

Guideline for Enteral Feeds and Surgical Procedures

Preamble

This guideline is meant to assist with the management of enteral feeding in critically ill patients that are going the operating room for a procedure. Although it addresses most situations it does not replace clinical judgment. The treating team may make a decision that reflects the best care of an individual patient given specific circumstances.

1. In intubated patients (with an orotracheal, nasotracheal or tracheostomy tube) and with a post pyloric feeding tube or a feeding jejunostomy tube, enteral feedings should continue to the time that the patient is called for transport to the Operating Room for surgery. Feeds would then be held for the procedure. If an insulin infusion is being administered this should be discontinued.
2. Intubated patients with an orogastric tube or nasogastric tube (Salem sump type tube), feeds would be held just prior to transfer to the OR and the tube placed to suction to remove any residual gastric contents, prior to proceeding.
3. In intubated patients with a single lumen nasogastric feeding tube (Entriflex or other), or a percutaneous gastrostomy tube, feeds would be stopped on transport to the OR and aspiration of gastric contents should be done with a syringe. (Wall suction should not be used on these tubes.)
4. On return from the OR from non-abdominal surgery, feeds are to be resumed at their prior rate.
5. For patients that have undergone abdominal surgery, feeds should usually be restarted at a reduced rate (10ml/h) until tolerance is established and advanced as per the feeding algorithm. There may be circumstances when the surgical team may direct that enteral feeding be held (eg. ischemic bowel or fistula).
6. Non-intubated patients who are either on an oral diet or receiving tube feeds, should be fasting for a minimum of 6 hours prior to any elective surgical procedure. These patients can receive their medications with small amounts of water. (Can J Anesth/J Can Anesth (2010) 57:58–87)

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