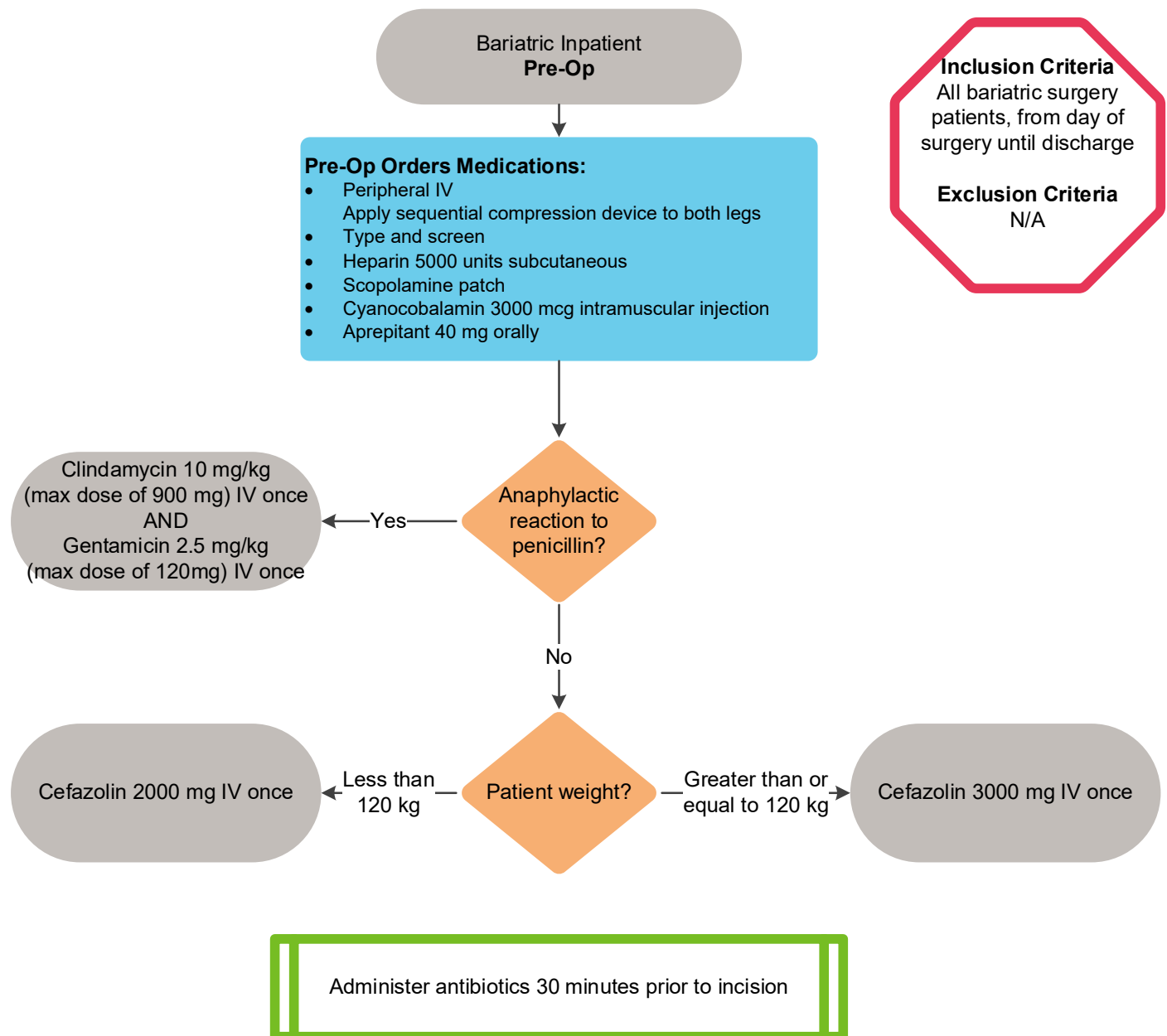


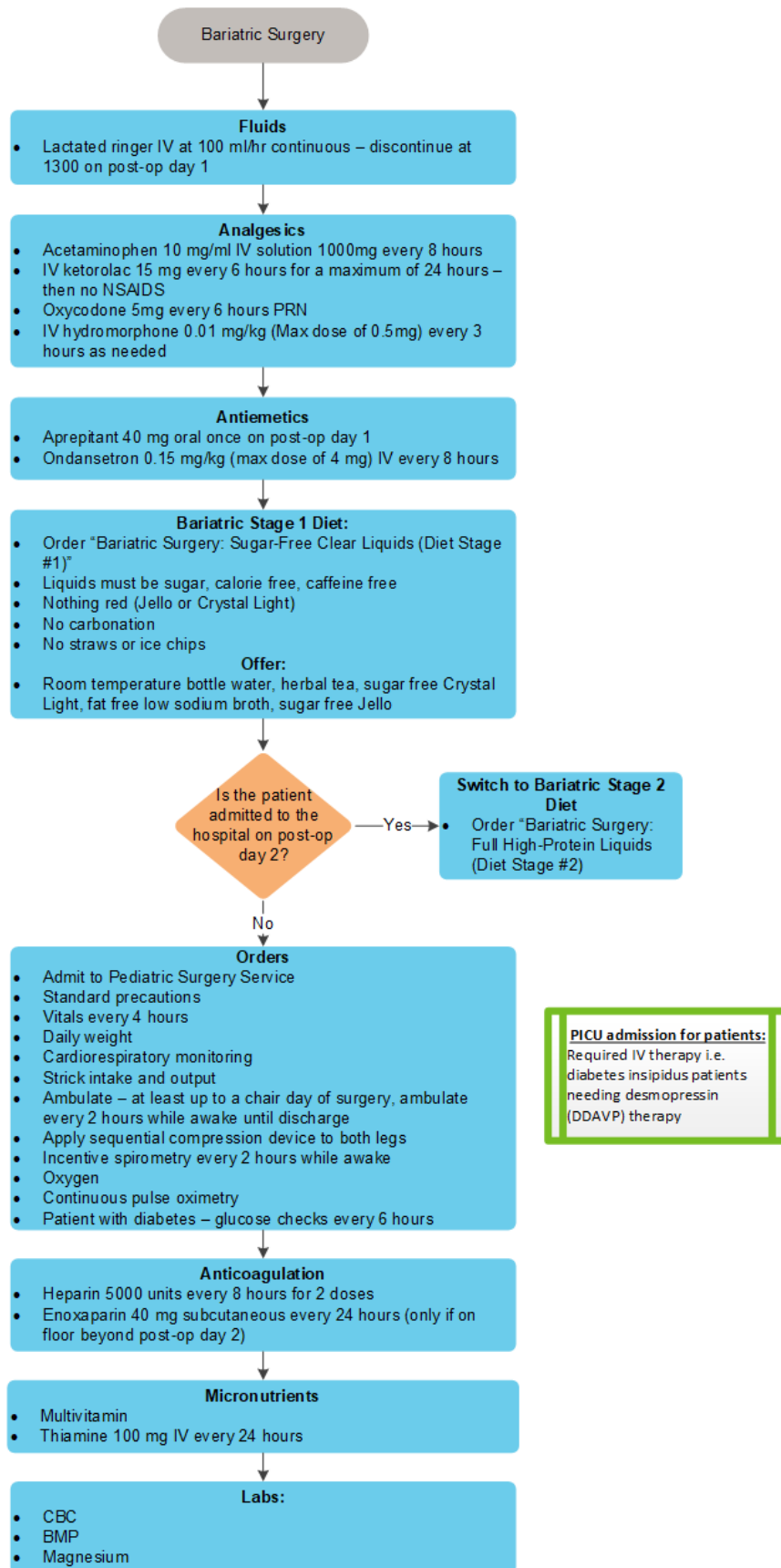
BARIATRIC SURGERY

ENHANCED RECOVERY AFTER SURGERY (ERAS) INPATIENT CARE OF THE BARIATRIC SURGERY PATIENT

ALGORITHM 1. PRE-OP



ALGORITHM 2. DAY OF SURGERY



ALGORITHM 3. POST-OP DAY 1 UNTIL DISCHARGE

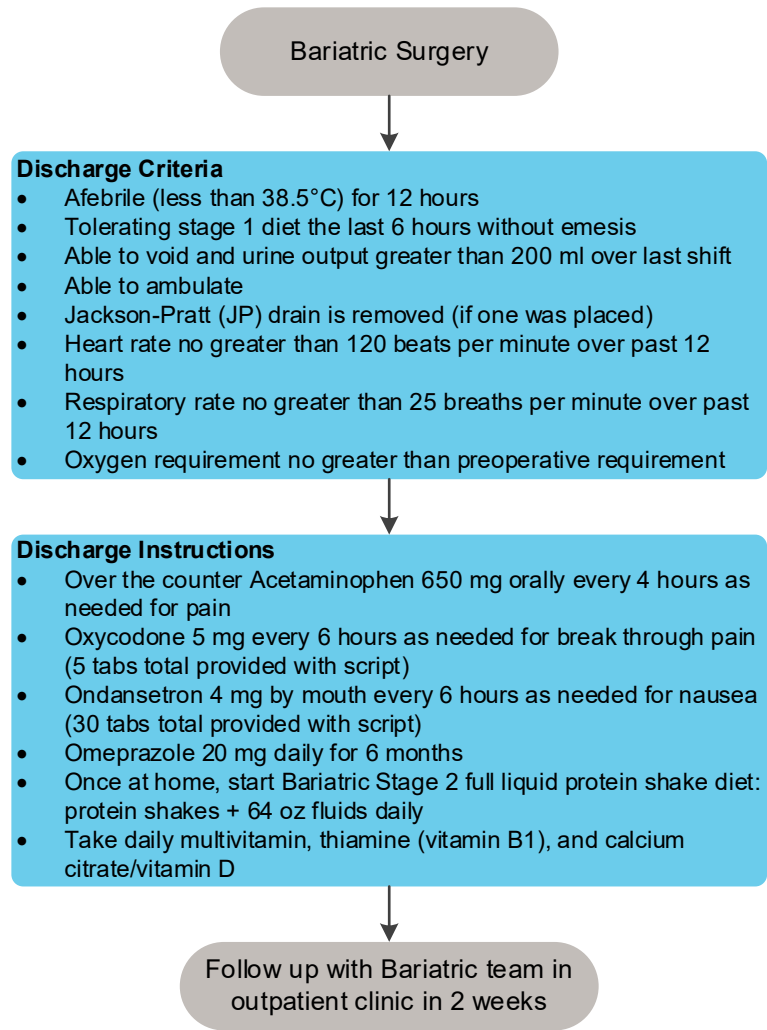


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TARGET POPULATION

Inclusion criteria

All bariatric surgery patients from day of surgery until discharge.

To be used by any hospital team member taking care of bariatric patients on day of surgery until discharge.

- Peri-op team
- Pharmacy team
- OR staff
- PACU team
- Anesthesia team
- Acute pain service
- PICU team
- Hospitalist team
- Nursing staff
- Surgical residents/fellows
- Radiology

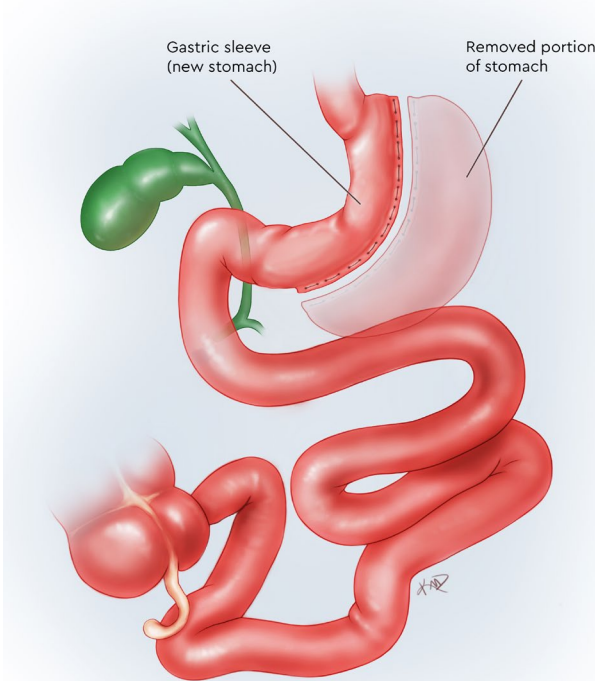
BACKGROUND ON BARIATRIC SURGERY

The Bariatric Surgery Center at Children's Hospital Colorado offers bariatric (weight loss) surgery as a treatment option for severe obesity and obesity related health conditions in adolescents. Bariatric surgery can provide effective and sustainable weight loss for adolescents who have been unable to lose a significant amount of weight with traditional weight loss measures. The Bariatric Surgery team at Children's Colorado takes a multidisciplinary team approach to the treatment of obesity, collaborating with experts from lifestyle medicine, pediatric surgery, endocrinology, nutrition, social work, and pediatric psychology.

Types of surgery offered

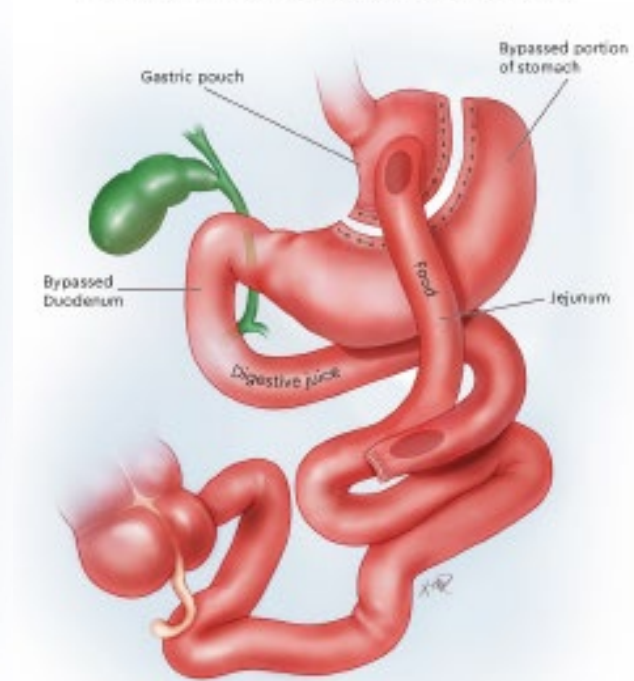
The Bariatric Surgery Center currently offers two types of bariatric surgery options. These include the vertical sleeve gastrectomy (VSG) and the roux-en-Y gastric bypass (RYGB). Bariatric surgery works by laparoscopically modifying the stomach (and intestinal tract for RYGB), reducing appetite and the amount of food needed to feel full. Adolescents and their parents must be willing to follow healthcare providers' recommendations before and after surgery. This includes committing to lifestyle changes that will help the teen remain healthy and keep the weight off for life. It also includes regular follow-up visits after surgery.

Vertical Sleeve Gastrectomy (VSG)



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Roux-en-Y Gastric Bypass (RYGB)



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Criteria for surgery

The Bariatric Surgery team carefully evaluates each patient to determine if they are a good candidate for surgery.

- BMI greater than 35 kg/m² or BMI greater than 120% with major obesity-related health conditions or a BMI greater than 40 kg/m² or BMI greater than 140% with other obesity-related health conditions
- Willingness to complete the pre-operative checklist
- Ability to understand surgery and the after care
- Understand and willing to adhere to nutritional guidelines after surgery

- Healthy family support system
- Clearance from the bariatric surgical team

INITIAL EVALUATION

Associated comorbidities

Bariatric surgery may help to reverse certain obesity-related conditions such as:

- Type 2 diabetes
- Obstructive sleep apnea (OSA)
- Hypercholesterolemia/dyslipidemia
- Hypertension
- Musculoskeletal problems - i.e. slipped capital femoral epiphysis, Blount's disease
- Polycystic ovarian syndrome (PCOS)
- Non-alcoholic fatty liver disease (NAFLD)
- Gallbladder disease
- Pancreatitis
- Pseudotumor cerebri
- Skin breakdown/infections
- Psychosocial problems

OUTPATIENT CLINICAL MANAGEMENT

The bariatric multidisciplinary team performs a comprehensive medical, surgical, and psychological evaluation to determine which patients are a good candidate for surgery.

- Comprehensive medical and surgical evaluation
- Lab work
- Behavioral evaluation with psychologist
- Nutrition evaluation with registered dietitian
- Referral to specialists as needed (Sleep medicine/sleep study, Endocrinology, Cardiology, Gastroenterology, Gynecology, etc.)
- 6-9 consecutive months of medically managed weight loss
- Evaluation for long term birth control methods (females)

ANESTHESIA/RESPIRATORY CONSIDERATIONS

Preoperative evaluation

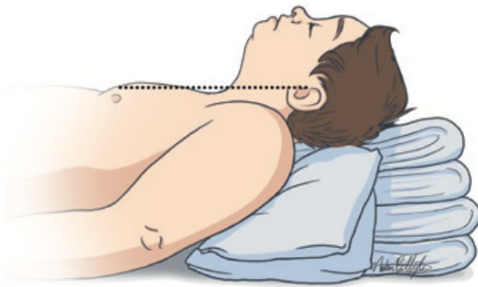
- Patient seen in Anesthesiology Preoperative Clinic within 1 week of surgery
- History and physical, airway and cardiopulmonary exam
- Evaluation of obesity related comorbidities – diabetes, insulin resistance, hypertension, hyperlipidemia, obstructive sleep apnea (OSA), non-alcoholic fatty liver disease (NAFLD) etc.
- Plan for stopping medications prior to surgery i.e. stop Lisinopril 72 hours prior to surgery

Operating room set up

- Endotracheal tube (ETT) 7 or 7.5, Mac 3/Miller 2 blade
- Two peripheral IV set ups including fluid warmer
- Arterial line and central line are rarely necessary
- Video laryngoscope available in the operating room
- Ramp for induction and intubation
- Appropriate bed for obese patient
- Hoovermat for patient transfer
- 34, 36 and 38 Fr Bougie Dilators
- 18F OGT and 60 ml cath tip syringe for air insufflation may be requested by surgeon to check for anastomotic leak

Intraoperative management

- Standard monitors as recommended by the American Society of Anesthesiologists (ASA) - Use appropriate sized blood pressure cuff; conical shape of upper arm may necessitate using forearm or leg, expect low tidal volume electrocardiogram (EKG) and partial pressure of carbon dioxide (PaCO₂) / end-tidal carbon dioxide (EtCO₂) mismatch
- Ramped position for induction and intubation



- Adequate preoxygenation
- Rapid sequence induction with propofol, fentanyl and succinylcholine (maximum 150 mg) or rocuronium
- Volatile agent, rocuronium and fentanyl for maintenance of general anesthesia
- Second peripheral IV access and fluid warmer
- Dexamethasone and ondansetron for postoperative nausea and vomiting (PONV) prophylaxis
- Intraoperative ventilation - Low tidal volume (6-8 mL/kg ideal body weight), modest levels of positive end-expiratory pressure (PEEP) 10-12 cm H₂O, maintain normocapnia, fraction of inspired oxygen (FiO₂) 0.5-0.8, intermittent alveolar recruitment
- Position in semi-recumbent (upper body - 25-30 degrees) or reverse Trendelenberg position
- Avoid supine or Trendelenberg position
- Extremities must be well padded to prevent peripheral nerve injuries
- Regional anesthesia not necessary as surgical procedures are laparoscopic
- Minimize long-acting opioid administration with a goal of less than 0.3 mg/kg total intravenous (IV) morphine equivalents (less than 4.5 mcg/kg IV fentanyl, less than 30 mcg/kg IV hydromorphone, less than 0.3 mg/kg IV morphine)
- IV acetaminophen and ketorolac may be used in the absence of nonalcoholic steatohepatitis (NASH). Consider dexmedetomidine administration.

- Anticipated blood loss is minimal.
- Typically limit intravenous fluids to less than or equal to 1500mL (despite overnight deficit)
- Head up position prior to extubation
- Extubate when fully awake

THROMBOSIS CONSIDERATIONS

Patients with severe obesity may be at increased risk for venous thromboembolism (VTE). Patients will receive 5000 units heparin subcutaneously on day of surgery and 5000 units heparin subcutaneously every 8 hours for 2 doses while in the hospital. Patients will receive enoxaparin 40 mg subcutaneously every 24 hours only if the patient remains on the floor beyond post-op day 2. Patients are encouraged to ambulate with at least up to chair on day of surgery and ambulating every two hours while awake post-op day 1 until discharge.

THERAPEUTICS

Pre-op orders/medications:

- Peripheral IV
- Apply sequential compression devices to both legs
- Type and screen
- Heparin 5000 units subcutaneous
- Scopolamine patch
- Cyanocobalamin 3000 mcg intramuscular injection once on operating room table
- Aprepitant 40 mg orally
- Less than 120 kg - cefazolin 2000 mg IV once
- Greater than or equal to 120 kg - cefazolin 3000 mg IV once
 - If anaphylactic reaction to penicillin - clindamycin 10 mg/kg (Max dose of 900 mg) IV once and gentamicin 2.5 mg/kg (Max dose of 120 mg) IV once

Fluids:

- Lactated ringer IV @100 ml/hr continuous. Discontinue @1300 on post-op day 1

Inpatient pain management:

- Acetaminophen 10 mg/ml IV solution 1000 mg every 8 hours
- IV Ketorolac 15 mg every 6 hours for a maximum of 24 hours then no NSAIDs.
- Oxycodone 5 mg every 6 hours as needed
- IV hydromorphone 0.01 mg/kg (maximum dose of 0.5 mg) every 3 hours as needed

Inpatient antiemetics:

- Aprepitant 40 mg oral once on post-op day 1
- Ondansetron 0.15mg/kg (maximum dose of 4 mg) IV every 8 hours

Post-op orders:

- Admit to Pediatric Surgery Service
- Standard precautions

- Vitals signs every 4 hours
- Daily weight
- Cardiorespiratory monitoring
- Strict intake and output
- Ambulate - at least up to chair day of surgery, ambulate every 2 hours while awake until discharge
- Apply sequential compression device to both legs
- Incentive spirometry every 2 hours while awake
- Oxygen
- Continuous pulse oximetry
- Patients with diabetes point of care glucose checks every 6 hours

Anticoagulation:

- Heparin 5000 units every 8 hours for 2 doses
- Enoxaparin 40 mg subcutaneously every 24 hours (only if patient remains on the floor beyond post-op day 2).

Micronutrients:

- Multivitamin: Centrum kids with iron 2 chewable tablets daily
- Thiamine 100 mg IV every 24 hours

Labs:

- CBC with diff, BMP, magnesium

DIETARY CONSIDERATIONS – PLEASE SEE ALGORITHM

Bariatric Diet Stage 1

Sugar Free Clear Liquids from day of surgery until discharge or post-op day 2

- Order “Bariatric Surgery: Sugar-Free Clear Liquids (Diet Stage #1)”
- Liquids must be sugar free, calorie free, caffeine free, and clear
- Nothing red (crystal light or jello)
- No carbonation
- No straws or ice chips
- Offer: room temperature bottled water, sugar free crystal light packets, herbal tea, fat free low sodium chicken, beef, or vegetable broth

Bariatric Diet Stage 2

Full High Protein Liquids

- Order “Bariatric Surgery: Full High-Protein Liquids (Diet Stage #2)” if patient is not discharged on post-op day 2.

Nasogastric (NG) or Nasojejunal (NJ) tube feeds for post-operative bariatric patients

Enteral Feeding

1. If a bariatric surgery patient is readmitted after surgery due to poor oral intake, consult the inpatient RD for enteral nutrition recommendations if the patient has a short-term condition, and has functional, absorptive gut capacity.

2. Enteral nutrition will most often be delivered via nasogastric (NG) route but nasojejunal (NJ) route may be considered.
3. Inpatient dietitian will consult with the Bariatric Surgery Team outpatient dietitian to select formula, intake goals and rate. PeptamenAF is recommended formula.
4. Formula options:
 - a. Peptamen AF (1.2 kcal/ml, hydrolyzed-whey, high protein formula)
 - b. Alternative for patients with dairy-protein allergy: Liquid Hope (1.5 kcal/ml, 14g/8oz protein, whole food, vegan formula)
 - c. Beneprotein (6 grams of whey protein per scoop/packet) may be ordered as a supplement to meet protein needs at any post-op stage
 - d. Premier Protein oral supplement given as enteral feed (160 kcal and 30 g protein per 11-ounce carton, whey protein)
 - i. If Premier Protein is chosen, contact:
 1. Room Service Coordinators group at roomservicecoordinators@childrenscolorado.org or call x76232 (dial 1 as a clinician) to have cartons delivered to the patient room AND
 2. Email Dietitian Assistants group at dietitianassistants@childrenscolorado.org to let them know the formula is being delivered to the patient's room via Room Service and they can treat the enteral order as "floor stock"
5. Protein/Calorie guidelines for patients **without** hypermetabolic conditions, refer to the table below for specific intake goals according to post-op time period.

Post-Operative Diet Stages					
Time After Surgery	Stage#/Diet Order	Daily Calorie Limit	Protein Goal	Meal Volume (if eating PO)	Fluid Goal
Days 1 and 2	#1: Sugar Free Clear Liquids	Less than 300	N/A	1 oz every 15 min	64 – 80 ounces (1900 – 2400 ml) daily
Day 3 – 14	#2: Full High Protein Liquids	300 – 500	60 – 90 g/d	2 oz every 15 min	
Weeks 2 and 4	#3: Soft Protein Foods	About 500	60 – 90 g/d	¼ to ½ cup per meal	
Weeks 5 – 12	#4: High Protein Foods, Vegetables & Fruits	500 – 750	60 – 90 g/d	½ to 1 cup per meal	
Lifelong, after week 12	#5: High Protein Foods, Vegetables, Fruits & Whole Grains	About 1000	≥60 – 90 g/d	About 1 cup per meal	
References: (Nogueira and Hrovat); (Fullmer et al.); (Schollenberger et al.); (Kanerva et al.)					

6. Fluid goals for bariatric surgery patients in a euvolemic state are 64 – 80 ounces (1900 – 2400 ml) daily.
 - a. Patients should be encouraged to meet their fluid needs by mouth, as tolerated
 - b. For patients tolerating clear liquids by mouth, but no food or high protein shakes, an oral high-protein clear can be considered to supplement both fluid and protein needs
 - i. Beneprotein added to other tolerated sugar-free clear fluids (e.g. herbal tea, Crystal Light)
 - c. If fluids are not tolerated by mouth or if goals are not being met by mouth, additional free water should be added to the enteral feedings

STAFF TRAINING | EDUCATION

- Preserve dignity and privacy
- Lifting: use correct body mechanics, never lift alone
- Utilize mechanical lifting technology when necessary
- Assemble team and plan before entering room

- Bariatric stage 1 and stage 2 diet

SPECIALIZED EQUIPMENT

Bariatric equipment on 6th floor

- Large briefs or adult briefs
- X-large anti-embolism stockings (Ted hose)
- Sequential compression devices (SCDs)
- Large blood pressure cuff
- Large gowns
- Booties
- Large/simple/non-rebreather masks
- Laryngeal mask (LMA) size 4 and 5

CONSULTATIONS

Consider consultations

- Cardiology
- Pulmonary (CPAP management)
- Pain team
- Anesthesia
- Clinical nutrition (RD and/or MD)
- Endocrinology
- Gastroenterology
- Hematology
- Infectious Disease
- Orthopedics
- Physical therapy
- Skin/wound nurse
- Psychiatry
- Child Life

DISCHARGE

Discharge criteria

- Afebrile (less than 38.5°C) for 12 hours
- Tolerating stage 1 diet the last 6 hours without emesis
- Able to void and urine output greater than 200 ml over last shift
- Able to ambulate
- Jackson-Pratt (JP) drain is removed (if one was placed)

- Heart rate no greater than 120 beats per minute over past 12 hours
- Respiratory rate no greater than 25 breaths per minute over past 12 hours
- Oxygen requirement no greater than preoperative oxygen requirement

Discharge plan

- Over the counter Acetaminophen 650 mg orally every 4 hours as needed for pain
- Oxycodone 5 mg every 6 hours as needed for breakthrough pain (10 tabs total provided with script)
- Ondansetron 4 mg by mouth every 6 hours as needed for nausea
- Omeprazole 20 mg daily for the first 6 months, re-evaluate the need to continue taking at 6 months post-op visit
- Once at home, start Bariatric stage 2 diet (full liquid): Protein shakes + 64 oz fluids daily
- Take daily multivitamin, thiamine (vitamin B1), and calcium citrate/vitamin D
- Follow up with Bariatric team in outpatient clinic in 2 weeks

PARENT | CAREGIVER EDUCATION

Discharge instructions for patients and families

- Please seek medical attention for increasing pain, nausea, vomiting, fever greater than 101°F, respiratory distress, racing heart, decreased urination, or other concerns
- Okay to shower, allow Steri-Strips to fall off on their own
- Acetaminophen 650 mg orally every 4 hours as needed for pain
- Oxycodone 5 mg every 6 hours as needed for severe breakthrough pain after Acetaminophen
- Once at home, start Bariatric stage 2 diet (full liquid): protein shakes + 64 oz water daily. Consume all fluids slowly (2 ounces per 15 minutes). Stay on the protein shakes until your first follow-up visit. At your follow-up visit, you will receive education about how to transition to the next diet stage(s)
- Make sure to consume adequate fluids per day. Drink a minimum 64 ounces (8 cups) per day, made up of both Clear Liquids and Full Liquids (protein shakes)
- Take the following over the counter vitamin supplements previously approved by your bariatric outpatient dietitian:
 - Multivitamin
 - Thiamine (vitamin B1) 100 mg 1 tab daily
- Calcium/Vitamin D Call Bariatric Nurse Practitioner with any clinical questions 720-777-5506
- For scheduling your follow up visit in clinic, please call 720-777-5202

FOLLOW UP

Follow up schedule with outpatient Bariatric Surgery team:

- 2 weeks
- 4-6 weeks
- 3, 6, 9, 12, & 18 month
- Yearly

RELATED DOCUMENTS

- Enhanced Recovery After Surgery (ERAS) Pediatric Protocols

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APPROVED BY

Clinical Pathways and Measures Committee – August 26, 2024

Pharmacy & Therapeutics Committee – November 4, 2024

MANUAL/DEPARTMENT	Clinical Care Guidelines/Quality
ORIGINATION DATE	2/21/19
LAST DATE OF REVIEW OR REVISION	7/30/2024
COLORADO SPRINGS REVIEWED BY	N/A to Colorado Springs Hospital
APPROVED BY	 Lalit Bajaj, MD Chief Quality and Outcomes Officer
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REVIEW | REVISION SCHEDULE

Scheduled for full review on August 26, 2027

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