**POSITIVE ORAL CONTRAST**

**Background:** Positive enteric contrast for CT imaging improves diagnostic accuracy for some clinical indications. However, use of positive enteric contrast is not needed for all abdominal indications and delays turn-around-time.

**Positive Enteric Contrast:** Pre-mixed 500mL (16.9 oz) bottle of Omnipaque® (Iohezhol) 350 oral solution (9mg iodine/mL).

**Positive Enteric Contrast indications:**

* Abdominal or pelvic surgery or CT in the last two weeks
* Abscess drain or wound vac
* Suspected or know enterocutaneous fistula
* Esophageal or Bowel perforation/ leak
* Abdominal/pelvic abscess
* Abdominal fluid collection
* Free air
* Biloma
* Pancreatic pseudocyst
* Pancreatic walled off necrosis
* Appendiceal cancer
* CT abdomen and/ or pelvis without IV contrast (not stone, bleed or adrenal protocol)
* Pelvic mass in females or gynecologic cancer
	+ Cervical
	+ Endometrial
	+ Uterine
	+ Ovarian
	+ Fallopian tube
	+ Any peritoneal nodule
	+ Pseudomyoxoma peritonei
	+ Omental caking
	+ Primary peritoneal cancer

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| --- | --- | --- |
| Route | Indication | Dosage |
| Oral | Routine | Administer 250ml (60 min prior to scan) and 250ml (30 min prior to scan). |
| Oral | Bariatric Post OP | Administer 150ml (on table), immediately prior to scan. |
| Oral | Esophageal Leak | Administer 100ml (on table), immediately prior to scan. |
| G-tube | Routine | Administer 500ml (60 min prior to scan). |
| G-tube | Check Placement | Administer 150ml (on table), immediately prior to scan. |
| J-tube | Routine | Administer 250ml (60 min prior to scan). |

NOTE:

* To guide CT protocoling: Speak with the patient, patient’s nurse and utilize the electronic medical record (including prior imaging reports).
* NO positive oral contrast agent is to be given for:
	+ CTA studies, (Pre- or Post-Stent)
	+ Renal studies
	+ Liver imaging
	+ Pancreatic imaging (water)
	+ Acute flank pain
	+ Acute trauma patients
	+ CT Urograms
	+ CT Cystograms
	+ GI Bleed studies
	+ Post OP complications for kidney transplant patients
	+ Shunt eval

**Water or Breeza can be used if requested**.

* The CT imaging exam should be performed 1 hour after the patient starts drinking, even if they cannot finish the bottle. Do NOT delay inpatient or ED scans.
* If the ordering team request no oral contrast or orders the exam STAT and the indication is one of the listed, consult the Radiologist.

**NEUTRAL ORAL CONTRAST (BREEZA FOR CT ENTEROGRAPHY (CTE)**

Technique: Three bottles of Breeza (500mL each) separated by 20 minutes prior to scan. One bottle at 60, 40 and 20 minutes prior to scan and 8oz (240mL) of water on exam table.

Protocols/ Indications to be followed:

* **Single phase CTE**
	+ Inflammatory bowel disease (IBD)
	+ Crohn’s
	+ Ulcerative colitis (UC)
	+ Inflammatory bowel syndrome (IBS)
	+ Familial adenomatous polyposis (FAP)
	+ Small bowel adenoma
	+ Polyp(s)
	+ Mass
* **Biphasic CTE**
	+ Non emergent bleed (melena or chronic anemia)
	+ Intestinal carcinoid or intestinal neuroendocrine tumor (NET)
	+ Angiodysplasia
	+ Intestinal arteriovenous malformations (AVMS). Including hereditary hemorrhagic telangiectasia (HHT).
* **Triphasic CT (GI bleed protocoling):**
	+ Chronic bleed
	+ In emergency, do NOT wait to administer Breeza, but do administer 8oz (240mL) of water on the exam table.

**RECTAL CONTRAST**

Technique: Mix 100mL (one bottle) Omnipaque®350 (lohexhol) in one gallon of water. Shake well and pour 1500-1800mL into enema bag (discard any leftover), then administer the mixture rectally per patient tolerance.

**Indications:**

* Evaluating for perforation or anastomotic leak after anorectal or colonic surgical intervention.
* Suspected or know rectal or colonic fistula.
* Re-evaluation of a pelvic abscess or fluid collection (if requested by ordering provider).
* Follow up of complicated diverticulitis (if requested by ordering provider).
* Colocutaneous or colovesical fistula
* Pelvic abscess or fluid collection
* Rectovaginal fistula

**NOTE**

* Oral contrast is preferred over rectal contrast due to patient comfort; although, both are likely equally diagnostic if post administration duration is long enough to allow for passage into the rectum.

(~2 hours is a safe estimate assuming normal bowel motility)