SURG-ONC RECOMMENDATIONS

Whipple Procedure Postop Orders to include:

DVT prophylaxis to begin 24 hours after surgery completion (ICU choice of drug)
Ulcer Prophylaxis (ICU choice of drug)
Perioperative Abx dosage for 24 hours only
General (patient non-specific!!) IV fluid rate of 1.25 – 1.50 x basal/maintenance (ie don't have to be run dry)
Zofran 1st choice for anti-emetic prn use
Begin central HAL POD 1 unless feeding tube present
Feeding Tube present – start D10W @ 15 cc/hr for 24 hrs on POD 2
Then TF's @ 20 cc/hr on POD 3-4 (jejunal TFs not to exceed 50 cc/hr)
Drains must be checked/stripped BID by ICU resident and Surg Onc resident
NG remains in until removal approved by staff.

GEN ONC: Dressings taken down POD 2 and Bacitracin ointment applied to incision daily
Toradol approved for analgesia in addition to epidural or PCA at 15 mg iv q6hr (if no contraindications)
Drain fluids are not to be sent for Amylase w/o discussing with staff.

Esophagectomy Postop Orders to include:

DVT prophylaxis to begin 24 hours after surgery completion (ICU choice of drug)
Ulcer Prophylaxis (ICU choice of drug)
Perioperative Abx dosage for 24 hours only
Feeding Tube present – start D10W @ 15 cc/hr for 24 hrs on POD 2
Then TF's @ 20 cc/hr on POD 3-4 (jejunal TFs not to exceed 50 cc/hr)
Start Digoxin 0.25 mg IV q6 to completely dig load over 24-48 hrs
NGT put to low intermittent wall suction.
NGT not to be used for medications (use feeding tube)
NGT not to be repositioned by nursing staff or junior house staff.
NGT patency to be checked daily by ICU resident and Surg-Onc resident
IF NG comes out partially/completely – Staff to be notified immediately Regardless of time of day. To be re-inserted only by Surg Onc attending, ICU attending if SO attg unavailable in OR etc) or Surg Onc chief or CT fellow.

If any alteration in cardiac rhythm, especially new Atrial Fibrillation/SVTs:
Check CXR for intra-thoracic dilated gastric bubble.
Check NGT patency
Consider Dig loading if not already done so. Check Dig levels and adjust.

(Continued)

Chest Tubes – to suction drainage for first 72 hours, then to water seal.
Chest Tubes not to be pulled if IVOR LEWIS (intrathoracic anastamosis) until swallow study completed, negative, and patient taking clear liquids without any change in output.
Chest Tubes may be pulled if TRANSHIATAL once output < 250 cc/day

GENERAL SERVICE:

Large (19FR) Blake drains exiting abdomen may be serving as chest tubes (placed through diaphragmatic/pleural opening) – to be put to suction and treated as chest tubes.

Major Liver Resections:

Ulcer Prophylaxis (ICU choice of drug)
Perioperative Abx dosage for 24 hours only
DVT prophylaxis to start only on approval of staff
General (patient non-specific!!) IV fluid rate of 1.0 x basal/maintenance (perfusion goals to be minimal adequate accepted urine output)(not overhydrate)
Colloid fluid boluses preferred over multi-liter crystalloid boluses.
NG may be removed on POD 1-2 if no distension or high outputs
Clear Liquids started on POD 1-2 as appropriate.
Check Phosphorus, Calcium, Mag levels daily and aggressively correct these levels if drifting below normal levels (esp Phos)
Alternatively add Kphos as part of maintenance IVF
ABSOLUTELY NO BENZODIAPINE USE
Liver function tests are not to be checked.
Ammonia level not to be checked with discussing with staff.

GENERAL SERVICE: jejunal feeding tube guidelines:
Feeding Tube – start D10W @ 15 cc/hr for 24 hrs on POD 2
Then TF's @ 20 cc/hr on POD 3-4 (jejunal TFs not to exceed 50 cc/hr)