Procedure:

Esophagectomy

Indication:

CA

Description:

Thoracic approach involves a thoracotomy and removal of esophagus and surrounding lymph nobes. General surgery performs from a transhiatal approach and creates a mid-abdominal incision and a cervical (neck) incision. The esophagus and surrounding lymph nodes are removed. Either approach uses what is left, either stomach or intestine, to create a tube and attach to the cervical esophagus to retain gastric continuity.

Post-op Implications:

Complications:

Pain: Epidural may be in place. IV opioids and opioid adjuncts will be used, no PO meds for 5-7 days.
Pulm: ARDS can develop due to inflammation and reduction of lymph clearance in thoracic cavity. The patient may have a chest tube. Aggressive pulmonary toileting is required due to frequency of pulmonary complications.
Hemo: Large fluid shifts can cause hypotension and edema. Anastomosis leak: swallow study can confirm a leak. CT scan can visualize extraluminal collections; these must be drained. Give systemic AbX for suspected leak. Usually ruled out by day 5-7.
A-fib: can occur in 20% of cases.
Conduit ischemia: Can present as a rapid deterioration with s/s of septic shock. May need gastrostomy.
Laryngeal nerve injury: May present as hoarseness, aspiration pneumonia, and/or dyspnea. Consult OTO.
Chylothorax: Chyle leak into thoracic cavity from thoracic duct. Can be seen as fats in chest tube output. May require surgical intervention.

Meds:

NPO, nothing per NGT.

Principles:

Decreased lymph clearance from thoracic cavity can cause pulmonary edema with too much IVF, however, hemodynamic instability may warrant fluid boluses. MIV most likely at a rate of 100-200 overnight, UOP 30ml/hr is accurate indicator of sufficient fluid resuscitation. NG tube will be in place, no manipulation or replacement of tube if it becomes dislodged; tube passes through the esophageal anastomosis. NPO for 5-7 days until anastomotic leak is R/O. May have J-tube for enteral feeding as well. If unable to resume enteral feedings, TPN may be started.

Care Plan:

Aggressive pulmonary toileting, hemodynamic monitoring and support, pain control, frequent turning, wound care, foley hygiene, NPO, manage IVF, donâ€™t manipulate NGT or replace if dislodged. Chest tube, A-line, J-tube, and epidural care if applicable.

Course of Care:

May come to SICU extubated or intubated. NPO 5-7 days. OOB as soon as able. NGT stays in place with no manipulation for 5-7 days. Foley stays in until mobilizing. Restart home Rx as soon as able. Stay in SICU until stable.

Room Setup:

Possible vent setup. Possible for A-line, epidural, chest tube, and J-tube. Have Extra IV pumps available. Suction for oral, NGT, and chest tube. SCDs. Possible PCA.