VANDERBILT UNIVERSITY MEDICAL CENTER

Surgical Intensive Care Unit

Head and Neck ENT Service Pathway

I. **Purpose:** To standardize the management of patients who undergo head and neck cancer resection with flap reconstruction.

II. **Process:**

A. **Free Flaps**: These patients will be in the unit for at least 72 hours (flap checks q1hour x 48 hours, q2hours x 48 hours, q4hours until discharge).

B. **Pectoralis or Latissimus Flaps:** These patients will be in the unit for 24h for airway monitoring after total laryngectomy. They do not require flap checks as it is a rotational flap. Otherwise, they follow the same pathway as free flaps. If they are in the SICU longer than 24 hours, continue to follow the below.

POD # 0	POD #1	POD #3
NPO D10W @30 mL/hr/Plasmalyte @70 mL/hr D/C arterial line after AM labs Daily BMP, Mg, PO4* until POD 4 Nutrition Consult for tube feeding needs PT/OT consult *Refeeding syndrome/refeeding phenomenon: If PO4 <1.4mg/dL, stop feeding and replace/recheck before resuming feeds at trickle and consider daily thiamine x 7 days	Trickle tube feeds (20 mL/hr) (Nutren 1.5 as standard formula but review dietician's recommendations) Perioperative antibiotics x24H OK for per tube meds *Multimodal pain regimen PRN oxycodone 5 mg and 10 mg PRN IV dilaudid for breakthrough DC Foley/art line if not already done Out of bed to chair/ambulation DC D10W and continue Plasmalyte @ 70 mL/hr *Scheduled Tylenol/Consider addition of scheduled gabapentin	Change to bolus tube feeds Initiate homebound TF teaching Add additional free water as clinically indicated D/c stress ulcer prophylaxis if not a home medication Ambulate as tolerated

C. **Common Complications:** Aside from EtOH withdrawal, complications are RARE with ENT patients. These include:
    a. **Urinary retention:**
        i. Voiding trial – remove Foley POD 1, and if no void in 4 hours, bladder scan and/or I/O cath x2 attempts. If no void after 2 I/O caths, replace foley
        ii. If voiding trial failed, start Cardura 1 mg daily (tamsulosin cannot be crushed). Maintain foley until 2 doses of Cardura has been given. If patient fails voiding trial again, maintain foley and consult urology for outpatient follow up.
    b. **EtOH withdrawal/DTs:**
        i. Consider medical options (dexmedetomidine, lorazepam, diazepam). We do NOT use the CIWA protocol in the ICU setting, but do initiate CIWA scoring.
        ii. Discuss with ICU attending.
        iii. Give multivitamin once per day, thiamine 100 mg once per day, and folate 1 mg once per day x3 days total.
    c. **Periop MI (RARE):**
        i. Biggest issue will be whether or not to anticoagulate (Cardiology, ENT attending and SICU attending will make this call)
        ii. Otherwise manage as any other ACS patient
        iii. Patients who have been seen in the HiRise clinic may be on the HiRise protocol which incorporates daily troponin/BNP with treatment algorithms based on the results (see HiRise protocol in SICU Box Resources)
    d. **Hypotension**
        i. The team should assess volume status, cardiac function, and CBC as part of the standard workup for postoperative hypotension
        ii. It is preferred to avoid the use of phenylephrine in patients with flap reconstructions

References:

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