Follow-up Clinical Protocol: Paediatric Surgery

Document Detail	
Sites covered	South Thames Region
Version	1.7
Approving body	STPN
Stakeholder Group	STPN General Surgery Working Group
Responsible Lead	Feilim Murphy, Clinical Director and Surgery Clinical Lead
Effective from	13/03/2025
Date last reviewed	-
Date of next review	03/2028

Contributors		
Name	**Title**	**Organisation**
Feilim Murphy	Clinical Director and Surgery Clinical Lead	South Thames Paediatric Network
Ancuta Muntean	Consultant Paediatric Surgeon	King's College Hospital
Ionica Stoica	Paediatric Urology Fellow	Evelina Children's Hospital
Kirsty Brennan	Consultant Paediatric Surgeon	Evelina Children's Hospital
Kristina Dzhuma	Consultant Paediatric Surgeon	Oxford John Radcliffe Hospital
Erica Makin	Consultant Paediatric Surgeon	King's College Hospital
Dean Rex	Consultant Paediatric Surgeon	St George's University Trust
Ben Woodward	Paediatric Surgery Trainee	St George's University Trust
Bommayya Narayanaswamy	Consultant Paediatric Surgeon	University Hospitals Sussex

Document History		
Date	**Comments**	**Approved by**

1. Purpose and Scope

- This protocol is a general description of patients who are agreed to be suitable for discharge or patient initiated follow-up (PIFU). It has been produced as a template to aid trusts in their implementation of standardising discharges and implementing PIFU and is designed to complement local guidance and professional judgement.
- This protocol should be considered alongside existing trust policies and processes such as Standard Operating Procedures (SOPs) and other PIFU documentation

2. Discharge Criteria

The following criteria should be used to assist the clinician in deciding whether to discharge a patient. This is at the discretion of the clinician but in most instances, the following patients should not be routinely followed-up.

Any decision regarding discharge or follow-up needs to be communicated to the patient and/or carer and the patients GP. Trust level policies should be considered and can provide guidance on the wording of patient and GP communications.

Pathway/Condition	Discharge if the patient meets the below criteria
Post op Hernia repair	Healed, no swelling
Post Orchidopexy	Testicle growing or stable size, Wound healed
Circumcision	Healed and no flow issues
Balanitis	No scarring

3. PIFU Criteria

If a patient is not suitable for discharge, clinicians should consider if they are suitable for PIFU. ***PIFU is not to be used where patients would otherwise have been discharged***.

Shared decision making is key to this process. Patients need to understand PIFU and how to access the service if needed. Clinicians need to ensure that patients understand how to manage their medication and cope with flare ups.

Any decision regarding discharge or follow up needs to be communicated to the patient and/or their carer and the patients GP. When using PIFU both the patient and GP need to be aware of the PIFU timeframe and subsequent review or discharge.

Trust level policies should be considered and can provide guidance on the wording of patient and GP communications.

The following criteria should be used to assist the clinician in deciding whether to consider PIFU:

Pathway/ Condition	Suitable for PIFU	PIFU timescale	Triggers for apt	Apt type
General Surgery of Childhood				
Benign skin and soft tissue lesions (angular dermoid cyst, pilomatrixoma, naevus, lipomas, anal skin tag)	Following diagnosis and treatments	1 year	Recurrence	F2F
Circumcision	NOT BXO	18/12	Meatal stenosis, voiding issues	F2F
Epigastric hernia	Yes	1 year	- Wound issues - Recurrence	F2F
Exomphalos minor / Hernia of the cord	Yes	1 year	- Wound issues - Recurrence	F2F
Hydrocele	If less than 3 years old and not encysted	To 5 years of age	Increase in Size, failure to resolve after 4 yrs of age	F2F
Inguinal hernia	If incarcerated initially	18/12	Pain, swelling, Testicular size change - recurrence on either side	F2F
IGTN	Post treatment	1 year	Recurrence or contralateral toes	F2F
Labial Adhesions	Post Treatment	1 year	Recurrence	F2F
Lymph Nodes	Post Diagnosis	6 months	Recurrence, Enlargement	F2F to Local paediatric team
Perianal abscess after laying open	Simple abscess Post surgery	6 months	Recurrence, Bleeding	F2f
Perianal fistula	Post surgery	6 months	Recurrence or new faecal incontinence	F2F

Pilonidal sinus surgery	Post Surgery	1 year	Recurrence	F2F
Testicular Torsion (Post event)	If testicular size stable after initial review.	Until 18 years old	Request for prosthesis or concerns re fertility	F2F
Testicular Prosthesis Insertion	CYP concerns	Until 18 years	concerns re infection, prosthesis dislodgement, - if pubertal growth not finished and large discrepancy	F2F
Tongue tie	Post treatment	6 months	Recurrence, FTT	F2F
Umbilical hernia / supraumbilical hernia	Yes	1 year	- wound issues - recurrence	F2F
Umbilical granuloma / polyp	Yes	1 year	- wound issues - recurrence	F2F
Urachal remnant	Yes	1 year	- wound issues - Discharge	F2F
Undescended testes	If single stage and initial, Follow up normal	2 year	- concerns re size of testis - concerns re position of other testis (ascending)	F2F
Varicocele	If unchanged after 2 years	Until 18 years	Pain, testicular size change, enlargement,	F2F
Specialised Surgery				
ACE procedures	Following surgery	12 months	ACE prolapse or stenosis	F2F
ARM (See Footnotes)	Must be continent of urine and bowels and safe and over 7 years old and no long term follow up clinic available	18 years	Constipation -soiling -chronic abdominal pain	Virtual
Foreign body ingestion	FB considered dangerous not requiring	2 year	Dysphagia, Chronic intermittent	F2F

	significant bowel surgery		Abdominal pain, Chronic Vomiting(see footnotes)	
Gastrostomy insertion	Yes Flange device if formal planned follow up not arranged	Up to 18 years or removal of device	if change to balloon device desired	F2F
Intussusception	Air Reduction or self-reduction	6 months	Pain, vomiting	Virtual
Laparoscopic uncomplicated cholecystectomy	After follow up clinic	1 year	Abdominal Pain, Jaundice, Wound concerns	F2F
Meckels' diverticulum	Uncomplicated resection	1 Year	Wound Issues, Chronic Abdominal pain, Chronic vomiting	F2F
Neck - thyroglossal, branchial remnants	Post-Surgery	1 year	Discharge, pain, dysphagia, recurrence	F2F
Negative exploratory laparoscopy	After normal follow up	1 year	wound issues - Chronic abdominal pain, - intermittent vomiting	F2F
Oesophageal anastomotic stricture	Post surgery	Until 16-18 years	Chronic Dysphagia	Telephone
Oesophageal atresia (see footnotes)	After 5 years old and if long term follow up is not routine	18 years	Dysphagia, Vomiting, Chest wall abnormality	F2F
Ovarian Torsion	After first follow up / stable ovary on scan	18 years	Pain, concerns re fertility	F2F
Pectus carinatum bracing	During bracing period	12 months	Skin issues	F2F
Vascular malformations	Once static	18 years	Change, Bleeding, Size change, CYP concern	F2F

PIFU exclusion criteria
This protocol is for benign conditions only.
Ideal waiting time between initial patient request and PIFU appointment
1-6 weeks (max waiting time of 6 weeks)
Footnotes
Long term follow-up for neonatal pathologies is ideal in specialist units but many paediatric surgery units are unable to achieve this at present. Therefore, improved parental education and use of the PIFU process is viewed as better than discharge in this population. Acute pain, abdominal swelling and vomiting require urgent surgical review and are not suitable for PIFU. As PIFU is only suitable for long term conditions.
Equality considerations that may necessitate amendments to the protocol
• Ensuring that the decision for the patient to be moved/discharged onto a PIFU pathway is a shared decision between patient and/or their carer and the clinician • Ensure that patient and/or their carer understand where and how to access the service when they need to • Ensure that the patient and/or their carer can understand the relevant patient leaflets and information provided

4. Follow-up Frequency

Pathway/Condition	Follow-up frequency	Apt type