

Patient Management Protocols

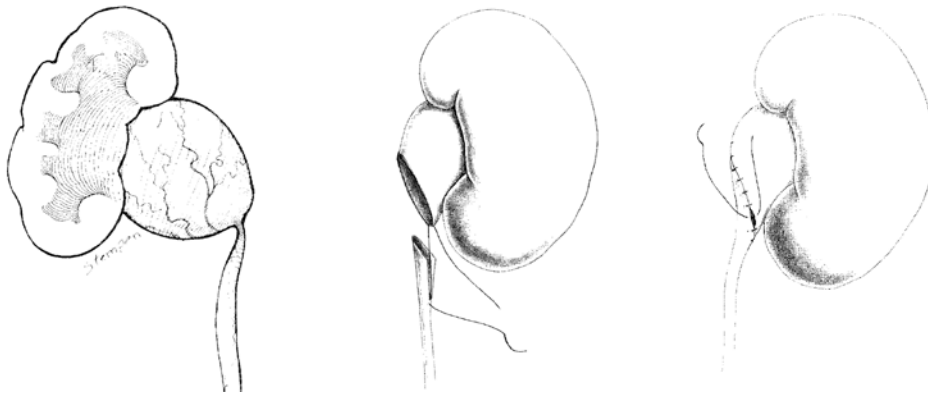
UC Davis Children's Hospital

[Pediatric Urologic Surgery Program - Pveloplasty](#)

This pathway is for educational and guideline purposes only. The orders should take precedence.

Background

This child had a surgery to reconstruct the attachment of the ureter to the renal pelvis. This is done for obstruction. This can cause kidney damage, stones or infection. We do not enter the peritoneal cavity during this surgery.



INPATIENT MANAGEMENT PROTOCOL AND EXPECTATIONS

Length of Stay: most children under age 5 years stay 24hrs. Older children between one and two days.

Diet/Nutrition: Patients can resume a normal diet immediately after surgery. Nausea and emesis is uncommon and usually occurs within 6 hours of surgery secondary to anesthesia. If this occurs, the house staff should be notified. An antiemetic can be prescribed if a more severe abdominal cause has been ruled out. Even with adequate oral intake, maintenance IVF should be continued until discharge to promote brisk urine output, which prevents clots in the bladder.

Pain: The patient should be comfortable with pain scores less than 3/10. We commonly use Toradol every 6hrs and Ditropan every 8hrs. Hycet or Tyl/Cod is prescribed for breakthrough pain. The most common complaint is "I have to pee". Most patients have a sense of urgency and/or bladder fullness despite the bladder being empty (assuming the foley is functioning). Bladder spasms are lessened with Toradol and Ditropan but not completely. If the complaint is frequent and/or severe, the house staff should be notified and bladder irrigation considered to rule out a foley clog due to blood clot.

Foley: The catheter should be secured to the patient's leg with tape. This should be checked each time the bag is emptied. We expect the urine to be clear or pink. If the urine is deep red or the clots are large, the house staff should be notified.

Penrose drain: this drain is outside the kidney to allow any leakage of urine to get out of the retroperitoneal space. The output is usually yellow or pink. The dressing will be damp to soaked for the first 24hrs and usually needs to be changed every 6hrs. If urine is pouring out and the dressing needs change every 2 hours, please call house staff.

Nephrostomy tube: this is placed inside the kidney and sometimes down the ureter. It is sewn to the skin and should have tape securing the catheter also. Most often this drain is placed between two diapers and for older children to a bag.

Activity: We prefer patients to stay in bed. The order should be for "bedrest". The length of stay is usually one day so ambulation is not necessary. Ambulation will often stimulate bladder irritation from the catheter. If a child insists on getting up, this is allowable.

DISCHARGE CRITERIA:

Tolerating liquids

No fever

Pain scale less than or equal to 3/10

DISCHARGE INSTRUCTIONS:

Diet: Regular

Activity: advance as tolerated, no strenuous activity or PE for 4 weeks

Wound care: if penrose present, then dressing changes prn wetness; if nephrostomy tube, drain to double diaper and ensure catheter is secured to skin with tape

Bathing: if penrose or nephrostomy tube, then sponge bath only until drain is removed

Medications: Hycet, Tylenol or Ibuprofen prn

Follow up: Pediatric Urology for drain removal (if present) or O.R. date for internal stent removal