

## Fetoscopic MMC Repair Post-op

### POD #0

#### IV Fluids

- Strict I/O's, including preop and intraoperative should be recorded
- Depending on amount of magnesium sulfate needed postop, fluid restriction may be needed (due to risk of pulmonary edema)

#### Magnesium sulfate

- 6g load in OR, then 3g/hr in OR
- Continue at 3g/hr for first 4-6 hours unless s/s of magnesium toxicity
- Consider adjusting to uterine activity (<2 ctx/10min) and magnesium levels from lab
  - Would expect patient to be on 2-2.5g/hr by 12 hours postop
- Mag should be continued for a total of 24 hours
- Check mag levels every 8 hours
  
- **IMPORTANT ISSUES**
  - Watch pulse ox and exam for signs of pulm edema
  - Watch urine output, magnesium levels rise as urine output falls
  - Watch for signs of mag toxicity (slurred speech, visual changes (blurred/double vision, respiratory depression, hypoxia, absent reflexes, arrhythmias)
  - Incentive spirometry should be used to improve lung recruitment and decrease pulm edema/atelectasis risk

#### Indomethacin

- 50mg preoperatively
- 50mg rectally q6h for 3 additional doses (4 total doses)

#### Antibiotics

- 2g ancef or 900 mg clindamycin + 5mg/kg gentamicin preoperatively
- Postop: 2g ancef (or 900mg clindamycin) q8h for a total of 24 hours

#### Pain management

- Epidural PCEA
- Scheduled Tylenol 1000mg q6h

#### Drains

- Foley

#### Surveillance

- Continuous toco

- FHR monitoring is dependent upon the preoperative decisions of the family. If the family does not desire fetal monitoring for cesarean for distress, FHR checks every 4-6 hours

#### Bowel regimen

- Colace 100mg BID

#### Diet

- NPO except meds

#### Activity

- Bed rest and bilateral lower extremity compression boots

### **POD #1**

#### IVF

- Total IVF restricted to 100 cc/hr with strict I/Os

#### Magnesium sulfate

- Generally, discontinue after total of 24 hours unless persistent palpable contractions

#### Nifedipine

- Start IR nifedipine 20mg q6h at 60-90 minutes after discontinuation of the magnesium. If maternal SBP <95 can use 10mg q6h, or if patient does not tolerate 20mg, can down titrate.
- If contractions remain palpable and persistent on the 6-hour dosing, can increase frequency to q4h.

#### Indomethacin

- After completion of 50mg x4 doses, start 25mg orally every 6 hours (first dose 6 hours from last dose of 50mg) for an additional 4 doses (24 hours).

#### Progesterone

- Start vaginal progesterone 200mg vaginally nightly

#### Antibiotics

- Discontinue

#### Pain management

- Epidural PCEA
- Scheduled Tylenol 1000mg q8h

#### Drains

- Foley with strict I/Os

#### Surveillance

- Continuous toco. FHR monitoring individualized based upon patient's desires for intervention. Minimum of FHR checks q4-6 hours.
- US for fetal and fluid assessment.

#### Activity

- Bed rest and bilateral lower extremity compression boots

#### Bowel regimen

- Colace 100mg BID

#### Diet

- Clears

#### **Key Points:**

- Mag discontinued after total of 24 hours
- Nifedipine to start **no sooner than** 60-90 minutes after stopping mag (due to cardiopulmonary risk of nifedipine + mag)
- Indomethacin decreased to 25mg

## **POD #2**

#### IVF

- Discontinue if tolerating clears

#### Nifedipine

- Start IR nifedipine 20mg q6h at 60-90 minutes after discontinuation of the magnesium. If maternal SBP <95 can use 10mg q6h, or if patient does not tolerate 20mg, can down titrate.
- If contractions remain palpable and persistent on the 6-hour dosing, can increase frequency to q4h.

#### Indomethacin

- After completion of 50mg x4 doses, start 25mg orally every 6 hours (first dose 6 hours from last dose of 50mg) for an additional 4 doses (24 hours).

#### Antibiotics

- Discontinue

#### Pain management

- Epidural PCEA to be discontinued
- Scheduled Tylenol 1000mg q8h

#### Drains

- Foley with strict I/Os. Can be discontinued after Epidural PCEA

#### Surveillance

- Continuous toco. FHR monitoring individualized based upon patient's desires for intervention. Minimum of FHR checks q4-6 hours.

#### Activity

- Bilateral lower leg compression boots should be continued when in bed. After epidural has been discontinued and Foley catheter removed, the patient should begin progressive mobilization, usually starting with sitting up in bed for several hours, followed by sitting on edge of bed and dangling legs and eventually when ready walking to the bathroom with assistance.

#### Bowel regimen

- Colace 100mg BID

#### Diet

- Advance as tolerated

#### **Key Points:**

- Patients commonly experienced dizziness and palpitations during the first one to two weeks of nifedipine treatment. As such, need to be aware of this when initiating mobilization on POD #2.
- Be aware of the risk for constipation
- DC epidural

### **POD #3**

#### IVF

- Hep-locked

#### Nifedipine

- Nifedipine dose continues at 20 mg every six hours or 10 mg every six hours if maternal systolic BP <95. Nifedipine dose can be increased to every four hours if palpable contractions are documented on the every six hours dosing

#### Indomethacin

- discontinued

#### Pain management

- Oxycodone PRN
- Scheduled Tylenol 1000mg q8h

#### Surveillance

- Toco based upon RN palpation of uterus and patient complaints.
- FHR monitoring individualized based upon patient's desires for intervention. If desiring intervention, BID NST. Minimum of FHR checks q shift.
- US for fetal and fluid assessment.

#### Activity

- bilateral lower leg compression boots should be continued when in bed. Expectation would be the patient is walking to the bathroom without assistance by end of the day. Patient may also shower if using a shower chair and someone should be available to assist if necessary.

#### Bowel regimen

- Colace 100mg BID (add additional medication PRN)

#### Diet

- Regular

#### **Key Points:**

- Patients commonly experienced dizziness and palpitations during the first one to two weeks of nifedipine treatment. As such, need to be aware of this when patient begins to walk to the bathroom and during showers.
- Start to coordinate housing plan for next day's discharge. If the patient desires, they can have a wheelchair, begin working on that arrangement if the patient desires.

## **POD #4**

#### Nifedipine

- Nifedipine dose continues at 20 mg every six hours or 10 mg every six hours if maternal systolic BP <95. Nifedipine dose can be increased to every four hours if palpable contractions are documented on the every six hours dosing

#### Pain management

- Oxycodone PRN
- Scheduled Tylenol 1000mg q8h

#### Surveillance

- Toco based upon RN palpation of uterus and patient complaints.

- FHR monitoring individualized based upon patient's desires for intervention. If desiring intervention, BID NST. Minimum of FHR checks q shift.

Activity

- Patient should be walking independently prior to discharge.

Bowel regimen

- Colace 100mg BID (add additional medication PRN)

Diet

- Regular

**Key Points:**

- Anticipated Day of Discharge, but patient must be contraction free, on regular diet, in good pain control, ambulating without assistance, has at least passed flatus, has a normal ultrasound evaluation and has a support person and housing arranged.
- Patient should be discharged with prescriptions for oral pain meds, nifedipine, a daily prenatal vitamin, iron if anemic, and colace (100 mg twice daily) for two weeks.
- Patient needs to be scheduled for weekly follow-up ultrasound and prenatal visits.