UCSD MEDICAL GROUP & CLINICAL GUIDELINES

DIAGNOSIS
Operative Splenic Injury

CASE MANAGEMENT GOALS
Coordinate care and anticipate future needs. Monitor daily progress. Assist with determination of treatment plan. Anticipate needs to discharge. Aid in transition to home or care facility.

PREADMISSION
ATLS protocol, work-up as mechanism and presentation dictate. Head CT as indicated. Rule out pelvic fracture if indicated. Abdominal ultrasound/diagnostic peritoneal lavage/CAT scan. Labs: ABG, Hgb, type and cross.

PREOPERATIVE
ACUTE

RECOVERY FACILITY
Dependent on needs at discharge (hove vs. SNF vs. rehabilitation).

HOME
Regular diet. Activity as tolerated based on associated injuries. Follow-up in clinic. May require home health follow-up.

DAY 1
SICU/IMU monitoring, CBC, chemistries as indicated. NPO, IV fluids. NGT to suction. OOB to chair, ambulate if associated injuries permit. Complete work-up as indicated. Venodynes. Pulmonary toilet.

DAY 2
IMU/Floor monitoring, CBC, chemistries as indicated. NPO, IV fluids. Pulmonary toilet. OOB to chair, ambulate as tolerated. NGT suction/gravity drainage. Discontinue Foley. Venodynes.
DAY 3
IMU/Floor monitoring, pulmonary toilet/OOB/ambulate. NGT gravity drainage vs. discontinue. Sips as tolerated if NGT discontinued. Discontinue arterial line. Venodynes. Teach patient/family wound care if indicated.

DAY 4
Floor monitoring. Advance diet. Continue pulmonary toilet.

DAY 5
Discharge.

GOAL LENGTH OF STAY
Five days. Exceptions: Associated injuries requiring additional treatment. Postoperative complications. Clinic follow-up: Routine postoperative or as associated injuries dictate.

KEY OUTCOMES