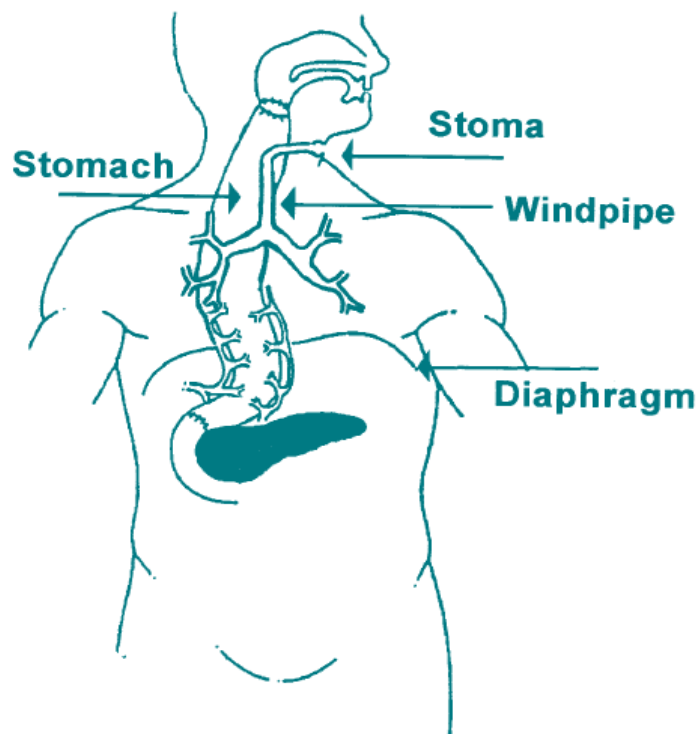


Care of the patient after pharyngo-laryngo-oesophagectomy (PLOG)

Cancers in the lower part of the pharynx arise in the area between the pharynx and larynx. Many of these cancers spread under the surface of the pharynx and into the oesophagus. If surgery is going to cure the cancer then it has to include removal of the pharynx, larynx and oesophagus.

Once the cancer is removed this leaves a gap between the base of the tongue and the stomach. Upper GI surgeons mobilise the stomach up into the neck where it is then joined to the base of the tongue, and the trachea is diverted out onto the skin as an end stoma. Thus the swallowing and breathing systems are completely detached. The thyroid and parathyroid glands are often removed.



Aims

- ☐ Early extubation/ self ventilation (often already undertaken in theatre).
- ☐ Effective analgesia with ability to deep breath, cough and cooperate with physiotherapy.
- ☐ Prompt diagnosis and management of problems: ischaemic anastomosis, leak, respiratory failure
- ☐ Effective management of neck breather and stoma.

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Admission

- ☐ Check ABC as for any admission.
- ☐ Monitoring 5 lead ECG.
- ☐ Jejunostomy tube in place – b.d. flush with 20mls H₂O.
- ☐ Fluid management: the patient has had a collapsed lung peri-operatively, give fluids as required but do not over hydrate
- ☐ Maintain haemoglobin >8g/dl. Administer single unit transfusion and recheck.
- ☐ Check serum calcium four hours post-op and regularly thereafter – parathyroid glands have usually been removed

Postoperative care

- ☐ Maintain epidural for 4 days, half infusion on day 4, if pain control good stop 3 hours later. If pain control poor, restart epidural rather than start PCA. Commence PCA on day 4 post op. – medical check!!
- ☐ Remove epidural catheter if pain controlled by PCA.
- ☐ ABG if clinical concern. Unexplained acidosis or rising lactate in early post op period - consider ischaemic acidosis. Surgical team consult: re endoscopy.
- ☐ Routine daily bloods incl. calcium, repeat chest x-ray if clinical changes: infection, collapse, atelectasis all common, possibility of pneumothorax, evidence of leak.
- ☐ Commence jej feeding 48 hours post op using jej protocol unless indicated by surgical team.
- ☐ Consider products such as dry shampoo for hair washing!!!! (aerosol spray can cause respiratory distress in these patients)
- ☐ Ensure strict mouth care, as patient will be more prone to a dry mouth and oral thrush.
- ☐ Emphasise patient comfort – consider aids such as v pillows for neck support, notepads/dry white boards for communication. Texting is a great form of communication, if mobiles allowed in unit. Discuss methods with family.

Drugs

- ☐ Single dose pantoprazole 40mg 8hrly, convert to lansoprazole down jejunostomy once in use
- ☐ Dalteparin 2500 - 5000iu sc od
- ☐ Epidural. – medical check!!
- ☐ Antibiotics – prophylaxis gentamicin amoxicillin and metronidazole
- ☐ Iv calcium dependent on serum calcium – will need 1- alpha calcidol and sandocal via jej once feeding established
- ☐ Thyroxine 100mcg to commence within 2 weeks if total thyroidectomy

Stoma care

- ☐ Nurse in semi-recumbent position – avoid excessive neck extension to minimise tension on anastomosis
- ☐ Clean skin and rim of stoma with sterile swabs dampened with sterile saline.
- ☐ Remove any debris/ crusts gently using forceps
- ☐ Use a torch to look inside the stoma (trachea). If any clots or mucous plugs use forceps to remove.
- ☐ Administer regular saline nebulisers to soften crusting / plugs and promote expulsion of these.
- ☐ Encourage the patient to gently cough regularly.
- ☐ Suction may be used but care must be taken not to push any debris into the lungs and care also not to damage the tracheal wall
- ☐ If oxygen therapy is used this must be humidified.
- ☐ If oxygen not used a Buchanan bib should be dampened and placed over the stoma.
- ☐ Cavilon cream (not spray) may be applied to protect the surrounding skin

Wound care

- ☐ Dress abdominal wound with Mepore dressing. Leave wound exposed if clean and dry.
- ☐ Abdominal wound clips – day 10.
- ☐ Neck wound clips out – day 7-10.
- ☐ Stoma sutures removed – day 10
- ☐ Neck drains to remain for min. 48 hours, only removed when drainage is < 20mls in 24hrs and by instruction by head and neck surgeon. Daily drainage should be recorded accurately.
- ☐ Chest drains- leave until instructed by GI surgeons
- ☐ Daily check of jejunostomy site and sutures – see care of jejunostomy information sheet

Discharge

- ☐ Transfer to ward 19a St. Johns Hospital when chest and abdominal drains removed and patient stable.
- ☐ Remove invasive monitoring lines before transfer.
- ☐ Ensure Buchanan bib is used on discontinuation of humidified oxygen (see PLOG box).
- ☐ Collate results in notes.
- ☐ Complete discharge summary, keep one to go with audit sheet.

Contact numbers

Head and neck nurse specialists:

*Fiona Haston: 07826891412
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ENT surgeon:

Andy Evans: 07837411726

Upper GI surgeon:

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Care of surgical jejunostomy tubes

Jejunostomy tubes are different from gastrostomy tubes. They are not held internally by a bumper / balloon.

-the only thing holding a jejunostomy tube in situ is the sutures holding the external fixation flange. On no account remove these sutures

Daily care requirements

1. 1. Ensure area around tube is clean
1. 2. Ensure suture integrity
-if concerned, ask the duty registrar to review and replace with 4.0 nylon
1. 3. Cover flange with clear occlusive dressing
1. 4. Ensure tube is gently flushed after every use to maintain patency
1. 5. Avoid tension on tubing at all times
1. 6. Ensure tube is supported during patient mobilisation

If the tube is displaced immediately re pass tube into fistula – if tube is heavily contaminated use a 9f feeding tube and contact GI nurse specialist to obtain a fresh tube

If the tube is out for any length of time the fistula will close – this is a significant event as the patient will require a laparotomy to re-site a jejunostomy

Prior to discharge

If tube is still required for supplemental nutrition at discharge please ensure:

1. 1. Sutures are replaced
1. 2. Tube / retention flange integrity is satisfactory
-if in doubt contact GI nurse specialist to replace tube
1. 3. Patient is educated regarding procedure if tube displaced
2. 4. Patient is discharged with 9f feeding tube in case of displacement