PHASE I

Inclusion Criteria
- Suspected diagnosis of bladder exstrophy

Exclusion Criteria
- Suspected diagnosis of cloacal exstrophy

Prenatal Consultations
- Urology
- Social Work

Delivery Recommendations
- Delivery at any location that is comfortable with bladder exstrophy care
- Provider to provider consultation available

Family Education
- Bladder Exstrophy: How to Care for your Child’s Bladder Before Surgery PE3009
- Bladder Exstrophy PE174

Provider Education
- Outside Provider Goals of Care

If child is stable, no need to transfer until mom can also be discharged

Go to Neonatal Phase
PHASE II

Inclusion Criteria
- Diagnosis of bladder extrophy

Exclusion Criteria
- Age > 12 months
- Cloacal extrophy

Addition of Evidence Ratings

Summary of Version Changes

Approval & Citation

Explain of Evidence Ratings

Cloacal Extrophy
- Will need general surgery involvement for ostomy + bladder plate closure

Initial Management

Imaging
- Renal US
- Pelvic xray

Diet
- Regular

Antibiotics
- None

Initial Management

Bladder Exstrophy Care
- Tegaderm over bladder plate in hospital; Tegaderm or Press and Seal at home
- Silk tie on umbilical cord

Activity Restrictions
- None

Consultations
- Urology
- Orthopedics (including Spica tiger brought to family)
- Social work
- Lactation

Standard Newborn Care

Family Education

- Bladder Exstrophy: How to Care for your Child’s Bladder Before Surgery PE3009
- Bladder Exstrophy PE174
- Latex Allergy PE001

Urology Folder: (Urology NP will give to family)
- Information about the Association for Bladder Exstrophy Community
- Medical Alert ID PE2417
- Urology Rounds PE3005
- Bladder Exstrophy: Care After Surgery PE2910
- Urinary Reflux PE181

Follow-Up Coordination
- PCP identified and appointment scheduled within 3-7 days of discharge
- Urology clinic visit in 2 months

Discharge Criteria

- Teaching complete
- Consults seen
- Follow-up scheduled
- Cleared by Pediatrics

Let us know if you have questions or if you’d like to discuss your care. BladderExstrophy@seattlechildrens.org

For questions concerning this pathway, contact: BladderExstrophy@seattlechildrens.org

© 2020 Seattle Children’s Hospital, all rights reserved. Medical Disclaimer

Last Updated: February 2020
Next Expected Review: May 2023
### Phase III

**Bladder Exstrophy**

#### Inclusion Criteria
- Diagnosis of bladder exstrophy

#### Exclusion Criteria
- Age > 12 months
- Cloacal exstrophy

### Pre-operative Visits

- **2 months prior to surgery**
  - Urology clinic
  - Orthopedics clinic
  - PASS clinic
- **2 weeks prior to surgery**
  - Urology clinic
  - Orthopedics clinic
  - Order car seat
  - PASS clinic - Type and Screen

### Outpatient Pre-Operative Management

- Anemia screen, if positive treat and discuss delaying surgery
- Car seat ordered at orthopedic RN visit
- OR team e-mail sent - Urology fellow after Monday AM conference
  - Pre-surgical Overview PowerPoint
  - Full Body Prep instructions
  - Pick lists
  - Huddle time

### Infection Control

- **2 weeks prior to surgery**
  - Bladder plate culture
    - If positive, treat with 7 days antibiotics to end on the day of surgery, then culture directive perioperative antibiotics
    - If negative, cefazolin only for perioperative antibiotics

### Intra Operative Care

- **Anesthesiologist**
  - **Pain control:**
    - Epidural, TAP or iliac fascial blocks when anatomy permits
    - Standing Tylenol post-operatively
    - Standing Toradol post-operatively if >6 months and no renal anomalies

- **Fluids/Lines/Tubes:**
  - A-line and 2 large IVs
  - Type and cross
  - Orogastric tube. Remove at the end of case.
  - mIVF on a pump with separate replacement of deficit and blood loss
  - Albumin 5% as needed
  - Transfusion guide

- **Infection Control:**
  - Antibiotics completed 30 minutes prior to incision

- **Extubation:**
  - Goal to extubate at end of case

- **Surgical tech**
  - Place urinary stents in a container to collect urine
  - Monitor and call out urine output for anesthesia
  - Open bladder extrophy specific pelvic osteotomy kit

- **Nursing**
  - Bladder Exstrophy: Full body prep
  - Radiopaque table
  - Positioning at end of table
  - Fluoroscopy available for osteotomy
  - Page Orthopedic surgeon at end of case to place spica
  - PACU nurse to petal spica
Bladder Exstrophy v2.0: Post-Operative

**PHASE IV**

**Inclusion Criteria**
- Diagnosis of bladder exstrophy

**Exclusion Criteria**
- Age > 12 months
- Cloacal exstrophy

**Initial Management**

**Family Education**
- Urology Rounds PE3005

**Vital signs**
- Standard vital signs per acute care guidelines
- Strict I/O

**Activity**
- Out of bed ad lib
- OK to hold baby

**Fluids/Electrolytes/Nutrition**
- D5 NS@maintenance IV+PO
- CBC, Chem7, Cr/BUN POD1
- Regular diet immediately after surgery

**Medications**
- Pain service consult in PACU
- Oxybutynin TID standing for bladder spasms

**Wound Care**
- Monitor incisions for early signs of infection

**Consults**
- Lactation consultation if nursing or pumping
- Social work

**Infection Control**
- Perioperative antibiotics for 24 hours after surgery
- No prophylaxis while bladder being continuously drained
- Urine culture 2 weeks prior to outpatient planned cast and tube removal
  - If positive, give culture driven antibiotics for 7 days (5 days prior to cystogram / VCUG, 2 days after)
- Antibiotic prophylaxis for vesicoureteral reflux if seen on outpatient VCUG at time of cast removal

**Supplies and teaching (care coordination to initiate)**
- Appropriate car seat
- Cather flush
- Petals / Mole skin
- Diapers

**Follow-up Coordination**
- Urology weekly visits x 6 weeks
- Spica cast removal at 4 weeks
  1. Orthopedics clinic visit for spica removal
     - Pelvic X-Ray to evaluate osteotomies
- 6 week visit for catheter removal
  1. Urology clinic visit for catheter removal
  2. Radiology:
     - Cystogram for bladder integrity; if (-), VCUG for VUR
     - Renal Ultrasound

**Discharge Criteria**
- Teaching complete
- Supplies ordered
- Car seat approved
- Follow-up appointments scheduled
- Medically cleared by Urology and Orthopedic surgery

**NICU Admission**
- At the discretion of the surgical and anesthesia teams
- Standard criteria for NICU discharge

**NICU Admission (once stable after surgery)**
- Bladder Exstrophy PE174
- Bladder Exstrophy: Care After Surgery PE2910

**STOP and RESOLVE if incisions are not clean, dry and intact**
Laboratory Monitoring

- Check blood gas every hour
- Check CBC and coags after osteotomies are complete or if concern for hemodynamic instability
- Consider TXA for high risk patients (i.e., high blood loss expected, malnourished, history of prematurity)
- **50 mg/kg** (maximum 2000 mg) intravenous over **15 min** followed by 5 mg/kg/hour continuous I.V. infusion until skin closure

<table>
<thead>
<tr>
<th>Lab Results</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hct &lt; 21 or hemodynamic instability</td>
<td>PRBC 10-15 mL/kg</td>
</tr>
<tr>
<td>Platelets &lt; 100k</td>
<td>Platelets 5 – 10 mL/kg</td>
</tr>
<tr>
<td>Fibrinogen &lt; 150</td>
<td>Cryoprecipitate 2 - 5 mL/kg</td>
</tr>
<tr>
<td>TEG &gt; 10 or INR &gt; 1.5</td>
<td>FFP 10-15 mL/kg</td>
</tr>
</tbody>
</table>
Management of the bladder plate
• The goal is to keep the bladder plate clean and moist
• Tegaderm should be placed over the bladder plate overlapping with the surrounding skin
• Change the tegaderm prn dislodgement or soiling
• Clean the bladder plate with saline flush if soiled
• The child can be bathed but the bladder plate should not be scrubbed

Management of the umbilical stump
• Silk suture should be used for the umbilicus
• This is preferred over the umbi clamp to reduce irritation of the bladder mucosa

Other Considerations
• Provider to provider consultation is available
• If child is stable:
  • No need to transfer until mom can also be discharged
  • Normal diet
  • No antibiotics
  • No activity restrictions
Bladder Exstrophy Approval & Citation

Approved by the CSW Bladder Exstrophy team for May 22, 2018 go-live

CSW Bladder Exstrophy Team:

Medical Staff Services, Owner: Paul Merguerian, MD, MS, FAAP
Medical Staff Services, Owner: Courtney Rowe, MD
Ambulatory Urology Nurse: Jean Dearn, RN
Pharmacy: Jia-Jan Seibel, PharmD
Orthopedics: Elizabeth Sheets, ARNP
Unit Based Educator: Angela Turner, BSN, RN, CPN
Urology: Valerie Nelson, ARNP
Urology: Nicole McMannis, ARNP

Clinical Effectiveness Team:

Consultant: Jean Popalisky, DNP
Project Manager: Asa Herrman
CE Analyst: James Johnson
CIS Informatician: Carlos Villavicencio, MD, MS/MI
CIS Analyst: Julia Hayes, MHIHIM
Librarian: Jackie Morton, MLS
Program Coordinator: Kristyn Simmons

Clinical Effectiveness Leadership:

Medical Director: Darren Migita, MD
Operations Director: Karen Rancich Demmert, BS, MA


Please cite as:
This pathway was developed through local consensus based on published evidence and expert opinion as part of Clinical Standard Work at Seattle Children’s. Pathway teams include representatives from Medical, Subspecialty, and/or Surgical Services, Nursing, Pharmacy, Clinical Effectiveness, and other services as appropriate.

When possible, we used the GRADE method of rating evidence quality. Evidence is first assessed as to whether it is from randomized trial or cohort studies. The rating is then adjusted in the following manner (from: Guyatt G et al. J Clin Epidemiol. 2011;4:383-94, Hultcrantz M et al. J Clin Epidemiol. 2017;87:4-13.):

Quality ratings are downgraded if studies:
- Have serious limitations
- Have inconsistent results
- If evidence does not directly address clinical questions
- If estimates are imprecise OR
- If it is felt that there is substantial publication bias

Quality ratings are upgraded if it is felt that:
- The effect size is large
- If studies are designed in a way that confounding would likely underreport the magnitude of the effect OR
- If a dose-response gradient is evident

Certainty of Evidence:
- High: The authors have a lot of confidence that the true effect is similar to the estimated effect
- Moderate: The authors believe that the true effect is probably close to the estimated effect
- Low: The true effect might be markedly different from the estimated effect
- Very low: The true effect is probably markedly different from the estimated effect

Guideline: Recommendation is from a published guideline that used methodology deemed acceptable by the team
Expert Opinion: Based on available evidence that does not meet GRADE criteria (for example, case-control studies).
Summary of Version Changes

- **Version 1.0 (05/22/2018)**: Go live
- **Version 2.0 (2/21/2020)**: Clarified Follow-up Coordination section on Post-Operative page
Medical Disclaimer

Medicine is an ever-changing science. As new research and clinical experience broaden our knowledge, changes in treatment and drug therapy are required.

The authors have checked with sources believed to be reliable in their efforts to provide information that is complete and generally in accord with the standards accepted at the time of publication.

However, in view of the possibility of human error or changes in medical sciences, neither the authors nor Seattle Children's Healthcare System nor any other party who has been involved in the preparation or publication of this work warrants that the information contained herein is in every respect accurate or complete, and they are not responsible for any errors or omissions or for the results obtained from the use of such information.

Readers should confirm the information contained herein with other sources and are encouraged to consult with their health care provider before making any health care decision.
Search Methods, *Bladder Exstrophy* Clinical Standard Work

Literature searches were conducted in two phases and executed by a medical librarian, Jackie Morton. The initial search in June 2017, targeted synthesized literature on bladder exstrophy, pelvic fixation methods, the use of anticholinergics, transfusion criteria, as well as the use of antibiotics and pain control and surgical recovery. It was executed in Ovid Medline, Cochrane Database of Systematic Reviews, Embase, National Guideline Clearinghouse and TRIP. The second search, in September 2017, was conducted in Medline and Embase to retrieve primary studies, focusing on pelvic fixation methods, transfusion criteria and the use of anticholinergics or any additional studies on bladder exstrophy. All searches were limited to items published in English, from Jan 2007 to date. The team added 3 citations not retrieved with the search strategy scope and limits. Results were exported to RefWorks for system de-duplication, then to Excel for the screening process.

Jackie Morton, MLS
April 30, 2017

<table>
<thead>
<tr>
<th>Identification</th>
<th>Screening</th>
<th>Eligibility</th>
<th>Included</th>
</tr>
</thead>
<tbody>
<tr>
<td>802 records identified through database searching</td>
<td>4 additional records identified through other sources</td>
<td>777 records after duplicates removed</td>
<td>193 records assessed for eligibility</td>
</tr>
<tr>
<td>777 records screened</td>
<td>584 records excluded</td>
<td>178 articles excluded</td>
<td></td>
</tr>
<tr>
<td>15 studies included in pathway</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Flow diagram adapted from Moher D et al. BMJ 2009;339:bmj.b2535


Bibliography


