Hernia~ Clinical Care Pathway



Prior to DOS	Implement Strong for Surgery pre- ospital clinical interventions	Clinic Staff Discuss Care Map with Patients & Set Expectations MRSA MSSA scree	A	f MRSA positive, Intranasal Mupirocin for 5 days prior		Impact drink, 6 days prior (optional)	Patient drinks 8 oz of apple juice b/f midnight, 1 day prior	midi	food after night; Clear iquids as nstructed
Day 0: Pre-On		k Glucose: If > 100, recheck O min after incision. If > 140, start insulin GTT	should b	ts needing Vancom e administered 60 r ior to operation		Minimum of 3	ection ONLY (5% of control of the original ori	an 12 So	Portable CDs in Pre- Op
	Fluids: If IV in place, LR at 50 ml/hr	Pain: 1000 mg Acetaminophen po (then po or IV q6h until discharge)	po (Gabapentin 300 m continue tid once rating pills again)		patients: aimed at	Epidural for ALL path upper level of incisio Lidocaine w/ Epi 1:2	n (tested	Heparin 5000 units subcu
Intra-Op per		Fluid: During surgery: 5 ml/kg/hi of LR . Target a urine output of 0.3-0.5 ml/kg/hr	W	od Loss – Replace ith colloid (5% umin) ml for ml		fused at 10 ml/hr	ricaine plus Fentanyl started ASAP after an ates (especially Morp	esthesia induc	ction.
		For patients not receiving Vancomycin, initiate IV Abx in OR	Glucos		a	nasogastric tubes t end of case if pla gastric decompres	ced for com	minal binder fort per surged discretion	-
Day 0: PACU	Glucose	uid: LR Target urine at 1 output of 0.3- nl/kg/hr 0.5 ml/kg/hr	PCEA w		by 3 cc N	S) and infusion inc	al Fentanyl (25-50 mi reased, by 2ml/hr - fo tion (1/10% then 1/89	ollowed by inc	reased

- ~ This pathway applies to all Ventral and Incisional Hernia Repairs where patients get admitted to the hospital, whether Open or Laparoscopic.
- ~ Excluded patients: Patients on daily pre-op opiates for >2 months; Abnormal LFTs; Abnormal coags; Abnormal Creatinine
- * Unless chronic opioid user (on narcotics within 1 week of surgery)

UW Medicine
TRANSFORMATION OF CARE

^{**} If BP low or marginal or pressors ongoing talk with surgeons about ketorolac (vs. bleeding vs. nephrotoxic risks vs. anastomotic risk). If BP unable to be controlled with low dose pressors or fluid bolus (500 cc) "split" epidural (take fentanyl out of epidural infusion and add IV opiate PCA) in preparation for, or as start of, stopping epidural.

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Target LOS = 3 to 4 days

Day 0

Mobility: Edge of bed after last set of post-op VS (usually 6 hours) with orthostatic VS Diet: Ice chips & sips of clears Incentive Spirometer
10x/hr while awake
until discharge

Sequential Compression Device on, unless ambulating, until discharge Heparin 5000units SQ Q8h

Glucose Mngmt

Day 1

PT visit on Day 1, latest Mobility: OOB for all meals.
Walk 3-4 times in the hall –
Goal 9 laps. OOB 6hr/day

Diet: Advance diet as tolerated. General Diet, if patient has no nausea, no distention, no belching/hiccups

DC Foley (just pull) Labs Days 1-4, as clinically indicated

Fluids: LR at 1 ml/kg/hr. Cease IV fluids asap. Saline lock IV fluids when oral intake greater than 500 or adequate urine output. Aim for early oral fluid intake Pain, PCEA and acetaminophen PO continued. After clear liquid lunch, start Ibuprofen 600 mg po q6h (consider ketorolac 15 mg q6h if opiate side effects and NPO).

Day 2

Mobility: OOB for all meals. Walk 3-4 times in the hall – Goal 18 laps. OOB 6hrs/day until discharge Pain: Epidural stopped and oxycodone started after breakfast tolerated (epidural pulled 4 hours later).

JP Drain Teaching

Day 3, 4

Stool Softener docusate 100mg PO BID (NOT Senna) DC Alvimopan (if bowel movement) Med Rec on Day before Discharge

Pain: Gabapentin discontinued on Day 3.

Pain: Acetaminophen and ibuprofen continued at discharge.*



^{*} Patients should be advised to stop Ibuprofen when oxycodone no longer needed more frequently than q6h.