Known or suspected binge, vomiting, lethargy, or abdominal pain/distension

Admit Patient for Observation

Is Patient stable and in no distress?

No

Evidence of gastric necrosis or perforation?

Yes

Emergent Surgery

There is no advantage to waiting for surgery.

Free Air?

Yes

Constipation

• Stool cleanout regimen
• Check for impaction either digitally or with fleet enema prior to starting oral cleanout
• Calorie restricted clear liquid diet
• Check TFTs, 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

No

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

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

Yes

• Recommend NPO and KUB flat plate and upright
• Rectal exam for stool guaiac

No

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.