Evaluation of Individuals with Prader-Willi Syndrome with GI Complaints

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

Admit Patient for Observation

Is Patient stable and in no distress?

- 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 gastric necrosis or perforation?

Yes

Emergent Surgery

There is no advantage to waiting for surgery.

No

Free Air?

Yes

No

Constitution

- 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

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

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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