VANDERBILT UNIVERSITY MEDICAL CENTER

Surgical Intensive Care Unit

Liver Transplant Pathway

All liver transplant patients will be cared for by a SICU NP and Attending as the critical care consultant team. Communication will be made through the SICU NP to the liver transplant chief resident or fellow as appropriate. Any pertinent changes to the status of the liver transplant patient will also be communicated to the SICU attending.

The Liver Transplant team is responsible for entering all orders pertaining to immunosuppression and antibiotics pertaining to immunosuppressive therapy.

The SICU team will be responsible for all other order entry.

Hours 0-24	Hours 24-48	Transfer
ICU Admission: *Labs Q6H x24 hrs (CBC, BMP, Ca, Mg, Phos, LFTs, INR, ABGs/lactate, fibrinogen if coagulopathic) *CXR for ETT and line placement if applicable *Neuro:* *Wean sedation if hemodynamically normal *If extubated, ensure adequate pain control with PRN oxycodone/Dilaudid initially; discuss with liver transplant team before adding low dose Tylenol or other adjuncts *Cardiovascular:* *MAP>55 *Monitor CVP >8 and <15 *Respiratory:* *Ventilator per SICU protocol *SBT if HDS *Consider extubation if HDS *Once extubated, ensure incentive spirometer at bedside *FEN, GI and endocrine:*SICU NP to replace electrolytes as needed *MIVF – Plasmalyte @75ml/h D10W @30ml/hr	*Neuro:* *Goal RASS *Continue oxycodone PRN with Dilaudid for breakthrough (d/c dilaudid if possible) *Tylenol 500mg Q6H scheduled per liver transplant team *Cardiovascular:* *MAP>55 *Consider restarting home antihypertensives or amlodipine 2.5-10mg Qday (if not taking antihypertensives at home) for SBP>160, unless hypervolemic and then consider diuresis *Respiratory:* *Supplemental O2 for SpO2 >92% *Pulmonary toilet including IS/DB Q1H *FEN/GI:* *SICU NP to replace electrolytes as needed *SLIVF unless NPO *Daily labs *Daily weight *Strict I/O *Evaluate need to start diuresis based on fluid status; always in	*When to Transfer to Floor status:* *Hemodynamic stability *Stable O2 requirement *Able to clear secretions *Discontinuation of invasive monitoring *Non-combative/cooperative

*NPO until cleared by liver transplant team*SICU insulin infusion protocol *Renal:* *Maintain Foley catheter in place *ID:* *Immunosuppression per HBS team *PCP, CMV and fungal prophylaxis per HBS team *Musculoskeletal:* *PT/OT consult *SICU early mobility protocol *Prophylaxis*: *Ensure appropriate stress ulcer prophylaxis *No chemical DVT prophylaxis until platelets >100 and approved by liver transplant team *Bowel regimen with docusate/senna BID *Tubes/Lines/Drains:* *All IV access to remain in place *JP drain management per liver transplant team *Transfusion triggers:* *Per HBS team *When to notify primary team:* *Vasopressors are started or increased *Increasing lactate/LFTs *When blood product transfusion may be warranted based on either labs or hemodynamics	consultation with liver transplant team *Continue advancing diet per liver transplant team; consider adding oral nutritional supplement *Renal:* *Consider removal of Foley if not already done *Monitor for AKI and renally dose medications as appropriate*ID:* *Immunosuppression per HBS team *PCP, CMV and fungal prophylaxis per HBS team *Endocrine:* *Transition to SSI once taking PO and if appropriate. Consider consult to endocrine service if indicated. *Restart home insulin regimen if indicated *Musculoskeletal:* *SICU early mobility protocol *Prophylaxis*: *Ensure appropriate stress ulcer prophylaxis *No chemical DVT prophylaxis until platelets >100 and approved by liver transplant team *Bowel regimen with docusate/senna BID; if no BM at this point, consider adding Miralax daily *Tubes/Lines/Drains:* *Removal of all extraneous access; removal of arterial line if no need for ongoing beat-to-beat hemodynamic monitoring; preferential removal of MAC central line first; removal of remaining central access when two adequate PIVs obtained *JP drains per liver transplant team	

Revised June 1, 2021:

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Approved: June 1, 2021