ESOPHAGECTOMY

Partial or Complete Removal of the esophagus

Depending on which portion of the esophagus is removed, physicians will make an incision either in the neck or on the lateral side of the chest along with a midline abdominal incision. The top of the stomach is then placed at the new end of the esophagus and secured with staples. Depending on space allocation, the stomach may be positioned in a tube shape.

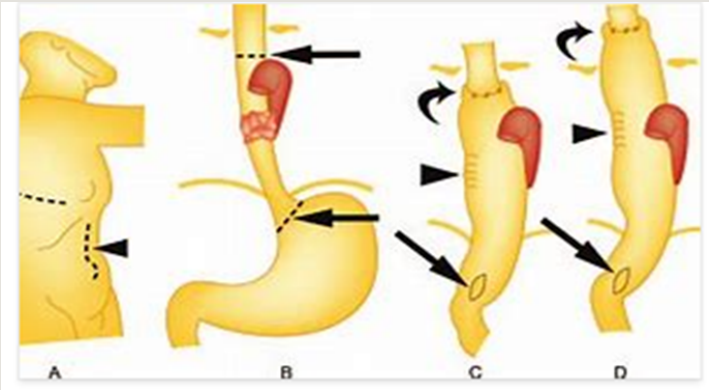
SURGICAL APPROACH: (TWO OPTIONS)

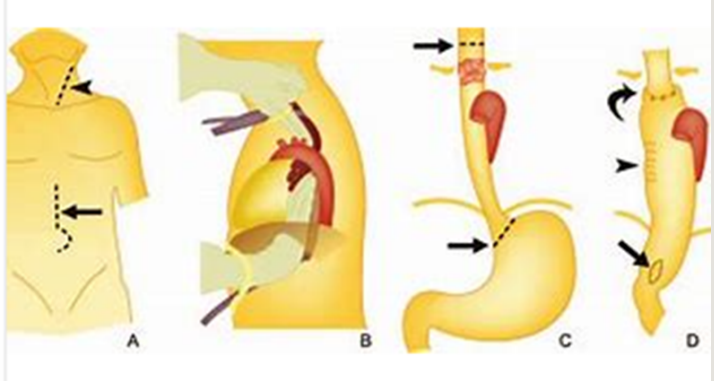
Ivor- Lewis

Right Thoracotomy- lung will be collapsed for exposure/access to esophagus

Midline Abdominal Incision- from umbilicus to sternal border

Patients will come up with chest tubes 2/2 thoracotomy, suction will be used to re-inflate the lung alongside pulmonary toilet





Trans-hiatal

Left Cervical Incision- access to esophagus

Midline Abdominal Incision- smaller than Ivor-Lewis

Trans-hiatal esophagectomy *is pain sparing and indicated for patients with marginal respiratory status. Incision goes through the left sternomastoid muscle*

Patients will come out of the OR with multiple tubes including

- Chest Tube
- JP Drain
- Gastric Tube
- Feeding tube

There are very specific care instructions for each of these tubes

Operations are performed by the thoracic surgery team and managed by the cardiac surgery team within the CVICU. Collaboration between teams is important and quick elevation of concers help to treat these low frequency patients within our unit.

Specific Post-Operative Orders

1. **NPO- to prevent anastomotic leak or fistula formation.**
2. **Aggressive pulmonary toilet (early and frequent IS)**
3. **Early mobility to improve GI motility and help with pulmonary toileting**

Drains-

NG Tube- DO NOT move or manipulate. If tube comes out, team will be paged for manipulation or placement

a. Decompresses the stomach, preventing tension on the suture line.
b. Low wall suction (40-60 mmHg)
c. Signage above the bed to prevent any manipulating of the NGT
d. Irrigate 30 mL NS q8Hours. If NGT does not decompress, troubleshoot or call the team.
e. When irrigating NGT- inject air through blue vent, ***do not*** place a cap on this tube

JP/Penrose Drain

a. **s**et to self suction, if not holding suction, elevate to the team.

Feeding Tube- J-Tube

a. Used to administer feedings/medication
b. Placed to gravity drainage/clamped for 24-48 hours
c. Flushed q8h with NS
d. All meds should be liquid or adequately flushed to prevent clogging.
e. Tubes started POD2 unless concern for ileus

DO NOT Manipulate Tube

Chest Tube-

a. -20 cmH20 for 24 hours then water seal
b. no Vaseline gauze around chest tube
c. change dressing daily

Possible Post Operative Complications:

Esophageal anastomotic leak
- May notice SQ emphysema or change in pleural drainage

Pulmonary Complications
- Pneumonia is most common: PULM TOILET
- Pre existing risks- smoking, COPD, steroid use, baseline deconditioning

Chyle Leak
- From lymphatic vasculature
- milky fluid in the chest tube

Gastic Necrosis

Infection

Esophageal stenosis/anastomotic stricture
- May notice swallowing difficulty once they can take PO intake