

Surgery G-Tube Consult and Pre/Post Op Information

G-Tube Consult, Questions to Consider:

- Why does patient need a G tube?
 - Depending on indication, are appropriate consultants involved? E.g. speech therapy, dietitian
- How is the patient currently fed? If anything other than **gastric bolus** feeds (i.e. continuous and/or post-pyloric), why?
- What other comorbidities, surgeries, or devices does the patient have?
- Have other feeding alternatives (PO, NG/NJ) been discussed with the family?
 - When to consider: Anticipated need <4-8 weeks, Size < 2 kg
- Have parents consented to the procedure?
- Are there any social barriers to G tube care once at home?
- Who will be managing the gtube and feeds? Pediatric Surgery does not do this outside of the perioperative period.

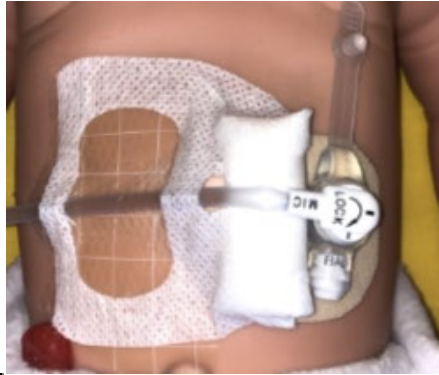
Pre-Op Checklist:

- NG/ND feeding trial to establish G tube feeding tolerance
 - Inpatients: required
 - Outpatients: ideal but not required
- Upper GI contrast study only required for:
 - other anatomic abnormalities: heterotaxy, major congenital anomalies (TEF, ARM, biliary atresia, etc) chromosomal abnormalities
 - Intolerance of bolus NGT feeds

- Consider reflux workup for
 - Clinical evidence of reflux causing Brief Resolved Unexplained Events
 - Patients with poorly controlled reflux on antireflux medications
 - Patients with multisystem disorders/ multiple comorbid pulmonary and/or neurologic diseases conditions (seizures, spastic CP, chronic lung disease, severe HIE – high aspiration risk)
 - Patients with rare metabolic/neurologic conditions (leukodystrophy, holoprosencephaly, mitochondrial cytopathy) – severity of neuropathology may progress
 - Patients with vocal cord paralysis (can't protect airway well)
 - Patients with subglottic stenosis (reflux can affect airway reconstruction surgery)
- Other studies that are not needed except in select circumstances:
 - Upper endoscopy: suspicion for eosinophilic esophagitis, hiatal hernia
 - Gastric emptying study: workup for gastric feed intolerance
- **Nutrition/tube feeding plan established (goals and timelines)**
- Home health care company identified

Intra-Op/Peri- Op:

- Dressing:
 - Leave tube capped
 - Cavilon + Mepilex Lite under the tube as illustrated
- Op note: document size, length, type of button and volume of water in balloon
- Admit to
 - If inpatient, patient returns to their primary service
 - If outpatient and with multiple comorbidities can be admitted to gen peds if discussed preop.
 - If doesn't meet above criteria, admit to pediatric surgery



Post-op Gastrostomy Tube Feeding Protocol:

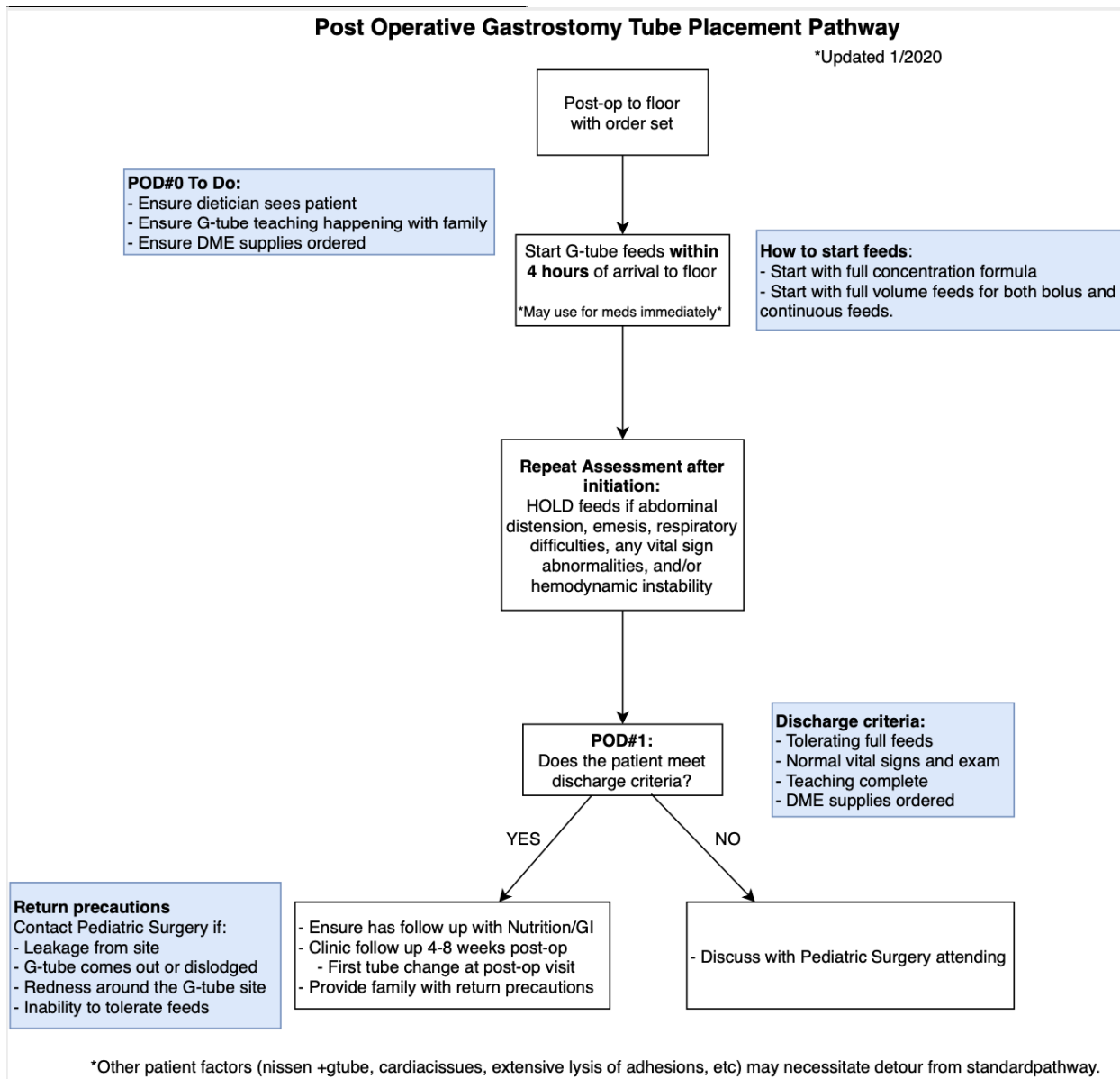
If on oral feeds preoperatively, ok to resume immediately

References

1. Valusek PA, St Peter SD, Keckler SJ, et al. Does an upper gastrointestinal study change operative management for gastroesophageal reflux? *J Pediatr Surg.* 2010;45(6):1169-72. [[PMID:20620314](#)]
2. Gonzalez KW, Dalton BG, Boda S, et al. Utility of Preoperative Upper Gastrointestinal Series in Laparoscopic Gastrostomy Tube Placement. *J Laparoendosc Adv Surg Tech A.* 2015;25(12):1040-3. [[PMID:26258954](#)]
3. Cuenca AG, Reddy SV, Dickie B, et al. The usefulness of the upper gastrointestinal series in the pediatric patient before anti-reflux procedure or gastrostomy tube placement. *J Surg Res.* 2011;170(2):247-52. [[PMID:21550057](#)]

Post Operative Gastrostomy Tube Placement Pathway

*Updated 1/2020



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- Abbas PI, Naik-Mathuria BJ, Akinkuotu AC, et al. Routine gastrostomy tube placement in children: Does preoperative screening upper gastrointestinal contrast study alter the operative plan? *J Pediatr Surg.* 2015;50(5):715-7. [PMID:25783382]
- Novotny NM, Jester AL, Ladd AP. Preoperative prediction of need for fundoplication before gastrostomy tube placement in children. *J Pediatr Surg.* 2009;44(1):173-6; discussion 176-7. [PMID:19159739]
- Berman L, Baird R, Goldin A, Olivere M, Wakeman D. Enteral Access systematic review. American Pediatric Surgical Association 2020 Virtual Meeting.

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