Lobectomy

Out of OR – CXR, CBC, BMP, Mg, Lovenox (to start on POD1) and SCD's, Chest tube suction in PACU waterseal upon transfer, Scheduled Nebs, Scheduled pain meds (IV Tylenol x3 doses followed by PO and Oxycodone 5-10mg every 4 hours), Diet clear liquids, Schedule metoprolol 12.5mg Q6 (or order home beta blocker if already on one for another reason), add additional metoprolol 12.5mg PRN for HR>70 Hold for MAP <60, LR @ 75/hr for 6-12hrs for IVF and any PRN boluses, low BP call MD for +/- bolus, PRN Mg & K+ replacement, Telemetry, IMC, Foley

POD 1 – CXR PA&Lat, CBC, BMP, Mg (replete PRN per protocol), DC IVF if didn't already time out, Advance Diet fluid restrict 1.5L, DC foley, remove chest tube if no air leak and output appropriate (no need for post pull CXR), adjust metoprolol dose PRN and change to BID dosing, transfer to R1, evaluate +/- home O2 needs, +/- DC home in afternoon on BID metoprolol and home meds as appropriate

POD 2 – CXR PA&Lat, CBC, BMP, Mg (replete PRN per protocol), diurese x1 PRN, DC home on BID metoprolol and home meds as appropriate

Segmentectomies/Wedge resections

Same as lobe except

floor (R1)

no scheduled metoprolol only afib prn protocol orders (unless on BB at home for another reason)

less intense electrolyte replacement (cannot do our intense protocol unless in IMC/ICU due to amount of RN work)

AFib Protocol

Check EKG, BMP, Mg; Give 2gms Mg empiric (do not wait for labs, the labs will tell you if the 2gms was enough)
Metoprolol 5mg IVP Q5min up to 3 doses (until SR or HR<100)
If still Afib with HR>100 then:

Diltiazem 10mg IVP then infusion 10mg /hr goal is HR<80 with MAP>60 (MAP>70 for esophagectomy)

If no conversion to SR in 24 hrs ask attending if they want a cards consult for possible DCCV
If no conversion to SR in 48 hrs ask attending +/- anticoagulation and if yes then ask Coumadin vs Eliquis vs Xeralto

Electrolyte replacement protocol for Mg and K+

Specific to our service and can be found in our postop order sets
Can only be used in IMC or ICU due to the amount of nursing work involved in the intense protocol

Bleb resection/Pleurodesis

Out of OR – CXR in PACU, CBC, BMP, Chest tubes to sxn do not disconnect and remain on suction for first 48 hours minimum
DAILY – CXR PA&Lat
POD2 – Chest tube to water seal at 48 hour mark if appropriate and d/w attending plans for tube removal (timing)

- Check post pull CXR after remove chest tube

Decortications

Out of OR – CXR in PACU, Labs PRN, Chest tubes to sxn do not disconnect and remain on suction for first 48 hours minimum, ultimate duration of suction to be determined by attending and will be specific to patient situation and characteristics
Daily – CXR PA&Lat
Chest tube removal timing – will be determined by attending and will be specific to patient situation and characteristics

Paraesophageal hernia repairs/Nissen

Out of OR – Strict NPO, IVF, Foley, CBC and BMP (CXR is not routine on these patients, only obtain if indicated)
POD1 – DC foley, Swallow evaluation for leak and obstruction if ok then DC IVF change to PO meds restarting home meds as appropriate and start clear liquids advancing to fulls as tolerated with goal of DC to home on fulls later in day
DC specifics – home on full liquids for 2 days then advance to soft diet for one week

Esophagectomy

Out of OR – admit to R1 IMC, chest tube to suction may come off suction for transport/ambulation, scheduled pain meds via J-tube, telemetry, scheduled IV metoprolol 5mg Q6h with additional 2mg Q2h PRN HR>80 hold for MAP<70 or SBP<100, scheduled reglan IV TID, NGT low constant sxn, Duonebs 3xday, SCD's, lovenox (start on POD1), strict NPO, LR @ 125/hr for IVF, foley, CXR single view in PACU, baseline labs CBC, BMP, Mg, phosphorous, assure PRN Mg and K+ replacement is ordered as well as PRN metoprolol for rapid afib, albumen and prealbumen every Monday and Thursday

GOAL MAP >70 for anastomosis perfusion – we will tolerate higher HR to maintain higher MAP,any ?'s ask attending

Daily – CXR PA&Lat, CBC, BMP, Mg; albumen and pre albumen every Mon Thurs

POD1 – DC arterial line if appropriate, consult dietary for tube feed rec's (if tube feed naïve ask for rec's regarding promote around the clock while in hospital and then osmolite 1.5 nocturnal at discharge), adjust scheduled metoprolol dose if nec., adjust IVF rate if nec.

POD2 – remove one chest tube if two are present and appropriate, start tube feeds at rate 20ml/hr, review fluid status and IVF rate, consult dietary for tube feed rec's if not already done (see POD1)

POD3 – Colace via J-tube or supp or fleets if no BM, if tol tube feeds advance as tol to goal, assess IVF for decrease in rate as TF increases, consult dietary for tube feed rec's if not already done (see POD1), transition IV metoprolol to PO liquid via J-Tube maintain Q6h dosing, transition other IV meds to PO liquid via J-Tube

POD4 – assess for BM treat PRN, consult dietary for tube feed rec's if not already done (see POD1), DC IVF and foley if appropriate, evaluate home safety and support, transition IV meds to PO liquid via J-tube if not already done on POD3

POD5 – wean off IV pain meds if still utilizing, consider NGT clamp trial

POD6 – NGT clamp trial if not done day 5

POD7 – Esophagram to assess for leak and follow down through pylorus to assess emptying of conduit, if ok per attending or official read then sips clear liquid & transition to nocturnal tube feeds & fill out nocturnal tube feed forms for vender if not already done, assess for chest tube removal

POD8 – assess for chest tube removal if not done on POD7, advance to full liquid diet & if tolerates DC to home with nocturnal tube feeds later in day

CRITICAL IMPORTANT NOTE FOR DISCHARGE OF ESOPHAGECTOMY PATIENTS

-All medications upon discharge are liquid via J-tube (except in special circumstances, any question regarding this should be directed to the attending)

-All medication prescriptions must be sent to the MMC outpatient retail pharmacy as some are compounded (ie metoprolol)

-Please note compounded medications will NOT be sent electronically and will instead automatically print. A box will pop up in the lower right hand corner of your screen when you complete the medication reconciliation telling you the medication(s) that will not transmit electronically and have automatically printed. It is then **YOUR responsibility** to sign any printed prescription(s) and send via tube system to the outpatient retail pharmacy for compounding.

-Once you have completed the med rec, update the sticky note to indicate that the med rec has been done and **ALL** medications have been sent to the pharmacy for preparation.