

PANCREAS +/- KIDNEY TRANSPLANTATION Post-op care

First 24 hours

On arrival from theatre/recovery the patient will be admitted in the routine fashion.

Early management issues:

1. **Potential for bleeding**
2. **Fluid balance** – these patients require significantly larger volumes of IV fluid than kidney transplantation alone. **Frequent assessment of volume status required.**
3. **Blood glucose control**
 - a. Patients often have transient hypoglycaemia in the first 24 hours following pancreas transplant and require IV glucose – see page 2 on how to manage.
 - b. Hourly blood glucose measurement is essential.
 - c. A BM > 12 for 2 hours **may indicate graft dysfunction and the on-call surgeon should be immediately notified.** See page 2 regarding blood glucose
4. **Electrolyte disturbance**

**DO NOT USE STANDARD WARD 118 MAINTENANCE FLUID OR INSULIN
REGIMEN FOR THIS PATIENT GROUP**

Investigations:

Admission:

- FBC, U&E, LFTs, Coagulation screen, Lab glucose, Amylase, ABG, Drain Amylase
- CXR – central line position: NG position - left in-situ for 24 hours
- 1 hourly glucose via ABG

8 hours:

- Repeat FBC, U&E, Lab glucose, Amylase, Drain Amylase
- Repeat coagulation screen if clinically indicated

PRESCRIBE

All routine medications except: ACE inhibitors, AT2 receptor inhibitors
NSAIDS, s/c insulin, oral phosphate binders,
erythropoietin.

DVT prophylaxis heparin 5000units sc bd

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**Critical Care Guidelines
FOR CRITICAL CARE USE ONLY**

GI prophylaxis

- Ranitidine 50mg IV TDS, if unavailable use PPI as below
- Pantoprazole 40mg IV od – until oral route established

IV fluid

- Initially crystalloid (plasmalyte) at urine output + 80mls/hr
- 250mls bolus if clinical signs of hypovolaemia
- NEEDS REGULAR CLINICAL REVIEW

Blood Glucose

Hypoglycaemia (BM < 4mmol/L)

- Check blood glucose hourly
- Patients often have transient hypoglycaemia in the first 24 hours following pancreas transplant and require IV dextrose
- Keep blood glucose > 4mmol/L with IV dextrose 10% or 20% at 50mls/hour and adjust rate to maintain > 4mmol/L
- **Every 6 hours stop dextrose infusion to assess for ongoing hypoglycaemia**
- Restart dextrose infusion if BM < 4mmol/L

Hyperglycaemia (BM > 12mmol/L for 2 hours)

- Start insulin as below if BM > 12mmol/L for 2 hours.
- **Immediately inform on-call surgeon as this may be a sign of graft dysfunction**

50 units Actrapid in 50mls N Saline:

- BM 8.1-10 1 units per hour
- BM 10.1-12 2 units per hour
- BM > 12 3 units per hour

Analgesia

- Epidural and/or Fentanyl PCA as charted
- Regular Paracetamol 1g qds
- Avoid NSAIDS

Immunosuppression

- Methylprednisolone 500mg –24 hrs reperfusion
- Prednisolone 20 mg mane thereafter
- Ongoing immunosuppression in consultation with the transplant team

Antimicrobials

- Cotrimoxazole 480 mg/day prophylaxis
- **In addition until duodenal culture result known:**
 - o Fluconazole 200mg od
 - o Tazocin 4.5grams od

Nutrition

- NG on free drainage due to risk of autonomic neuropathy
- High nutritional risk patients will also have NJ placed in theatre to have feed commenced at 12 hours post-op following discussion with transplant surgeon (as per SPK nutritional protocol – appendix III)