History and physical exam consistent with pyloric stenosis

- Progressive non-bilious emesis
- Palpation of olive in epigastrium

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Labs: Hypochloremic, hypokalemic metabolic alkalosis
Ultrasound: Muscle width > 3 mm, length >14 mm

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Plan:
- Admit to Surgery
- If clinically dehydrated, bolus NS (see adjacent schematic)

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- MIVF at 1.5 x maintenance with D5 ½ NS
- Add 10 meq KCl once UOP established

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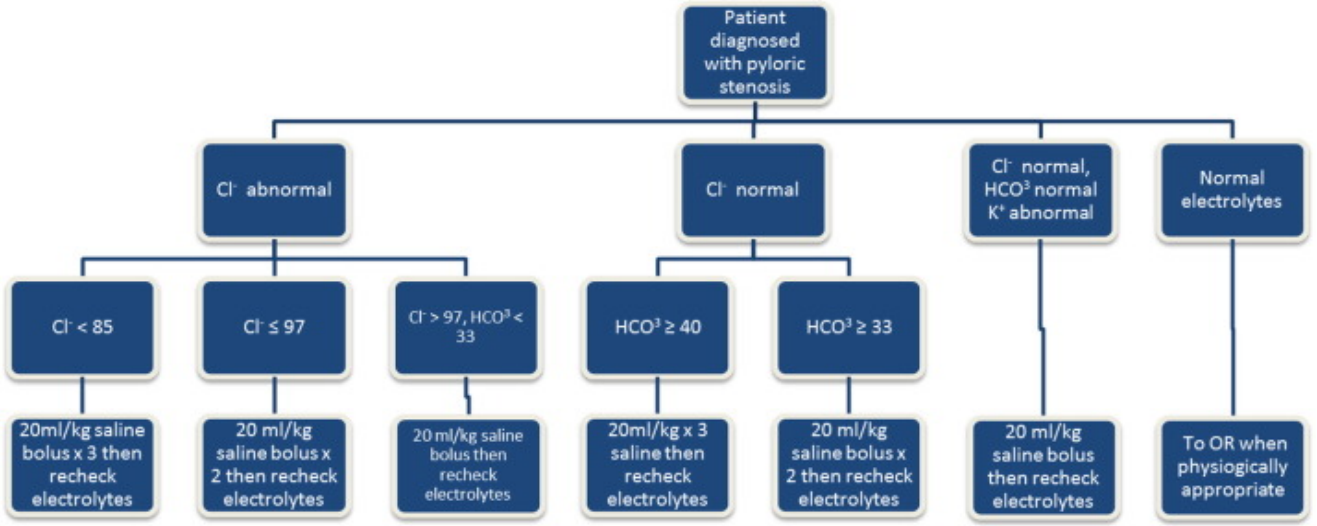
To OR when HCO3<30, Cl>100, and K normal (Ancef on call)

Suggested Resuscitation:

Source: Dalton BGA, et al. Optimizing fluid resuscitation in hypertrophic pyloric stenosis. J Pediatr Surg 2016;51(8):1279-1282.



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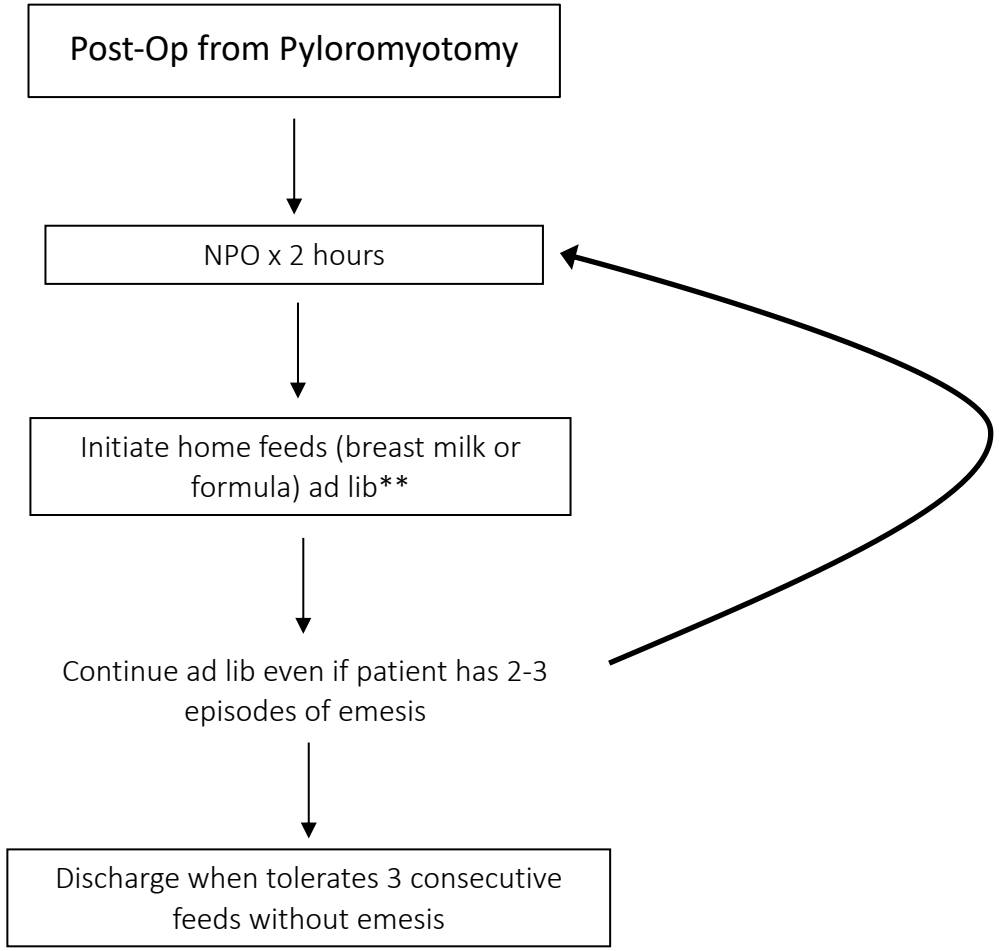

If persistent emesis, can make patient NPO x 2 hours and then re-start feeds

***Note: Ad lib feeding is associated with equivalent or shorter hospital stay (compared to protocolized feeding), although patients on ad lib feeds may have more emesis.*

Sources:

- Markel TA, et al. A randomized trial to assess advancement of enteral feeds following surgery for hypertrophic pyloric stenosis. *J Pediatr Surg* 2017;52(4):534-539.
- Adibe OO, et al. Protocol versus ad libitum feeds after laparoscopic pyloromyotomy: A prospective randomized trial. *J Pediatr Surg* 2014;49(1):129-132.
- Graham KA, et al. A review of postoperative feeding regimens in infantile hypertrophic pyloric stenosis. *J Pediatr Surg* 2013;48:2175-2179.

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