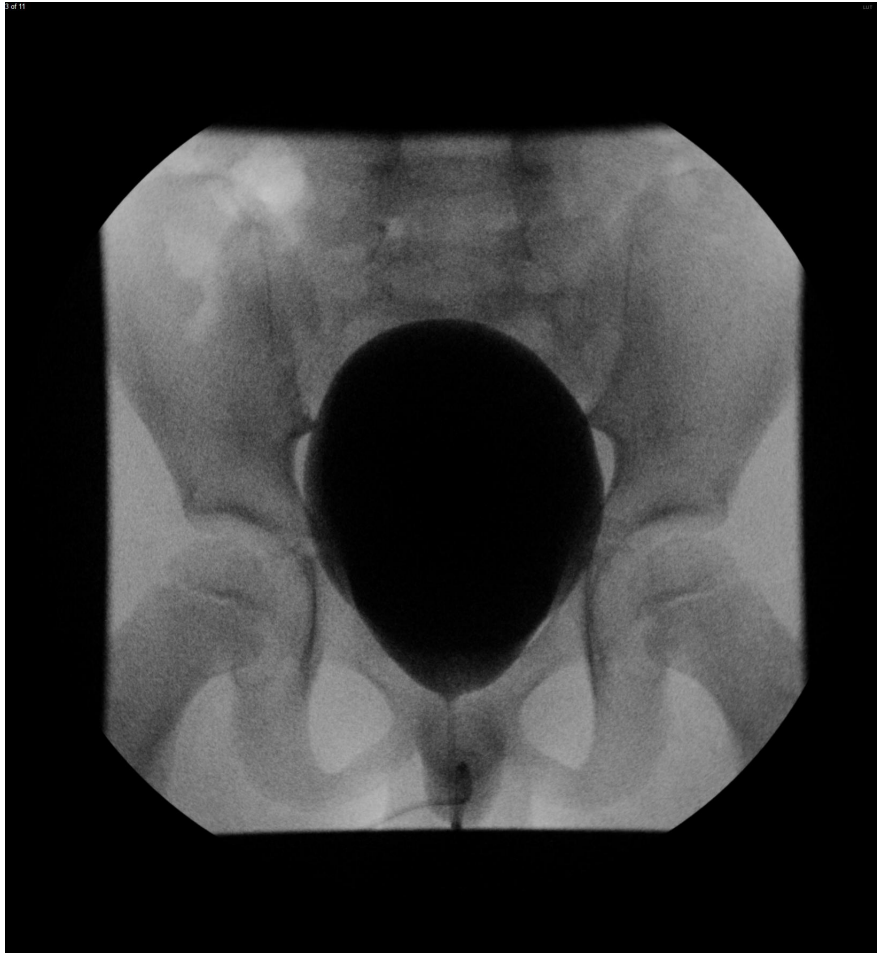
VCUG

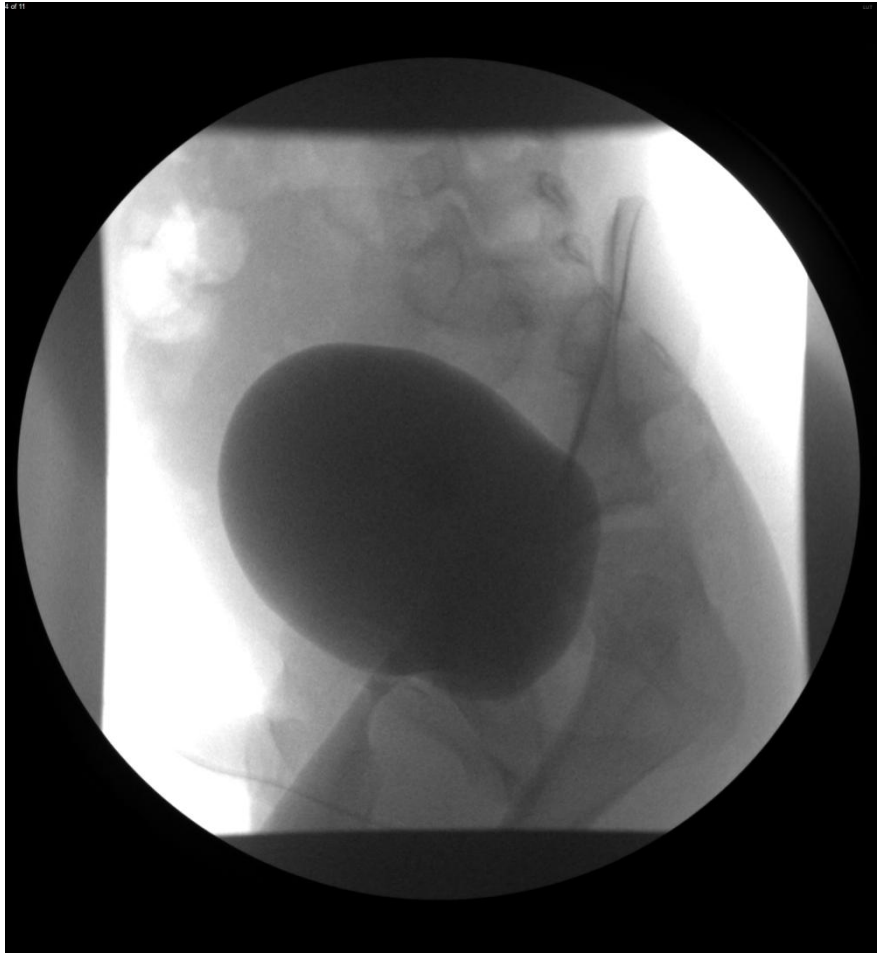
- Fluoro store (last image hold) adequate for most images, except final image of kidneys (see below)
- Key images
 - Scout (some attendings will not obtain scout images, so be sure to remove from your dictation)
 - Bladder: AP Early Fill, +/- additional view at maximal distension
 - Bladder: Bilateral Obliques (to see the UVJ area)
 - Voiding Image
 - AP in Females, Oblique in Males
 - Need at least one image of urethra without the catheter
 - Post-void bladder
 - Post-void image of renal fossa
 - This should be a real exposure
- Obviously, more images can/should be obtained if there are positive findings on the exam

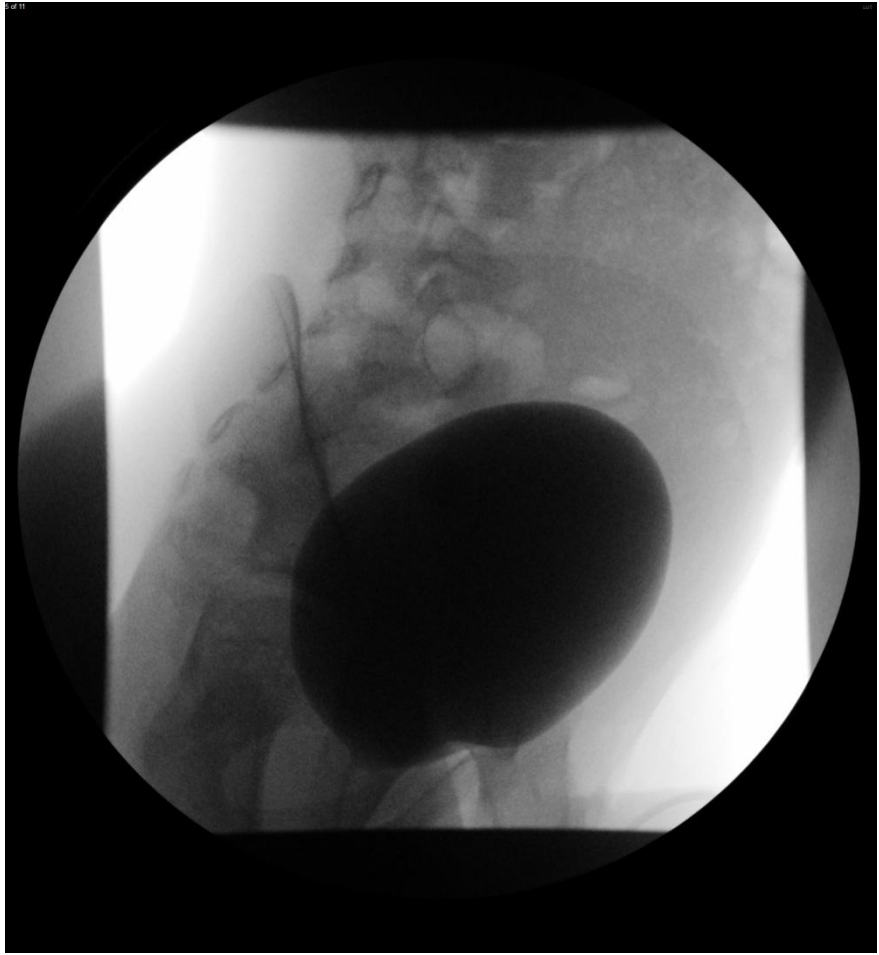
VCUG

















Contrast Enema

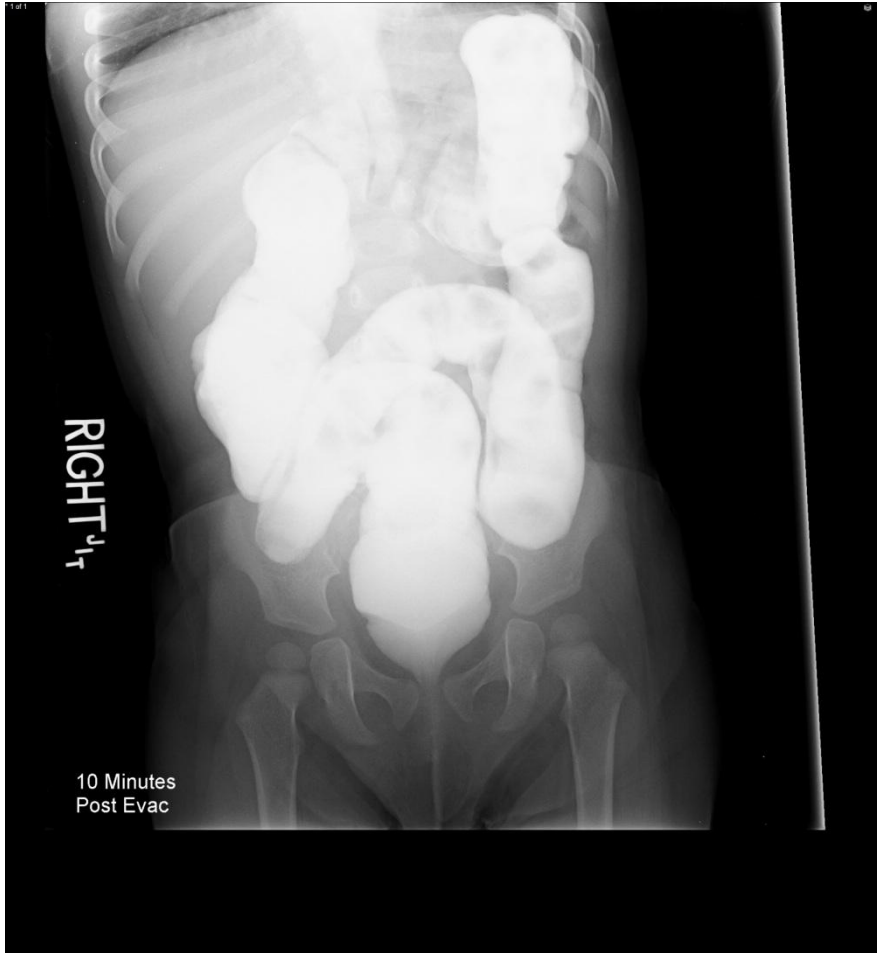
- This exam is performed for a variety of reasons and in a wide range of ages
- Thus it is critical to review the indications and history before walking into the room
 - i.e. what is the question you are trying to answer
- Always water soluble contrast (never barium per rectum in kids)
- Always have an attending present/available for contrast enemas on NICU babies.

Normal Contrast Enema (baby)



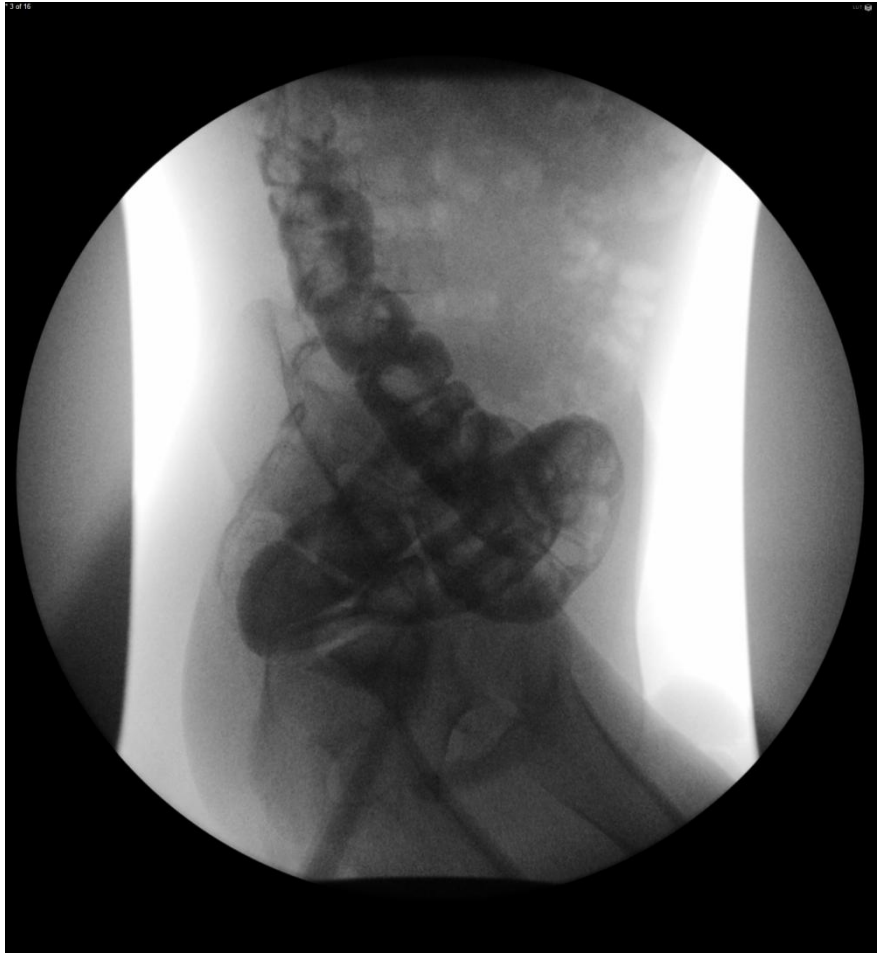






Normal Contrast Enema (older child)

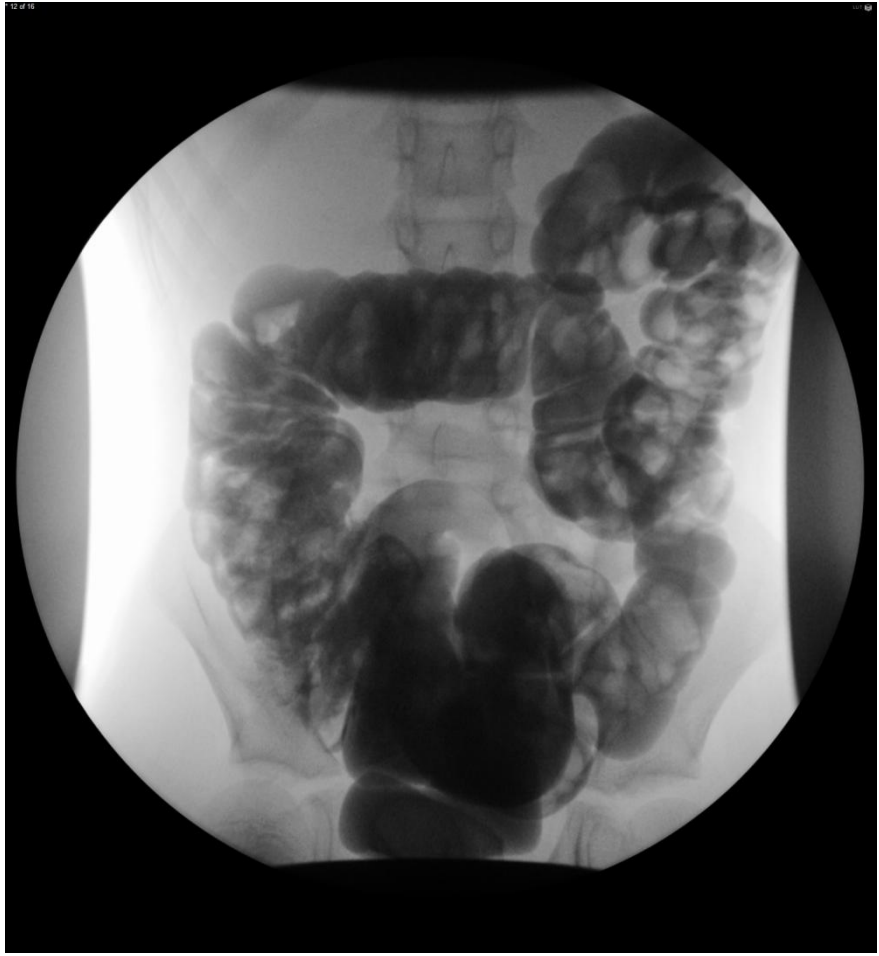












Bilateral obliques



Abnormal Contrast Enema

