**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 |
|  |  |  |
| **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 |
|  |  |
| **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.* |