

Family experiences regarding fasting and thirst in the perioperative period of children with cleft lip and palate

Vivência de familiares sobre jejum e sede no perioperatório de crianças com fissura labiopalatina

Vivencias de familiares sobre el ayuno y la sed en el período perioperatorio de niños con fisura labiopalatina

Yasmin Vitória dos Santos Rodrigues^a 

Camila Moraes Garollo Piran^b 

Mariana Martire Mori^b 

Alana Vitória Escritori Carginin^b 

Laís Moreira Martins^b 

Maria Fernanda do Prado Tostes^a 

Marcela Demitto Furtado^b 

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ABSTRACT

Objective: To understand the experience of family members of children with cleft lip and palate in relation to fasting and thirst during the perioperative period of primary and secondary surgeries.

Method: This is a descriptive-exploratory study with a qualitative approach, based on the theoretical framework of Family-Centered Care, conducted at the *Associação de Apoio ao Fissurado Lábio-Palatal de Maringá*, Paraná, Brazil. The semi-structured interviews with family members were conducted between August and September 2024, via Google Meet®, recorded, fully transcribed and analyzed through content analysis, thematic modality. The study was approved by the Ethics Committee for Research with Human Beings.

Results: Seven family members of children with cleft lip and palate participated. Three categories emerged that demonstrate that fasting and thirst in the surgical context can generate emotional distress not only in the children, but also in their caregivers. Family members reported shared food restrictions, use of toys and prior conversation with the child as strategies used during the period. Clear communication from the team, consistent with family-centered care, reduces family discomfort.

Conclusion: Fasting and thirst in the perioperative period cause emotional distress to the child and family, making individualized management focused on family support essential, in line with Family-Centered Care.

Descriptors: Perioperative period; Cleft lip; Cleft palate; Child; Fasting; Thirst.

RESUMO

Objetivo: Compreender a vivência de familiares em relação ao jejum e sede durante o período perioperatório de crianças com fissura labiopalatina.

Método: Estudo descritivo-exploratório com abordagem qualitativa, fundamentado no referencial teórico do Cuidado Centrado na Família, conduzido na Associação de Apoio ao Fissurado Lábio-Palatal de Maringá, Paraná, Brasil. As entrevistas semiestruturadas com os familiares foram realizadas entre agosto e setembro de 2024, via *Google Meet®*, gravadas, transcritas na íntegra e analisadas por meio da análise de conteúdo, modalidade temática. O estudo foi aprovado pelo Comitê de Ética em Pesquisa com Seres Humanos.

Resultados: Participaram sete familiares de crianças com fissura labiopalatina. Emergiram três categorias que evidenciam que o jejum e a sede no contexto cirúrgico podem gerar sofrimento emocional não apenas às crianças, mas também em seus cuidadores. Os familiares relataram a restrição alimentar compartilhada, uso de brinquedos e conversa prévia com a criança como estratégias utilizadas durante o período. A comunicação clara da equipe, conforme o cuidado centrado na família, reduz o desconforto das famílias.

Conclusão: O jejum e a sede no perioperatório geram sofrimento emocional à criança e à família, sendo essencial o manejo individualizado com foco no suporte familiar, conforme o Cuidado Centrado na Família.

Descritores: Período perioperatório; Fenda labial; Fissura palatina; Criança; Jejum; Sede.

^a Universidade Estadual de Maringá (UEM). Departamento de Enfermagem. Maringá, Paraná, Brasil.

^b Universidade Estadual de Maringá (UEM). Programa de Pós-Graduação em Enfermagem. Maringá, Paraná, Brasil.

RESUMEN

Objetivo: Comprender la experiencia de familiares de niños con labio y paladar hendido en relación al ayuno y la sed durante el perioperatorio de cirugías primarias y secundarias.

Método: Este es un estudio descriptivo-exploratorio con enfoque cualitativo, basado en el marco teórico de la Atención Centrada en la Familia, realizado en la *Associação de Apoio ao Fissurado Lábio-Palatal de Maringá*, Paraná, Brasil. Las entrevistas semiestructuradas con familiares se realizaron entre agosto y septiembre de 2024, a través de Google Meet®, se grabaron, transcribieron íntegramente y analizaron mediante análisis de contenido, modalidad temática. El estudio fue aprobado por el Comité de Ética en Investigación con Seres Humanos.

Resultados: Participaron siete familiares de niños con labio y paladar hendido. Surgieron tres categorías que demuestran que el ayuno y la sed en el contexto quirúrgico pueden generar angustia emocional no solo en los niños, sino también en sus cuidadores. Los familiares informaron sobre la restricción alimentaria compartida, el uso de juguetes y la conversación previa con el niño como estrategias utilizadas durante el período. La comunicación clara del equipo, en consonancia con la atención centrada en la familia, reduce el malestar de las familias.

Conclusión: El ayuno y la sed en el período perioperatorio causan sufrimiento emocional al niño y a la familia, y es esencial un manejo individualizado con foco en el apoyo familiar, de acuerdo con la Atención Centrada en la Familia.

Descriptores: Periodo perioperatorio; Labio leporino; Fisura del paladar; Niño; Ayuno; Sed.

INTRODUCTION

Cleft lip and palate is the most common congenital craniofacial anomaly requiring one or more surgical corrections. It results from a failure in the embryonic fusion process, which causes anatomical distortions of the upper lip, nose, and/or palate, and may or may not be due to the presence of any other anomaly⁽¹⁾.

Studies estimate that there is one case of cleft lip and/or palate for every 600 live births. In Brazil, it is estimated that there is one case for every 1,000 live births, with a higher prevalence in the South and Southeast regions, with 0.72 and 0.54 per 1,000 live births, respectively⁽¹⁻³⁾.

Patients with cleft lip and palate undergo cheiloplasty and/or palatoplasty in the first year of life, considered primary reconstructive surgeries. Lip repair aims to restore the functionality of the orbicularis Oris muscles, reconstruct the lips, and improve aesthetic function. Palatoplasty, on the other hand, aims at the reconstruction of the palate⁽⁴⁾.

Depending on the severity of the case, these children undergo secondary surgeries during rehabilitation to address clinical conditions related to the cleft⁽⁵⁾. Thus, in most cases, they are submitted to several surgical procedures, for which they remain fasting for a certain period that is, they are deprived of oral intake before surgery and, occasionally, for some time afterward. This ultimately generates various discomforts, including thirst^(6,7).

The perioperative period is considered the interval between activities during each surgical period, divided

into late preoperative, immediate preoperative, transoperative, intraoperative, and immediate and late postoperative periods⁽⁸⁾.

Thirst is a common complaint during the preoperative and postoperative periods, especially in pediatric patients, who have a lower capacity for understanding and tolerance for restriction. Thirst refers to the physical sensation and physiological desire to drink water, due to an individual's lifestyle habits and physiological factors⁽⁹⁾. When thirst is not relieved, it becomes an undeniably unpleasant sensation, surpassing all others⁽¹⁰⁾.

A methodological study developed by Brazilian researchers resulted in the development and validation of a safety protocol for managing thirst in the immediate postoperative period in children aged three to 12 years. It considers the evaluation of the level of consciousness, movement, airway protection, respiratory pattern, and nausea and vomiting, aiming to guide the safe provision of fluids in the postoperative period. However, even with established protocols, thirst remains as little considered in child care⁽¹¹⁾.

Periods of fasting and dietary restrictions, along with necessary hospitalizations during rehabilitation, can also generate distress and anxiety in families⁽¹²⁾. In this context, Family-Centered Care (FCC) is a relevant approach that emphasizes the importance of bonding and harmony between healthcare professionals, family members, and children, contributing to less traumatic experiences and more humanized care⁽¹³⁾.

In this regard, researchers in India identified the need for guidance and involvement of family members regarding fasting in the preoperative period of outpatient

pediatric surgeries, which can reduce excessive fasting time and all the discomfort associated with this process, including thirst, resulting in less traumatic outcomes for children and their families⁽¹⁴⁾.

Water restriction is intensified by anesthetic medications, blood loss, and surgical procedures. In the postoperative period, thirst becomes more stressful for the child, potentially surpassing hunger and pain, and triggering emotions such as irritability, anxiety, and despair⁽¹⁵⁾. A study shows that, in the preoperative period, 58% of pediatric patients self-reported feeling thirsty, and 58.9% of caregivers of children aged zero to three years old reported that the child had a desire to ingest something⁽¹⁰⁾.

Based on the above, the study sought to answer the following research question: What are the experiences of family members of children with cleft lip and palate regarding fasting and thirst during the perioperative period of primary and secondary surgeries? Although studies on thirst in the pediatric context are available, studies focusing on children with cleft lip and palate are still incipient. This gap highlights the need to understand, from the families' perspective, how the emotional repercussions and coping strategies are set, supporting more humane and family-centered practices.

Therefore, the objective of the study was to understand the experiences of family members of children with cleft lip and palate regarding fasting and thirst during the perioperative period.

■ METHOD

This is a descriptive-exploratory study with a qualitative approach conducted with seven family members of children with cleft lip and palate undergoing primary and/or secondary surgeries. To ensure the quality of the study report, the recommendations of the Consolidated Criteria for Reporting Qualitative Research (COREQ)⁽¹⁶⁾ were followed.

The theoretical-philosophical framework adopted was the FCC, which considers the family as fundamental in the care process and includes the principles of dignity and respect, information sharing, participation, and collaboration⁽¹⁵⁾.

The study was conducted in partnership with the Maringá Association for Support of Cleft Lip and Palate

Patients (*Associação de Apoio ao Fissurado Lábio-Palatal de Maringá - AFIM*), a nonprofit civil society organization with its own headquarters in the municipality of Maringá, Paraná, Brazil. Founded in 1987, the association currently serves approximately 500 children and adolescents, with professionals in dentistry, nutrition, psychology, speech therapy, social work, and educational support.

Family members over 18 years old who accompanied the children during hospitalization for the surgical procedure and accompanied them during consultations at AFIM were included. Family members of children aged three months to 11 years and less than 12 months who underwent surgery within the last 12 months were also included. This age range was chosen due to the age at which primary and secondary surgeries are performed^(4,17) and its alignment with the definition of childhood according to the Child and Adolescent Statute (*Estatuto da Criança e do Adolescente - ECA*)⁽¹⁸⁾.

A 12-month period following surgery was established as a strategy to preserve the reliability of events and experiences, without compromising episodic memory and chronological recollections of the event, since the episode generated emotional burdens and feelings capable of consolidating memories, providing meaning and minimizing memory free of errors⁽¹⁹⁾. Family members with cognitive impairments that could affect their understanding of the questions were not included.

Data collection took place during August and September 2024. Initially, contact was made with the service to identify patients who met the inclusion criteria and to check their availability for participation. The sample was defined by convenience, based on participant availability.

There was no previous relationship between the researcher and the participants before the interviews. Individual, semi-structured interviews were conducted online, via Google Meet®, after prior contact from the institution with the guardians for authorization to provide their phone contact, on days separate from the appointment days, to avoid interfering with the service. Before starting the interviews, the researchers presented and explained the study's objectives, highlighting its relevance to the scientific community.

The interviews were conducted remotely, as recommended by the institution, since most patient

appointments are scheduled every three months, many participants live in municipalities neighboring Maringá, and there are occasional missed appointments, which would extend the data collection period.

The interviews were conducted by the main researcher, a fourth-year nursing student, and by a nurse doctoral student in nursing. Both had previous experience in qualitative research, which contributed to sensitive listening and the interviews' conduct. Although it is recognized that this involvement may generate assumptions about family suffering or the actions of the healthcare team. Reflexivity was maintained throughout the data collection process through reflective notes and discussions with co-authors, aiming to reduce potential bias. No pilot test was performed.

A total of twenty-four family members were contacted, ten of whom declined due to lack of interest, lack of availability to contribute to the research, and insecurity in discussing their diagnosis. Seven did not respond after four attempts. Thus, seven family members of children with cleft lip and palate were included in the study.

After consenting to participate, the semi-structured interview began with the following guiding question: "Tell me about your experience with fasting and thirst during the perioperative period of primary and/or secondary surgery of your child with cleft lip and/or palate?" It is important to note that all families were explained the concept of the perioperative period to help them respond easily to the questions and share their experiences. Additionally, a sociodemographic and health questionnaire was applied to the child and their family, and supporting questions were used to gather information about the family and the child, such as fasting time and the family's understanding of surgical periods, age, gender, place of residence, marital status, education level, and family income.

The interviews were digitally recorded and fully transcribed to ensure accurate recording. The average duration of each interview was fifteen minutes. Data collection ended when the researchers identified repetition among the responses, indicating theoretical saturation of the data. Since no new elements emerged from the collected data, adding more information was

unnecessary, as it would not change the understanding of the study object⁽²⁰⁾.

A thematic content analysis was performed, following the following steps: a) pre-analysis: the data were organized and prepared for analysis, identifying the central idea; b) material exploration: the data were analyzed in depth, highlighting the most relevant units for the research using meaning units (excerpts from the statements); c) data categorization: categories were organized by regrouping content with similar meanings, and the results were processed with interpretations and inferences⁽²¹⁾.

The categories were constructed from the collected data but guided and interpreted in light of the theoretical-philosophical framework of the FCC, which offers a conceptual framework for understanding the experiences and practices reported by the participants. This framework guided the interpretation of the meanings, contributing to the organization of the categories and the analysis of the results⁽¹⁵⁾.

The analysis was conducted manually by two researchers, independently, and later the findings were discussed among all authors to reach a consensus, ensuring greater rigor and reliability of the results.

Validation of the transcripts or results with participants was not performed due to logistical limitations of remote data collection. This step was not performed, considering the interpretative nature of the study and recognizing that knowledge is not necessarily constructed through repetition and validation of statements, but through their interpretation.

The study complied with the guidelines of Resolution No. 466/12 of the National Health Council/Ministry of Health and was approved by the institution's Permanent Ethics Committee for Research with Human Beings (COPEP), under opinion No.7,041,250, in August 2024 (CAAE: 81990024,0,0000,0104). All study participants signed the Informed Consent Form through an online form via the Google Forms platform, which was sent during the interviews. To ensure anonymity, interviewees were identified with "F" for family, a number according to the interview sequence, the child's age, and the type of surgical procedure performed (e.g., F1, 2 years old, cheiloplasty).

■ RESULTS

Six mothers (85.7%) and one grandmother (14.3%) participated in the study, all of whom were the main caregivers of the children, ranging from 28 to 52 years old. Regarding their place of residence, only one resides in Maringá (14.3%), while the others live in neighboring cities (85.7%). Six are married (85.7%) and one is in a stable relationship (14.3%). Three participants have completed high school (42.8%), one has completed higher education (14.3%), two have incomplete elementary education (28.6%), and one has incomplete high school (14.3%). Three participants were unemployed (42.8%). Their monthly income ranges from three to seven minimum wages and supports three to six people living in the same household.

The children's ages ranged from seven months to almost 11 years, with four being male (57.2%) and

three female (42.8%). Regarding surgical history, three children had undergone only primary surgeries (42.8%), and three had undergone secondary surgeries (42.8%). The search for support and information began at the time of the cleft diagnosis: for five families during pregnancy (71.4%), through ultrasound examinations, and for two after birth (28.6%).

Through careful reading and detailed analysis of the interviews, it was identified that fasting and thirst led to different experiences for both caregivers and children with cleft lip and palate. Chart 1 presents a summary of the analysis process leading to the construction and development of thematic categories, which were: 1. Experiences and feelings resulting from fasting and thirst in children and caregivers; 2. Coping mechanisms for fasting and thirst; 3. The role of the healthcare team in communication and management of prolonged fasting.

Chart 1 – Coding and construction of thematic categories based on data analysis. Maringá, Paraná, Brazil, 2024.

Initial codes	Intermediate codes	Thematic categories
Prolonged fasting time Family food restriction Family members' negative feelings regarding fasting and thirst Positive understanding of fasting Calm child and calm preoperative period	Prolonged fasting time Feelings and behaviors of caregivers during the follow-up of children	Experiences and feelings resulting from fasting and thirst in children and caregivers
Children's feelings and expressions regarding fasting and thirst Children's understanding of fasting Distraction techniques to cope with fasting Use of playful strategies to cope with fasting	Difficulties with fasting and child behavior Use of strategies to minimize fasting	Coping mechanisms for fasting and thirst
Alternatives to minimize fasting Presence or absence of professional support	Importance of professional assistance and support	The role of the healthcare team in communication and management of prolonged fasting

Experiences and feelings resulting from fasting and thirst in children and caregivers

For six family members, the preoperative fasting period for cleft lip and palate correction was perceived as prolonged, lasting between eight and ten hours, considering that this is a pediatric population and, therefore, has particularities.

He had to fast early and also after the postoperative period. (F1, 7 months, cheiloplasty)

She fasted for more than eight hours, almost ten hours. (F2, 1 year and 3 months, cheiloplasty and aortic coarctation)

The fasting lasted eight hours before surgery. (F6, 11 years, cheiloplasty, palatoplasty, and periodontal graft)

From the perspective of FCC, stands out the way family members participate in the process alongside the children since when confronted with the children's suffering, they recognize the need to reframe their role as caregivers. A common attitude among caregivers was restricting their own food intake during the child's fasting period, to share their suffering and support the children.

I just cried out of pity, my heart was aching. I said, 'My son is not drinking, I won't drink either.' You can imagine what it's like to feel thirsty, hungry. So, the feeling he was having, I was going to go through it with him. And that's what happened. (F1, 7 months, cheiloplasty)

I didn't want to eat around him, I skipped lunch. I only ate lunch after he went to the operating room because I felt bad about eating in front of him. I didn't eat, I didn't drink water, I didn't do anything in front of him. (F6, 11 years, cheiloplasty, palatoplasty, and periodontal graft)

I also don't eat around him, so he doesn't feel bad. (F7, 11 years, cheiloplasty, palatoplasty and bone graft)

It's clear that the caregiver's experience of caring for their children brings a lot of feelings. For some, feelings of sadness and anguish take over when they perceive

the child's despair and desire to satisfy their needs. The caregiver's voluntary decision to restrict their own food intake highlights the principle of active participation present in Family Centered Care, by sharing the experience of fasting with the child and offering emotional support in the face of their suffering.

I cried too, because I felt sorry for him, he wanted to breastfeed, but he couldn't. (F1, 7 months, cheiloplasty)

The hardest period is this fasting. It's sad. (F6, 11 years, cheiloplasty, palatoplasty, and periodontal graft)

Although fasting and thirst bring up different feelings for children and their families, the experience was redefined through the understanding of the need to face this process in the perioperative period, even with the ambivalence of wanting to ease the child's suffering.

The feeling that the child is hungry is very bad, but I knew that (the surgery) was a good thing for him. (F1, 7 months, cheiloplasty)

A mother always wants to feed her child when she can, but she can't, so we understand. (F7, 11 years old, cheiloplasty, palatoplasty, and bone graft)

For two family members, the preoperative experience was calm, mainly due to the child's calm behavior and the alignment of the fasting period with the child's usual formula routine, or even with the sleep routine.

In fact, it was fine. At ten o'clock, I gave her the last bottle, and she even slept in the hospital. She didn't cry, because to hunger or anything like that. (F2, 1 year and 3 months old, cheiloplasty and aortic coarctation)

I believe the fasting wasn't hard, because she slept the whole trip, then arrived, and was admitted. She was admitted at seven, and I think the surgery was around eight. (F4, 2 years old, palatoplasty)

Given these experiences, it can be noted that the implications of fasting were heightened by a prolonged period of food restriction. The caregiver's experience is sometimes a reflection of the child's behavior, facing an emotional dilemma that includes understanding

the need for fasting and the caregiver's experience of the situation, revealing the emotional stress caused by the surgical process.

Coping mechanisms for fasting and thirst

The postoperative fasting period caused distress in children, such as crying and despair. Reports indicated that a lack of understanding of the dietary restrictions worsened the emotional and physical effects of fasting.

He was already getting weak from crying so much, he was hungry [...] he wanted to nurse. (F1, 7 months, cheiloplasty)

He drinks a lot of water, but there (at the hospital) he couldn't. So water, for him, is essential. I believe that [thirst] is worse than hunger. (F5, 5 years, cheiloplasty and palatoplasty)

Even upon the desire to drink water or food, some children showed understanding and adaptation to the dietary restrictions, especially when there was prior communication between some family members and the children about the need for fasting. Negative feelings, such as stress, were present in a more subtle form. This situation reflects shared care, in which the family assumes responsibility for mediating the child's hospital experience.

Even the nurses found it strange, because she is a different child. She didn't cry, she sang. She didn't cry post-surgery, she was very calm. All children cry a lot, but she didn't. She slept, she sang. (F2, 1 year and 3 months, cheiloplasty and aortic coarctation)

He knows he can't drink, and he doesn't complain. But we know he's stressed and thirsty and hungry. (F7, 11 years old, cheiloplasty, palatoplasty, and bone graft)

The FCC is also expressed in creative strategies and distraction techniques used to try to minimize thirst and hunger. Caregivers used resources available to them to make the fasting period more bearable.

You have to try to turn the situation around, pretend everything's fine, and try to deceive. Usually,

we go for hospitalization at lunchtime, there's the smell of food, people eating right next door. I have to pick her up and walk around the room so she doesn't smell the food. You have to try to deceive her, to get through it. (F3, 2 years old, cheiloplasty, palatoplasty, and tympanotomy)

Others chose to use playful strategies, such as toys, games, conversations, and the use of technology to entertain the children. The adoption of playful resources highlights the FCC principle of dignity and respect, by considering the child's uniqueness and seeking ways to make the hospital experience lighter and more tolerable.

I bring a new toy, I buy it and carry it in my suitcase, and when I get to the hospital, where she's admitted, I give her the toy. Because that's where she gets distracted, I manage to gain some time. (F3, 2 years old, cheiloplasty, palatoplasty, and tympanotomy)

Distract him with something. [...] A game, a topic, a conversation, a window, a car passing by. (F5, 5 years old, cheiloplasty and palatoplasty)

Not strategy, but I brought him a cell phone to play, and he stayed on the game he likes. (F6, 11 years old, cheiloplasty, palatoplasty, and periodontal graft)

Younger children showed difficulty in understanding the importance of fasting, which resulted in actions such as crying. Given these experiences, it became clear that the caregivers' ability to provide distraction and prior communication with the children may have been crucial in minimizing the negative experience of fasting and their hospital stay. Reinforcing the centrality of the family in hospital child care, according to the FCC, by showing that caregivers, by assuming an active and empathetic role, contribute to reducing the negative impacts of hospitalization and fasting.

The role of the healthcare team in communication and management of prolonged fasting

During the preoperative period, especially up to eight hours before the procedure, professionals provided guidance on strategies to minimize the discomfort from fasting, such as administering clear liquids orally.

This strategy was seen by family members as a form of care and a concrete expression of the FCC.

They [healthcare professionals] let them drink clear, residue-free tea a few hours beforehand [...]. They give them this tea, so they don't go hungry for too long. (F6, 11 years old, lip repair, palatoplasty, and periodontal graft)

To alleviate the symptoms of hypoglycemia and dehydration, professionals found alternatives to help children and families during this waiting process to be able to eat and drink fluids again.

To keep him from getting dehydrated, they gave him a bit of something sweet [glucose]. Because his glucose level, she said, was dropping, and she ended up giving him a few drops of glucose, just to satisfy him a little, just so he could swallow [...] they started giving him [glucose], just to reactivate him a bit, because he was getting really weak from crying so much, he was hungry. (F1, 7 months old, cheiloplasty)

They [healthcare professionals] let him drink a clear, residue-free tea, water, a few hours beforehand at the CAIF [...]. They give them this tea, so they don't go hungry for too many hours. (F7, 11 years old, cheiloplasty, palatoplasty, and bone graft)

The family feels welcomed when healthcare professionals provide support beyond childcare, extending attention to the needs of the family member, providing emotional support and encouragement, and helping with the demands and challenges of each stage of the process, as recommended by the FCC.

And the doctor, the nurse said, "No, you have to eat, you have to drink to be strong, to stay firm." I said, "But I can't." Because we keep thinking about our child, he can't do it, how are we going to do it? I said, "Can you imagine what it's like to be hungry, thirst" (F1, 7 months old, cheiloplasty)

The nurse told us as soon as we left the room next to the surgery, which is the observation room, that

she would be very nauseous, because the effects were still wearing off. (F4, 2 years old, palatoplasty)

When expectations of professionals are frustrated or not met, the family member tends to feel helpless, insecure, and disoriented, since there is no closeness or effective communication. This affects the care provided to the child in the hospital environment and especially upon returning home, where the demands are greater.

There's no nurse there to help you, to guide you, it's very vague, and so my experience wasn't very good. (F4, 2 years old, palatoplasty)

The doctor forgot to leave the prescription in the chart. Girl, I couldn't take it anymore, my feet in sneakers, from morning to night. The only thing I didn't like was the time we spent in the hallway, waiting for surgery. In my opinion, the child should be hospitalized because he travels all night and is tired, he needs to take a bath and lie down to rest. (F7, 11 years old, cheiloplasty, palatoplasty, and bone graft)

Before the surgical procedure, the consumption of clear liquids reduced hunger and helped prevent dehydration. However, after the surgical procedure, the professionals used glucose to alleviate hypoglycemia and provide minimal comfort for the children while they were still fasting. Effective communication and continuous emotional support are essential to ensure comprehensive, effective, and high-quality care, as the experience of fasting and surgical procedures presents several emotional and physical challenges for both children and their caregivers.

DISCUSSION

Preoperative fasting in children should be conducted with caution, as prolonged fasting can trigger discomfort, thirst, hunger, dehydration, and hypoglycemia, as well as increasing anxiety levels. A study conducted at a pediatric hospital in Shanghai found that fasting times for pediatric patients followed the same criteria as for adult patients, failing to consider the specific

needs of children⁽²²⁾. Thus, the FCC principles reinforce the need for practices that consider the singularity of each child and family, through adapted care and shared decision-making⁽¹⁵⁾.

There is a clear need for a protocol regarding fasting in pediatric surgeries in the hospital setting to ensure the safety and well-being of children during the procedure and throughout their hospitalization. It can also improve metabolic response and reduce preoperative symptoms such as thirst, hunger, irritability, headache, nausea, and dehydration^(23,24). Protocols should be developed and implemented based on active listening and the sharing of truthful information with families and children⁽¹⁵⁾.

A recent study suggests that a new "6-4-3-1" regimen, with a fasting period of 6 hours for solids, 4 hours for formula and non-human milk, 3 hours for breast milk, and 1 hour for clear fluids, can be safely adopted for pediatric patients⁽²⁵⁾.

Thirst must be recognized as a significant discomfort experienced by patients, and thus, measures should be proposed to alleviate this sensation. Sensory stimulation in the oral cavity, such as cold temperatures and menthol, can activate receptors that signal the brain to reduce the sensation of thirst even without actual large volumes of fluids. Therefore, simple strategies, such as mentholated chewing gum and mentholated popsicles, combine low temperature and receptor activation, reducing the discomfort caused by thirst⁽²⁶⁾.

Another randomized clinical trial evaluated the consumption of mentholated substances, such as lip balm and ice popsicles. Researchers found that mentholated substances can reduce thirst intensity, dryness, and bad taste in the oral cavity, and promote hydration in patients in the preoperative phase, with just one application^(27,28).

In pediatric surgeries, parents experience concern and emotional stress, which can be intensified by the diagnosis of children with disabilities, structural anomalies, or congenital anomalies, such as cleft lip and palate. This is due to heightened insecurity and overprotection, which influence how they deal with the demands of these children's conditions^(2,29). Professionals must adopt the FCC in clinical practice to assist in these contexts,

recognizing and supporting family members' needs through an attitude of dignity and respect⁽¹⁵⁾.

Additionally, caregivers often feel powerless in the face of their child's suffering, sometimes even restricting their own food intake as a form of empathy. A communication gap between healthcare professionals and the child is also observed, despite the recognized benefits that such interaction can bring to the well-being of the patient, the companion, and even the professionals themselves⁽³⁰⁾.

The experience of caregivers during their children's hospitalization and facing surgical procedures carries a significant emotional burden⁽³¹⁾. For many, feelings of sadness and anguish predominate, especially when faced with the despair of children who cannot meet their needs due to fasting restrictions^(10,32).

On the other hand, some family members are able to cope with the situation more calmly, understanding the long-term benefits of the procedure. These caregivers find strength and calm by focusing on the positive outcome of the surgery, knowing that the medical intervention will significantly improve the child's quality of life⁽³³⁾. Knowledge and previous preparation appear to act as moderating factors, reducing anxiety and helping caregivers remain calm⁽³⁴⁾. Therefore, families should be seen as part of the care process and have the right to clear communication and the exchange of relevant information to minimize suffering and strengthen the bond between professionals, families, and children⁽¹⁵⁾.

Preoperative preparation and guidance offered to parents and children contribute to their acceptance and coping with the situation⁽³⁵⁾. However, some children have difficulty understanding new routines and hospital care. In this context, the use of age-appropriate playful strategies is an important tool for both families and healthcare professionals. Playful strategies include games, toys, and activities that allow children to express themselves and understand the moment they are experiencing in a pleasant way, serving not only as a distraction but also as a valuable developmental technique⁽³⁶⁾.

Studies suggest that the implementation of clinical guidance protocols and information leaflets about operative fasting, combined with an effective approach, encourage parents to fill out the leaflet with the date

and time of their last intake. These factors, combined with an oral approach to the observations and benefits of fasting and individualized nutritional counseling, resulted in greater compliance with the hospital fasting guidelines, potentially avoiding prolonged fasting, which could affect the child's physical and emotional state⁽²⁶⁾.

It is also important to emphasize the importance of continuous support from the healthcare team to guide and reassure caregivers. Comprehensive care promotes the emotional well-being of children and their caregivers throughout the process, highlighting the importance of practical knowledge that is sensitive to individual reactions and preferences⁽³⁷⁾.

The results of this study provide relevant contributions to the management of pediatric healthcare services by highlighting the emotional impacts of fasting and thirst on caregivers and children undergoing surgical procedures, providing support for more effective psychological support, reducing anxiety and stress. Clear and continuous assistance from healthcare professionals to family members aims to ensure that children's needs are met effectively and promptly, as recommended by the FCC, which expands the vision of care beyond the technical procedure, integrating emotional, social, and relational aspects.

A limitation of this study is that some children had undergone more than one surgical procedure, which may have influenced the family member's experience and their way of dealing with fasting and thirst during this period. However, it is believed that the findings can contribute to reflections on the elements involved, such as the experience of family members of children with cleft lip and palate undergoing primary and secondary surgeries. Another limitation that can be highlighted is that interviews were conducted online, which may have hindered the establishment of a bond between the researcher and the participants. However, to minimize bias, all interviews were conducted remotely, avoiding discrepancies in data collections.

■ FINAL CONSIDERATIONS

Fasting and thirst during the perioperative period caused emotional repercussions in the children and their caregivers, such as sadness, anguish, crying, and tension. In this context, family members developed

coping strategies, such as reframing suffering, shared food restrictions, and the use of various distractions (toys, games, conversations) and communication to minimize discomfort. Participants highlighted the importance of the healthcare team in properly managing fasting, through the provision of clear fluids and glucose, combined with emotional support and communication, which, when effective supported families, showing practices based on the FCC.

Beyond the aspects observed regarding caregivers' experiences with fasting and thirst, it is emphasized that care must be individualized, considering the particularities of each child and their family context. Continuous support is vital, as the reports demonstrate the deep connection between the children's emotional state and how caregivers dealt with the situation.

Given the negative impacts of prolonged fasting, such as metabolic changes, increased stress, anguish, and suffering, it is necessary to discuss and implement evidence-based protocols that aim to reduce fasting time and minimize thirst, promoting greater comfort and better postoperative recovery.

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■ Authorship contribution

Conceptualization: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Data curation: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Formal analysis: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Investigation: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Methodology: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Supervision: Mariana Martire Mori, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Visualization: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Writing-original draft: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

Writing-review & editing: Yasmin Vitória dos Santos Rodrigues, Camila Moraes Garollo Piran, Mariana Martire Mori, Alana Vitoria Escritori Cargnin, Laís Moreira Martins, Maria Fernanda do Prado Tostes, Marcela Demitto Furtado

The authors declare that there is no conflict of interest.

■ **Corresponding author:**

Mariana Martire Mori

E-mail: mari_mmori@hotmail.com

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