

SUBTOTAL GASTRECTOMY/GASTRIC RESECTION

Subtotal gastrectomy or gastric resection is indicated for gastric hemorrhage/intractable ulcers, dysfunctional lower esophageal sphincter, pyloric obstruction, perforation, cancer.

CARE SETTING

Inpatient surgical unit.

RELATED CONCERNS

Cancer
Pancreatitis
Peritonitis
Psychosocial aspects of care
Surgical intervention
Total nutritional support: parenteral/enteral feeding
Upper gastrointestinal/esophageal bleeding

Patient Assessment Database

Data depend on the underlying condition necessitating surgery.

TEACHING/LEARNING

Discharge plan considerations: **DRG projected mean length of inpatient stay: 3.5 days**
Assistance with administration of enteral feedings/total parenteral nutrition (TPN) (if required) and acquisition of supplies
Refer to section at end of plan for postdischarge considerations.

NURSING PRIORITIES

1. Promote healing and adequate nutritional intake.
2. Prevent complications.
3. Provide information about surgical procedure/prognosis, treatment needs, and concerns.

DISCHARGE GOALS

1. Nutritional intake adequate for individual needs.
2. Complications prevented/minimized.
3. Surgical procedure/prognosis, therapeutic regimen, and long-term needs understood.
4. Plan in place to meet needs after discharge.

(In addition to nursing diagnoses identified in this CP, refer to CP Surgical Intervention.)

NURSING DIAGNOSIS: Nutrition: imbalanced, risk for less than body requirements

Risk factors may include

Restriction of fluids and food
Change in digestive process/absorption of nutrients

Possibly evidenced by

[Not applicable; presence of signs and symptoms establishes an *actual* diagnosis.]

DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:

Nutritional Status (NOC)

Maintain stable weight/demonstrate progressive weight gain toward goal with normalization of laboratory values.
Be free of signs of malnutrition.

ACTIONS/INTERVENTIONS	RATIONALE
<p>Nutrition Therapy (NIC)</p> <p>Independent</p> <p>Maintain patency of NG tube. Notify physician if tube becomes dislodged.</p> <p>Note character and amount of gastric drainage.</p> <p>Caution patient to limit the intake of ice chips.</p> <p>Provide oral hygiene on a regular, frequent basis, including petroleum jelly for lips.</p> <p>Auscultate for resumption of bowel sounds and note passage of flatus.</p> <p>Monitor tolerance to fluid and food intake, noting abdominal distension, reports of increased pain/cramping, nausea/vomiting.</p> <p>Avoid milk and high-carbohydrate foods in the diet.</p> <p>Note admission weight and compare with subsequent readings.</p>	<p>Provides rest for GI tract during acute postoperative phase until return of normal function. <i>Note:</i> The physician/surgeon may need to reposition the tube endoscopically to prevent injury to the operative area.</p> <p>Will be bloody for first 12 hr, and then should clear/turn greenish. Continued/recurrent bleeding suggests complications. Decline in output may reflect return of GI function.</p> <p>Excessive intake of ice produces nausea and can wash out electrolytes via the NG tube.</p> <p>Prevents discomfort of dry mouth and cracked lips caused by fluid restriction and the NG tube.</p> <p>Peristalsis can be expected to return about the third postoperative day, signaling readiness to resume oral intake.</p> <p>Complications of paralytic ileus, obstruction, delayed gastric emptying, and gastric dilation may occur, possibly requiring reinsertion of NG tube.</p> <p>May trigger dumping syndrome. (Refer to ND: Knowledge, deficient, [Learning Need].)</p> <p>Provides information about adequacy of dietary intake/determination of nutritional needs.</p>
<p>Collaborative</p> <p>Administer IV fluids, TPN, and lipids as indicated.</p> <p>Monitor laboratory studies, e.g., Hb/Hct, electrolytes, and total protein/prealbumin.</p> <p>Progress diet as tolerated, advancing from clear liquid to bland diet with several small feedings.</p> <p>Administer medications as indicated: Anticholinergics, e.g., atropine, propantheline bromide (Pro-Banth 1-ne);</p> <p>Fat-soluble vitamin supplements, including vitamin B₁₂, calcium;</p>	<p>Meets fluid/nutritional needs until oral intake can be resumed.</p> <p>Indicators of fluid/nutritional needs and effectiveness of therapy, and detects developing complications.</p> <p>Usually NG tube is clamped for specified periods of time when peristalsis returns to determine tolerance. After NG tube is removed, intake is advanced gradually to prevent gastric irritation/distension.</p> <p>Controls dumping syndrome, enhancing digestion and absorption of nutrients.</p> <p>Removal of the stomach prevents absorption of vitamin B₁₂ (owing to loss of intrinsic factor) and can lead to pernicious anemia. In addition, rapid emptying of the stomach reduces absorption of calcium.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Nutrition Therapy (NIC)</p> <p>Independent</p> <p>Iron preparations;</p> <p>Protein supplements;</p> <p>Pancreatic enzymes, bile salts;</p> <p>Medium-chain triglycerides (MCT).</p>	<p>Corrects/prevents iron deficiency anemia.</p> <p>Additional protein may be helpful for tissue repair and healing.</p> <p>Enhances digestive process.</p> <p>Promotes absorption of fats and fat-soluble vitamins to prevent malabsorption problems.</p>

<p>NURSING DIAGNOSIS: Knowledge, deficient [Learning Need] regarding procedure, prognosis, treatment, self-care, and discharge needs</p> <p>May be related to</p> <p>Lack of exposure/recall Information misinterpretation Unfamiliarity with information resources</p> <p>Possibly evidenced by</p> <p>Questions, statement of misconception Inaccurate follow-through of instruction Development of preventable complications</p> <p>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</p> <p>Knowledge: Disease Process (NOC) Verbalize understanding of procedure, disease process/prognosis. Verbalize understanding of functional changes.</p> <p>Knowledge: Treatment Regimen (NOC) Identify necessary interventions/behaviors to maintain appropriate weight. Correctly perform necessary procedures, explaining reasons for actions.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Review surgical procedure and long-term expectations.</p>	<p>Provides knowledge base from which informed choices can be made. Recovery following gastric surgery is often slower than may be anticipated with similar types of surgery. Improved strength and partial normalization of dietary pattern may not be evident for at least 3 mo, and full return to usual intake (three “normal” meals/day) may take up to 12 mo. This prolonged convalescence may be difficult for the patient/SO to deal with, especially if he or she has not been prepared.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p>	
<p>Independent</p>	
<p>Discuss and identify stress situations and how to avoid them. Investigate job-related issues.</p>	<p>Can alter gastric motility, interfering with optimal digestion. <i>Note:</i> Patient may require vocational counseling if change in employment is indicated.</p>
<p>Review dietary needs/regimen (e.g., low-carbohydrate, low-fat, high-protein) and importance of maintaining vitamin supplementation.</p>	<p>May prevent deficiencies, enhance healing, and promote cooperation with therapy. <i>Note:</i> Low-fat diet may be required to reduce risk of alkaline reflux gastritis.</p>
<p>Discuss the importance of eating small, frequent meals slowly and in a relaxed atmosphere; resting after meals; avoiding extremely hot or cold food; restricting high-fiber foods, caffeine, milk products and alcohol, excess sugars and salt; and taking fluids between meals, rather than with food.</p>	<p>These measures can be helpful in avoiding gastric distension/irritation and/or stress on surgical repair, dumping syndrome, and reactive hypoglycemia. <i>Note:</i> Ice-cold fluids/foods can cause gastric spasms.</p>
<p>Instruct in avoiding certain fibrous foods, and discuss the necessity of chewing food well.</p>	<p>Remaining gastric tissue may have reduced ability to digest such foods as citrus skin/seeds, which can collect, forming a mass (phytobezoar formation) that is not excreted.</p>
<p>Recommend foods containing pectin, e.g., citrus fruits, bananas, apples, yellow vegetables, and beans.</p>	<p>Increased intake of these foods may reduce incidence of dumping syndrome.</p>
<p>Identify foods that can cause gastric irritation and increase gastric acid, e.g., chocolate, spicy foods, whole grains, raw vegetables.</p>	<p>Limiting/avoiding these foods reduces risk of gastric bleeding/ulceration in some individuals. <i>Note:</i> Ingesting fresh fruits to reduce risk of dumping syndrome should be tempered with adverse effect of gastric irritation.</p>
<p>Identify symptoms that may indicate dumping syndrome, e.g., weakness, profuse perspiration, epigastric fullness, nausea/vomiting, abdominal cramping, faintness, flushing, explosive diarrhea, and palpitations occurring within 15 min to 1 hr after eating.</p>	<p>Can cause severe discomfort or even shock, and reduces absorption of nutrients. Usually self-limiting (1–3 wk after surgery) but can become chronic.</p>
<p>Discuss signs of hypoglycemia and corrective interventions, e.g., ingesting cheese and crackers, orange/grape juice.</p>	<p>Awareness helps patients take actions to prevent progression of symptoms.</p>
<p>Suggest patient weight self on a regular basis.</p>	<p>Change in dietary pattern, early satiety, and efforts to avoid dumping syndrome may limit intake, causing weight loss.</p>
<p>Review medication purpose, dosage, and schedule and possible side effects.</p>	<p>Understanding rationale/therapeutic needs can reduce risk of complications, e.g., anticholinergics/pectin powder may be given to reduce incidence of dumping syndrome; antacids/histamine antagonists reduce gastric irritation.</p>
<p>Caution patient to read labels and avoid products containing ASA, ibuprofen.</p>	<p>Can cause gastric irritation/bleeding.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p>Teaching: Disease Process (NIC)</p> <p>Independent</p> <p>Discuss reasons and importance of cessation of smoking.</p> <p>Identify signs/symptoms requiring medical evaluation, e.g., persistent nausea/vomiting or abdominal fullness; weight loss; diarrhea; foul-smelling fatty or tarry stools; bloody or coffee-ground vomitus/presence of bile, fever. Instruct patient to report changes in pain characteristics.</p> <p>Stress importance of regular checkup with healthcare provider.</p>	<p>Smoking stimulates gastric acid production and may cause vasoconstriction, compromising mucous membranes and increasing risk of gastric irritation/ulceration.</p> <p>Prompt recognition and intervention may prevent serious consequences or potential complications such as pancreatitis, peritonitis, and afferent loop syndrome.</p> <p>Necessary to detect developing complications, e.g., anemia, problems with nutrition, and/or recurrence of disease.</p>

POTENTIAL CONSIDERATIONS following acute hospitalization (dependent on patient's age, physical condition/presence of complications, personal resources, and life responsibilities)

Nutrition: imbalanced, risk for less than body requirements—change in digestive process/absorption of nutrients, early satiety, gastric irritation.

Fatigue—decreased energy production, states of discomfort, increased energy requirements to perform activities of daily living (ADLs).