UR MEDICINE | GOLISANO CHILDREN'S HOSPITAL

Pediatric Surgery OR G Tube Checklist

Pre-Op: Before Incision

[ ] Confirm procedure type (open vs laparoscopic) and availability of necessary instruments

Smaller children (< 15kg) use neonatal instruments with 4mm 30 degree scope and reusable 4mm metal trocar – need 1 cm piece of 22F Foley 1cm up the trocar.

Bigger children (>15kg) use 5mm laparoscopic instruments with 5mm 30 degree scope and disposable 5mm trocar.

[ ] Confirm we have expected gastrostomy tube (Malecot vs appropriately sized button) **and dilator set**

ABx: Cefazolin (Ancef) 1 dose (30mg/kg) within 60 mins of incision (if needed, redose at 4 hrs). No post-op doses needed. If allergy, give Clindamycin (10 mg/kg)

[ ] Give 14F red rubber catheter, 60 ml GU (cath tip) syringe, and Kelly (or similar) clamp to anesthesiologist

Remove old feeding tube

Place red rubber via mouth into stomach (once intubated)

[ ] Set Bovie and insufflation pressure appropriately

CO_2 at 4 for cardiac kids & neonates, can go up to 6 or 8 (see neonatal laparoscopy checklist)

8 -12 for older infants/children depending on size/age

Intra-op: See next page →

Post-Op: After skin closure

[ ] Place grip lock on skin in LLQ. If extension tubing to be left connected (vented), place tubing in grip lock

[ ] Loosely place abdominal binder or ½ of ace wrap (4-6 inch).

[ ] Document in Op Note (in findings): Tube type and size, volume of water in balloon

- Usually start feeds POD1 [may delay longer in children with congenital heart disease (single ventricle physiology)]

-Meds can be given per tube, but they should be liquid or completely dissolved. **No crushed meds unless approved by surgeon**. Consider IV meds early to ensure adequate absorption (bioavailability)

****In general, if extension tubing is connected to feed, it needs to be in the grip lock. If not feeding, extension tubing should be removed to decrease the risk of it being tugged on and tube dislodgement.****

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Intra-Op: Lap G

Access at umbilicus

[ ] Measure expected length of tube with needle and ruler and open the tube*

Gastropexy sutures:

- 2-0 Monocryl on CT1 for smaller children – buried in subQ and tied down
- For large kids with thicker abdominal walls (longer than 2.0 cm tube), use 1 Prolene and tie over the tube and cut out sutures on POD 3-7

Anesthesiologist inflates stomach with air via red rubber catheter*

Needle inflated stomach and insert wire*

Serially dilate the tract (8F > 12F>16F>20F)*

Insert tube over the 8F dilator over the wire*

Inflate with 4-5 ml of **WATER** (not saline)*

[ ] Confirm intra-gastric position by injecting air via extension tubing*

Tie down sutures*

Close umbilical site: 3-0 Vicryl for smaller kids (<15kg), 2-0 Vicryl for bigger kids (>15 kg)

Close skin: if incision through the umbilicus → 5-0 fast gut

If incision is infra-umbilical, 5-0 Monocryl for < 15kg, 4-0 Monocryl for > 15kg

Dermabond wounds

[ ] Cover balloon port with tape*

[ ] Send all extra G tube supplies (connection tubing, etc) with patient in chart in biohazard bag*

Intra-Op: Open Stamm G

[ ] Have 10Fr and 12F Malecot tube available

Upper midline laparotomy

Stamm gastrostomy with Malecot tube out LUQ

Suture tube to skin

Bolster dressing

For Open G button see steps in Intra-Op: Lap G with *