Cheatsheets
Laparoscopic Pyloromyotomy
By M. Newbern

Pre-op: Evaluate pre-op [Cl^-], and bicarb. Results should be Cl^- >100 mEq/dL, Bicarb <28mEq/dL. Note this dx is a medical not a surgical emergency. Evaluate for signs of dehydration (depressed fontanelle, decreased skin turgur, slow capillary refill, dry mucous membranes).

Pre-medication: No pre-op sedation, consider atropine 0.1mg IV prior to gastric suctioning, consider volume loading and case delay (10-20ml/kg normal saline IV) if patient appears hypovolemic

- Following atropine administration and prior to induction of general anesthesia, you will suction the stomach several times (using the large red rubber suction catheter), moving the patient to R/L decubitus and prone positions for each pass. Please note that our red rubber catheters contain latex and should not be used in latex-sensitive patients.

Induction: RSI with full dose succinylcholine (2mg/kg) and Propofol 3mg/kg

Lines: PIV x 1; must be placed prior to induction; inhalational induction NOT appropriate due to aspiration risk

ETT: Cuffed ET tube (typically 3.0 cuffed)

Positioning: supine, baby (not bed) turned 90 degrees on OR table so that head is on anesthesiologist's right-hand side (except when Dr. Tagge is surgeon then head will be on anesthesiologists's left-hand side). Red rubber catheter and open to air (surgeon will ask for air insufflation to evaluate for gastric leak later in case).

Drips/ Fluids: Normal Saline, Consider 5% Albumin 10-20mL/kg (note be prepared for hypotension following induction and initiation of volatile anesthetic, as well as after insufflation)

Intra-op management: Rocuronium 1mg, at time of prep/draping, volatile anesthetic will be d/c'd as soon as the pylorus is being spread apart. Administer full reversal at end of case. At non-teaching institutions, cases are often done with succinylcholine only due to short surgical times.

Pain Management: IV Tylenol, avoid opiates* until post op and only if significant signs of pain (these patient usually tolerate this surgery very well)

Notes: The key to this surgery is adequate volume resuscitation, without overzealous fluid administration. Patients will be hypotensive with volatile but will

respond to fluids. Also remember rapid fluid administration has been known to reopen a closed ductus arteriosus.

*These patients have metabolic derangements that will increase their chances of post op apnea should they receive narcotics, only use narcotics (or other drugs that cause respiratory depression) in the post op period and only use them judiciously.