Abdominal Wall Reconstruction Comprehensive Care Pathway

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**NOTE: Pathway only applies to patients undergoing AWR/complex hernia repair, not patients undergoing minor hernia repair. Please speak with the attending surgeon for Qs.*

Pre-op Holding area

1. **Oral premedication** with acetaminophen (1000mg PO), celecoxib* (400mg PO) & gabapentin (600mg PO) if no contraindications. (*Contraind: Hx CAD, CKD, PUD/GI ulcer, bleeding)
2. **DVT prophylaxis -** 5,000 units unfractionated Heparin in preop.
3. **Accelerated bowel function - Entereg (Alvimopan)**** 12 mg PO x1 Pre-operatively, then BID until +documented bowel function or POD#7. **ONLY for complex AWR cases**
4. **(Thoracic epidural) – Not routinely used for AWR patients**

Immediate Post-Operative Care: Ward Patients

1. **Brief operative note** using "GSBRIEFOPNOTEHERNIA1" template (under Dr. Orenstein's SmartPhrase list).
2. **Activity:** Order placed to Ambulate at least TID
3. **Diet**: *Ensure proper diabetic version is ordered, if applicable.
   a. **POD#1 –** Unlimited Clear liq + TID clear liq protein supplements [**IsoPure**]
   b. **POD#2** – Regular diet + TID Protein supplements (can switch to milk-based shakes, if desired).
   c. Nancy's yogurt (or yogurt containing Lactobacillus plantarum, L. casei, L.rhamnosus, or L.reuteri) → ordered at least once daily starting POD 1.
4. **DVT prophylaxis**
   a. **POD#0**: Switch to prophylactic dosing of Lovenox the evening of surgery (dosed as standard PM dosing on POD#0).
      i. NOTE: The patient receives a single preop dose of 5,000 units of unfractionated Heparin in the preop holding area.
5. **Postoperative Antibiotics** – No routine abx unless:
   a. High concern for infection, infected mesh removal, chronic MRSA infection, …
   b. Treat with abx until final intra-operative cultures are neg.
6. **Entereg (Alvimopan)*** → 12 mg PO x1 Pre-op, then BID until + documented bowel function or POD#7. *This may not apply to all AWR patients.
7. **Bowel Regimen**
   a. Scheduled Colace 100mg PO BID + Senna 1 tab PO BID
   b. PRN Milk of Mag 30 mL PO BID (start POD#4 if no BM)
   c. PRN Dulcolax suppository* (*only if passing flatus)
8. **Fluids**
   a. POD#1: D5 ½ NS w/ 20 KCl @75/hr
   b. POD#2: Cont MIVF; Heplock at end of POD#2 if tol PO
   c. POD#3: Heplock if not done on POD#2
9. **Foley catheter** – removed on POD 1 unless needed for monitoring.
10. **Analgesia – Multi-modal pain therapy**
    a. (If epidural, this will be managed by the Acute Pain Service.)
    b. TAP (Transversus Abdominis Plane) Block – intraoperative
    c. Hydromorphone PCA until POD#3, then transition to oxycodone
    d. Oxycodone 5 mg PO 1-2 tabs q4-6 hrs PRN starting on POD#3
    e. Acetaminophen 1000 mg PO q 6 hours (scheduled, not PRN)
    f. Gabapentin 300 mg PO TID during hosp. (scheduled; not for discharge)
    g. Diazepam* (for muscle spasm) Give 2 mg PO q6 hrs x 48 hours
       - Scheduled, not PRN, with HOLDING PARAMETERS for sedation).
       - *DON'T order if Hx OSA, age ≥65, or poor renal function. (not for discharge)
11. **Post-operative monitoring:** For patients with BMI >35 or anyone with OSA, post-op orders to include continuous pulse oximetry with remote telemetry until IV or epidural opioids have been discontinued.
12. **Abdominal binder** ordered for comfort only.
13. **Physical Therapy** to evaluate and treat on POD 1.
14. **Labs:** CBC, Renal function set and magnesium to be ordered for POD 1, then only as indicated thereafter.
15. **Drains:** should be stripped twice daily on rounds by MD, and by RNs TID. To be removed sequentially once output is less than ~30 ml/24 hours and non-bloody. If more than one drain is in place within a given space, then only one drain per space is to be removed at a time.

Miscellaneous:

- High rate of DVT/PE in these patients – have low threshold to get bilateral duplex and/or chest CTA
- The pathway revolves around patients tolerating their diet. With small emesis, nausea, bloating/distention, OK to wait for symptoms to improve/resolve and then advance.
- **NGT placement defines being completely off the pathway.**
- Drain removal may be a limiting factor for early discharge. This will be dealt with on a case-by-case basis, but with goal of 30cc/day.

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