Evaluation of Individuals with Prader-Willi Syndrome with New GI Complaints

Known or suspected binge, unusual vomiting, **loss of appetite**, lethargy or abdominal pain/distension

Admit Patient for Observation

Is Patient stable and in no distress?

NO

- NPO, and place NG. Urgent surgery consultation, CT abdomen
- Rectal exam
- Consider CBC, cortisol, CMP, amylase, lipase, lactate, ABG, PT/PTT, UA, BG

Evidence of free air, gastric necrosis or perforation?

YES

Emergency Surgery
There is no advantage to waiting for surgery.

NO

- Admit to ICU for observation
- Surgical consultation
- Check plain film every 6-8 hours unless examination changes
- Assess for other etiologies

YES

- Recommend NPO and KUB flat plate and upright
- Rectal exam and stool guaiac

Is there evidence of gastric distension or constipation / impaction / obstruction?

Constipation

- Stool cleanout regimen
- Check for impaction either digitally or with fleet enema prior to starting oral cleanout
- Calorie restricted clear liquid test
- Check TFTs, CMP, phos, mag
- Consider GI or surgical consultation, especially if stool guaiac positive
- Reassess plain film in 12-24 hours
- Increasing distension or failure to clear stool may indicate impaction or obstruction. Further GI or surgical consultation should be considered.

Gastric distension

- NPO
- NG for decompression
- Make surgery aware of Patient and update
- Reassess plain film in 6-8 hours unless condition worsens then urgent CT
- Consider GI consultation, especially if guaiac positive stool

Neither

- Check for UTI, pancreatitis, cholelithiasis, etc.
- RUQ ultrasound
- If patient vomiting, consider esophageal obstruction or toxic ingestion

NOTE:

Individuals with Prader-Willi syndrome have decreased muscle tone and pain response so clinical evaluation for acute abdomen is altered similar to a patient on steroids.

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