

PROTOCOL FOR: Head and Neck Procedures: Oral Cavity and/or Oropharyngeal Resection, Care of the Patient

SUPPORTIVE DATA: An oral cavity resection or oropharyngeal resection is performed for treatment of cancers of the buccal mucosa, pharynx, tongue, lip, gingiva, floor of mouth, palate or tonsils. Depending on the location and size of the tumor, the surgical resection may be accomplished via the open mouth, lateral neck or midline mandibulotomy. For those patients requiring a mandibulotomy, a tracheotomy is performed. Reconstructive procedures such as a compression plate for a mandibular resection or a split thickness skin graft or muscle flap to reconstruct surgical defects may also be performed.

DESIRED

PATIENT OUTCOMES:

1. The patient will have minimal to no complications related to the oral resection or oropharyngeal resection.
2. The patient will be able to communicate his/her needs effectively.
3. The patient will have adequate pain control.
4. The patient will begin to demonstrate positive coping mechanisms related to diagnosis.
5. The patient's nutritional status will be maintained or improved.

**CLINICAL
ASSESSMENT AND
CARE:**

A. Respiratory Assessment

1. Assess airway patency and monitor for any signs or symptoms of respiratory distress.
2. Administer oxygen therapy as ordered.
3. Assess lung sounds every eight hours, and prn.
4. Obtain an oxygen saturation level via pulse oximetry every four hours for 24 hours or per physician order.
5. Maintain a suction set-up at the bedside with both a Yankauer Suction Tip and #12 - #14 French long suction catheters.
6. Gently suction the oral cavity as needed to prevent pooling of saliva on suture lines, grafts and flaps.
7. Encourage coughing and deep breathing and/or use of incentive spirometer every hour while awake.
8. Maintain a complete sterile tracheotomy set readily available on the unit.

B. General Post-Operative Management

1. Assess vital signs every four hours for 24 hours. Advance to every eight hours when stable.
2. Maintain the head of the bed at 30° or higher to promote respiratory function and to prevent or lessen edema.
3. Assess the patient's pain level on a scale of zero to ten at least every four hours. Medicate as ordered for pain and assess the patient's response to analgesia.
4. Encourage the patient to be out of bed to the chair and ambulating (with assistance as needed) two times on post-operative day one and three times a day thereafter.
5. Consult with the physician and the unit Case Manager regarding the need for community services.

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6. Notify the physician for:
 - a. any signs or symptoms of respiratory distress.
 - b. signs of hemorrhage.
 - c. changes in baseline vital signs.
 - d. inadequate pain control.
 - e. any signs or symptoms of wound complication.
 - f. poor tolerance to diet or inadequate fluid intake.
 - g. any signs of poor coping.

C. Wound Care

1. Intra-oral Wounds

- a. Assess the intra-oral incisions, flaps or grafts for signs of hemorrhage, edema, dehiscence, necrosis or infection.
- b. Per the physician's order, cleanse the oral cavity using the power spray as follows:
 - 1) As needed, pre-medicate the patient with a prescribed analgesic.
 - 2) Fill the atomizer bottle with a solution of half strength hydrogen peroxide and normal saline.
 - 3) Connect the atomizer bottle to the power spray machine and cleanse the entire oral cavity with particular emphasis on cleansing the affected area(s). Gently suction the hydrogen peroxide and normal saline solution from the oral cavity with the Yankauer suction device. Continue to cleanse the oral cavity until the atomizer bottle is empty.
 - 4) Fill the atomizer bottle with normal saline solution.
 - 5) Connect the atomizer bottle to the power spray machine and rinse the oral cavity with normal saline. Gently suction the oral cavity with the Yankauer suction device. Continue to rinse until the oral cavity is free of the hydrogen peroxide.

2. External Incisions

- a. Assess the incision(s) for signs of hemorrhage, edema, dehiscence, necrosis or infection.
- b. As ordered, cleanse the incision(s) every eight hours with a solution of half-strength hydrogen peroxide and normal saline followed by a normal saline rinse and a light application of bacitracin ointment. Use cotton-tipped applicators or gauze when providing wound care.

3. Assess for signs of a fistula.

D. Nutritional Support

1. Assess the patient's nutritional status.
2. If required, administer tube feedings as ordered and assess the patient's response. Do not manipulate the nasogastric feeding tube if present.
3. Maintain a strict NPO status until oral feedings are ordered by the physician.
4. Advance diet as ordered and assess the patient's tolerance to oral feedings.

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5. If the patient requires speech therapy for swallowing rehabilitation, consult with the speech therapist and patient to determine the patient's needs and progress.
6. Consult with the dietitian and physician regarding specific nutritional needs.

E. Communication Needs

1. If the patient has acquired a speech deficit, assist the patient with communication in the immediate post-operative period by providing the patient with paper and pencil, or a communication board with words, letters and/or pictures.
2. If speech therapy has been initiated, consult with the speech therapist and patient to determine the patient's needs and progress.
3. Encourage the patient to speak and allow time for him/her to communicate vocally.

F. Emotional Needs

1. Assess the patient's personal coping mechanisms as well as the presence of family and their ability to provide the patient with emotional support.
2. Assess the patient's and family's response to the diagnosis, treatment and altered body image and/or communication pattern.
3. Encourage the patient and family to ask questions and to verbalize their concerns. Provide them with emotional support and rationales for interventions.
4. Encourage the patient to be independent with self-care needs and ambulation.
5. If applicable, encourage the patient and family to participate in wound care and assess their response.
6. Encourage visitors and interaction with others.
7. Encourage the patient to participate in social activities after discharge.

PATIENT

- EDUCATION:
1. Instruct the patient and family in the signs and symptoms of wound complication and infection.
 2. If applicable, instruct the patient and family in the specific wound care ordered.
 3. Instruct the patient and family in the importance of maintaining adequate nutritional and fluid intake after discharge.
 4. As applicable, discourage smoking and/or heavy alcohol consumption. Provide the patient with information regarding community services as needed.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/01

REVISION DATES: 12/02, 10/03