Evaluation of Individuals with Prader-Willi Syndrome with GI Complaints

Known or suspected binge, vomiting, lethargy, or abdominal pain/distension
Admit Patient for Observation

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

Is Patient stable and in no distress?

Free Air?

Evidence of gastric necrosis or perforation?

- Constipation
  - Stool cleanout regimen
  - Check for impaction either digitally or with fleet enema prior to starting oral cleanse
  - Calorie restricted clear liquid diet
  - Check TFFs, electrolytes
  - 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 consultation should be considered

- Gastric distension
  - NPO
  - NG for decompression
  - Make surgery aware of Patient
  - 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

- Yes
  - Emergent 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

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

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.