**npatient Sleeve Management:**

*Pain management* – Tylenol 650 mg PO q 4 h standing (IV on POD 0, then can be crushed or elixir).

Toradol 30 mg IV q 6 h x 4 doses standing (unless pt has allergy/ renal insufficiency or case was oozy)

Exception : Sheu prefers 15 mg IV q 6h x 4 doses ( unless pt has allergy/ renal insufficiency or case was oozy)

-Dilaudid .2-.4 mg IV q 4 hr prn severe pain

-Oxycodone 5-10 mg PO q 4 hr prn (the goal is to try the oxycodone as first line and give IV as second line). This will allow us to know whether patients can tolerate an oral regimen earlier.

*Gastrointestinal* – Sips only starting in PACU. Stage 1 starting on arrival to floor, transition to Stage 2 in AM of POD 1 if stage 1 tolerated. Requirement for discharge based on total PO intake of 500cc on POD 1.

Antiemetics-Zofran 4 mg PO/IV q 6h . Stop this medication if the patient has migraine headaches, If zofran is ineffective, consider decreasing the dose of narcotic, and replacing Zofran with standing Compazine

*Genitourinary* – LR at 100cc/hr to be discontinued at 6am POD 1. Fluid will need to be tailored further based on a history of CHF or renal failure etc.

*Endocrine* – Hold all antidiabetic medications, start insulin sliding scale. Order consult (IP Diabetes Endocrinology ) with initial order set. Aim to have all patients be seen once in the morning of POD 1 to monitor BG.

*Hematology* – Prophylactic Heparin SQ to start POD 0. If on POD1 H/H and Creatinine are stable, transition to prophylactic Lovenox. Patients with a BMI of > 50 will receive extended prophylaxis of 60 mg daily for 28 days.

Make sure you order Lovenox teaching and bedside delivery. Other indications for prolonged prophylaxis include: Personal history of VTEs, impaired mobility, and underlying malignancy.

*Lab work* - Standard CBC and BMP in AM. If HCT drops greater than 6, and WBC is greater than 15, repeat in PM. Ensure creatinine and electrolytes within standard range for that patient (i.e. baseline Cr in the setting of CKD).

*Culture change* – Ensure that all the nurses and allied health team members understand the initiative to get well patients home on POD 1 and that we all send the same clear message.

The above does not apply to patients who are clinically not ready for discharge including but not limited to: those with nausea, vomiting, pain not under control, abnormal vitals, concerning abdominal examination, abnormal lab work, comorbidities that preclude their discharge.

**Inpatient Bypass Management :** ( Not for revision pts)

*Pain Management* : As above for the sleeve except do not transition to PO tylenol/oxycodone until the patient taking Stage 2 diet.

*Gastrointestinal* – Sips only starting in PACU. Stage 1 starting on arrival to floor, transition to Stage 2 in AM of POD 1 if stage 1 tolerated. Requirement for discharge based on total PO intake of 500cc on POD 1.

Anti Nausea: Scopolamine patch to be placed in PACU before case. It should not be ordered if the patient has a history of urinary retention and should be discontinued postop if the patient develops urinary retention

-Dexamethasone 4mg can be considered for high risk patients

*Genitourinary* –LR IV at 100cc/hr to be continued through end of POD 1.

Hematology – Standard inpatient prophylaxis with heparin depending on BMI. For those patients who may need home anticoagulation, these patients could likely be identified pre-operatively so that everyone including the patient is aware and this could expedite POD 1 teaching in the morning and limit this as a reason for not discharging the patient. Patients with a BMI > 50 will receive extended prophylaxis of 60 q.d. Other indications for prolonged prophylaxis include: Personal history of VTEs, impaired mobility, and underlying malignancy.

*Lab work* - Standard CBC and BMP in AM. If HCT drops greater than 6, and WBC greater than 15, repeat in PM. Ensure creatinine and electrolytes within standard range for that patient (i.e. baseline Cr in the setting of CKD).

*Disposition*: Expected day of dc is POD1, but exceptions are made on a case by case basis.

**Medication Guidelines for Sleeves/Bypass pts post discharge:**

Hold ACEI at discharge and have the patient follow up with their PCP ( unless its a CHF patient or directed to do otherwise by Chief/Attending)

Begin chewable multivitamin and VIT D when transitioned to Stage 3A diet.

Esomeprazole 20mg po qd (open capsule) x 30 days, or preop dose of PPI if home med.

Transition all ER meds to IR formulation or elixirs, ( See Bariatric Pharmacy Guidelines)

NSAIDS and tylenol: Ok to tell sleeve pts to take perioperatively.

NSAIDS should be avoided for all gastric bypass patients postop and not used for chronic longterm use to reduce the marginal ulcer risk

Zofran 4 mg po q 6 hrs prn for Sheu pts, give 5 tabs. Do not discharge Vernon or Robinson pts on Zofran, if these pts are having recurrent nausea, they likely are not ready for dc.

OCP should not be resumed for 1 month postop.

Medications to discuss with chief/fellow:

Diuretics -> most discharge on 1/2 of home dose

Immunomodulators -> Remicade, Humira etc

Anticoagulation

Hormonal therapy -> Tamoxifen

Steroids