INFECTION REDUCTION RELATED PROTOCOLS:

I. Pre-operative:
1. Weight reduction
   - If obese or above baseline weight, refer to weight loss clinic (Mary Huizinga 3-1529)
   - Council regarding daily routine walking 30 min to 1 hour
2. Smoking cessation
   - Pre-op IS for smokers +/- MDI
   - Prescribe Chantix and/or patch X 1 month prior to OR
   - goal of total abstinence for 3 weeks prior to OR
   - perform urine test for compliance in office prior to OR
3. Hibiclens shower the morning of OR
4. Bowel preparation for those patients undergoing abdominal or colon surgery
   a. Ventral Hernia (No STSG)
      i. Clears x 1 day
      ii. Mechanical Bowel Prep
         - Bottle of magnesium citrate the afternoon prior to surgery
   b. Planned Ventral with STSG
      i. Clears for 1-2 days
      ii. Mechanical bowel prep
         - Bottle of magnesium citrate the afternoon prior to surgery
   c. Large Bowel Procedure
      i. Clears for 1 -2 days
      ii. Mechanical bowel prep
         - 2 bottles of magnesium citrate the afternoon prior to surgery
         - Fleets Sodium phosphate enema the pm before OR
      iii. Oral antibiotics for low rectal anastomosis
5. Previous MRSA infection or colonization:
   a. Mupirocin (Bactroban) nasal ointment, available by prescription, is used to eliminate bacteria from the nose. A small amount should be squeezed onto a cotton swab applicator (Q-tip), and rubbed in a circular motion into the inside of one nostril. This should then be repeated with a clean cotton swab on the other nostril. Ointment should be applied twice a day (morning and night) for 7 days.
   b. To get rid of staph from the skin, an over-the-counter chlorhexidine soap (like Hibiclens) should be used in the bath or shower twice a day for seven days. It is important to do this during the same week as the antibacterial ointment is used in the nose. The liquid chlorhexidine soap should be applied to the enter body with a washcloth to insure all skin surfaces are treated.
   c. In addition to the chlorhexidine showers, bathing in bleach has been reported to be effective. Take ½ cup of bleach, and add to a full bath. Soak for 15 minutes. This should be done twice during the same week as the nasal ointment is used.
   d. Consider rifampin (300 mg twice daily) and doxycycline (100 mg twice daily) for 7 days

II. Perioperative:
1. Peri-op Antibiotics
   i. Clean – none
   ii. Clean + implant – ancef 2 gms or levaquin 500 mgs(Pen allergy)
   iii. Elective Biliary – 2 gms cefoxitin
   iv. Elective Bowel or ECF Case – Invanz 1 gm(Levaquin 500mg /flagy 500mg for Pen allergy)
   v. Add Vancomycin 1 gm for known history of MRSA wound infection or colonization
2. Peri-op preparation

i. Hair removal with clippers
ii. ChloraPrep (or Hibiclens when alcohol contraindicated)
iii. Rectal irrigation for colostomy takedown (NS +/- Betadine)
- Rigid sigmoidoscopy to document length, rule out stricture
- Consider foley placement to assist in identifying stump

3. Operative
i. Maintenance of normothermia (36.5C or above) with
- Warm fluids
- Blankets in holding area
- Elevate room temperature
- Bear Hugger
- Warm vent gases

ii. Closed suction drains for large potential space or fluid collections
iii. Pulse irrigation
- All patients with significant flaps, obesity, contamination, prosthetic insertion
- 6 liters with PulseEvac
- ¼% Dacons solution

iii. Utilize PDS Plus, Vicryl Plus, Monocryl Plus sutures when non-absorbable sutures are appropriate (antiseptic eluting)
iv. If fluid collections are likely, place closed suction drains
v. Betadine gel in wound
- Consider for patients with significant obesity, clean/contaminated cases

vi. Silverlon dressings for contaminated or clean-contaminated cases

<u>Measures for future collaboration with anesthesia:</u>

1. Use of 80% supplemental oxygen
2. Glucose control
- to be measured and determined by collaboration with anesthesia

PREOPERATIVE EVALUATION OF CARDIOPULMONARY RISK AND GASTROINTESTINAL INTEGRITY

I. Pre-operative Workup
   1. Cardiac
      i. EKG within 6 months (age> 45)
      ii. Stress Test vs. Stress ECHO for patients with cardiac risk,
      iii. Cardiology Consult for high risk (Recent AMI in 6 months, Pacer, AICD)
   2. Respiratory
      i. CXR – basic general anesthesia (min. 6 mons.)
      ii. PFT & ABG - Hx. of smoking, COPD, ARDS, VAP
   3. GI
      i. Document Rectal exam and tone
      ii. Prior to Major Abdominal Surgery & Ostomy takedown
         - Barium enema for all ostomy takedowns
         - plus coloscopy for diverticulosis, history of cancer, and age >50
         - Fistula gram for ECF
         - Ostomy takedown after pelvic fracture with sacral fracture component
            - Consider ureteral stents for colostomy takedown
            - Consider Anal Monametry prior to osotomy takedown (Christopher Lind, MD – GI)
         - Consider Rectal Training after prolong colostomy period (> 12mons), sacral plexus injury after pelvic fracture, documented proctitis of disuse on colonoscopy
            - Retention enemas for 1 month prior to surgery
   4. Ventral Hernia
      i. CT scan abdomen/pelvis for planning of reconstruction (within 6 months of planned surgery)
      ii. Consider repeat CT scan to rule out on going inflammatory process.
         - IBD
         - resolving pancreatitis
         - IAA
   5. Labs
      i. Basic – no significant medical history
         - CBC, BMP
      ii. Moderate level of Case
         - CBC, CMP, PT/PTT
      iii. Major Case
         - CBC, CMP, PT/PTT, Pre-op ABG, T&S

II. Pre-op Scheduling
   1. VPEC scheduling
      i. if co-morbid conditions, advanced age, high risk
      ii. Minor Surgery (ie. MAC anesthesia)
         - No VPEC
      iii. Major Surgery (ie. General Anesthesia => VPEC)
         - VPEC
   2. Scheduling Request considerations
      i. Epidural for pain
      ii. Pulse irrigation
      iii. Positioning
      iv. Post-op destination
      v. Isolation
      vi. Biologic or Prosthetic materials