**OESOPHAGEAL OBSTRUCTION PATHWAY**

***= yes = no***

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| **TOP TIPS**   * **Oesophageal obstruction is an emergency**. Lack of action can cause perforation. Discuss with gastroenterology **early** * DO NOT use fizzy drinks or medications to try and disimpact oesophageal obstructions. * Most cases have underlying oesophageal disease. * Chicken and fish bones are RARELY seen on x-ray. * Some obstructions above the sternal notch are managed by ENT/ORL +/- Gastroenterology | | |
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| **Is the history consistent with oesophageal obstruction**? *i.e. Recent ingestion of food or foreign body with subjective sensation of object retained in oesophagus* | | |
| Yes 🡪 Continue |  | No 🡪 Stop pathway   Give appropriate clinical care |
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| **Ensure baseline management and investigations:**  Nil by mouth  IV Analgesia — Paracetamol 1g IV qds + Morphine 1mg IV to be titrated  IV Fluids — 0.9% Saline *give replacement and resuscitation requirements*  Bloods — FBC, U+E, LFT, coagulation screen & G+H  **Diabetic patients:**  GIK in place of IV saline for replacement fluids (*see local protocols)* | | |
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| warning-sign-red-50**Does the patient have any signs of high grade obstruction or airway compromise?** | | |
| Stridor  Hypersalivation  Inability to swallow own saliva | | |
| No |  | Yes |
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|  |  | **Senior decision needed for removal. Contact:**  Anaesthetist for airway support  Gastroenterology Registrar (In hours) *(if available otherwise general medical registra*r) or Consultant (out of hours) for OGD |
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| warning-sign-red-50**Does the patient have any signs of oesophageal perforation?** | | |
| Fever  Subcutaneous crepitus *e.g. neck, upper thorax*  Swelling of neck may be focal or general  Tachycardia > 100 BPM | | |
| No |  | Yes |
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|  |  | **This patient needs urgent imaging and surgical assessment:**  CT Contrast Neck and Chest  Contact Surgical registrar for urgent assessment  Contact Gastroenterology registrar (In hours) or Consultant (Out of hours) for possible urgent OGD  Contact Anaesthetist for airway support |
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| **Identify:**  Time of impaction\_\_\_\_\_\_:\_\_\_\_\_  Type of food / object Ingested  Site of impaction—Above or below sternal  Previous impaction, oesophageal disease or psychiatric disorder? | | |

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|  | **SOFT FOOD BOLUS** | **SHARP OBJECT BELOW STERNAL NOTCH *OR* BLUNT OBJECT AT ANY LOCATION** | **SHARP OBJECT ABOVE STERNAL NOTCH** |
| No CXR or Neck X-Ray  Discuss with gastroenterology *(if available otherwise general medical team*) before referral to medicine  Time D/W Gastroenterology \_\_\_:\_\_\_  send referral for OGD  IF NO SIGNS OF HIGH GRADE OBSTRUCTION AIM IS TO REMOVE SOFT FOOD BOLUS WITHIN 24 HOURS OF IMPACTION  These patients are likely same day discharges. | CXR + Lateral Neck X-Ray *Confirm location, size and number*  Discuss with gastroenterology *(if available otherwise general medical team*) before referral to medicine  Confirm if anaesthetic support required for OGD and if to be performed in theatre or gastro suite.  Time D/W Gastroenterology \_:\_  send referral for OGD  AIM IS TO REMOVE SHARP OBJECTS, MAGNETS AND BATTERIES WITHIN 6 HOURS OF IMPACTION | CXR + Lateral Neck X-Ray *Confirm location, size and number*  Discuss with local ORL/ENT + Gastroenterology at your providing centre 24/7  Discuss with anaesthetics *may need airway support for transfer* |
| **LOCATION OF OGD:** |
| Most procedures done in Gastro Department  High risk cases done in theatre, decision made by gastroenterology consultant  **Arrange:**  Acute theatre booking  Referral form for OGD  Inform theatre and anaesthetic coordinators |
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| **POST OGD Discharge Planning**  Commence PPI in most cases  Post procedure and discharge instructions as per OGD report  *Most cases require elective repeat OGD after period of PPI to exclude underlying pre-disposing pathology.* | | | |