SCHOOL OF MEDICINE
DEPARTMENT OF OBSTETRICS & GYNECOLOGY

STANDARD OPERATING PROCEDURE- GUIDELINE

ROUTINE POST-OPERATIVE CARE FOLLOWING PELVIC RECONSTRUCTIVE SURGERY

SCOPE/APPLICABILITY:

All patients require continued medical management following pelvic reconstructive surgery. Although some procedures require inpatient management while others are treated on an outpatient basis, postoperative care is similar regardless of the procedure performed. The purpose of this policy is to standardize the Division's approach to post-operative care.
This policy applies to women who undergo in-patient or out-patient surgical management by an Urogynecology attending at UNM, OSIS, or SRMC.

PURPOSE:

To describe routine post-operative care for the majority of Urogynecology patients presenting for inpatient or outpatient surgical management such as postoperative lab work, activity restrictions, discharge prescriptions, return to work, and clinical follow up.

EVIDENCE:

The postoperative care of Urogynecologic patients includes whether or not to include postoperative laboratory studies, management of voiding dysfunction, follow-up visits as well as postoperative activity restrictions. Studies evaluating the utility of routine postoperative laboratory studies after pelvic reconstructive surgery and hysterectomy have not demonstrated much benefit, and increase the cost of providing care[1,2]. Universally accepted or standardized protocols for voiding trials following pelvic reconstructive surgery have not been established. Two common methods consist of retrograde filling the bladder with 300 milliliters (mL) of normal saline or until the patient reports maximum bladder capacity has been reached. The catheter is removed and the patient is allowed to void. If the post-void residual (PVR) is less than or equal to 50% of the instilled bladder volume within 30 minutes of filling, the catheter can be left out[3]. Another method is to remove the catheter and wait for the patient to spontaneously void and the voided volume and residual volume (as determined by bladder scan or catheterization) are recorded. If the voided volume is less than on equal to 50% of the voided volume the catheter can be left out, if insufficient the Foley catheter is replaced. A randomized trial comparing these two voiding trial methods at the time of mid-urethral sling placement found that the retrograde filled voiding trial group spent less time in the postoperative anesthesia care unit (PACU) (299.5 min vs 226.6 min) and were less likely to be discharged home with a Foley catheter (61.5% vs 32.1%;P=0.02)[4]. This study suggests that it may be better for patients undergoing outpatient surgery to have a retrograde filled voiding trial. The follow-up intervals following surgery has traditionally been at 1-2 weeks, 6-8 weeks, 3 months, 6 months and a year. Not all women need to be seen at these intervals, and less frequent follow-ups result in less patient and clinical burden.

Likewise, there is very little evidence to support post-operative restrictions, how long to limit such activities, or when a patient may return to work[5]. Postoperative diet restrictions compared to placing women on a regular diet following gynecologic and colorectal surgery have not been found to be beneficial and may delay hospital discharge.

PROCEDURES:

1) Standing labs should not be ordered reflexively after surgery but may be appropriate for some patients. The decision to order postoperative labs should be discussed with the attending surgeon.
2) Trial of void
    a. Evaluation for ability to void can be done by removing the Foley catheter and waiting for the patient to spontaneously void, or by retrograde filling the bladder with 300cc of normal saline and then asking the patient to void. With either approach the voided volume should be measured by collecting it in a hat and a post-void residual should be checked by bladder scan or straight catheterization. If the patient voids at least 50 of the total bladder volume they can be discharged home without a Foley. For those patients that do not pass the trial of void, the Foley catheter should be replaced and follow-up scheduled at the clinic within a week for a repeat voiding trial.
    Please see the standard operating procedure regarding catheter care for further instruction on caring for these patients.
3) Postoperative follow-up visits
    a. After surgery all patients should have a postoperative visit approximately 1-2 weeks after surgery and most patients will also need follow up scheduled approximately 6-8 weeks after surgery. Follow-up beyond that period is at the discretion of the attending physician.
4) Postoperative restrictions
    a. Postoperative restrictions are not standardized and are at the discretion of the attending physician.
5) Diet
    a. Most patients should be advanced to a regular diet postoperative day one following surgery
6) Medications/prescriptions
    a. Inpatient: many of the medications patients take at home can be resumed postoperative day 1. Patients will also need medication for pain control, possibly nausea and vomiting. Intravenous fluids will typically be continued until the patient is able to tolerate PO.
    b. Outpatient: patients can resume most of the medications they used prior to surgery, additionally they will need pain medication and a stool softener. The medications chosen for this purpose should be based on the patients' allergies and what has worked for them in the past.

REFERENCES:

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3. Kleeman S, Goldwasser S, Vassallo B, Karram M. Predicting postoperative voiding efficiency after operation for incontinence and prolapse. Am J Obstet Gynecol 2002;187:49-52.
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5. Nygaard I, Flamad NM, Shaw JM. Activity Restrictions after gynecologic surgery: is there evidence? Int Urogynecol J. 2013;24(5):719-724

APPROVALS:

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