Practice Bariatric Case Study - Postoperative Assessment

Directions: This case study will be used to reinforce the variables and definitions presented in this module. Answer the Case Study test questions using this case study. Remember to apply the variable definitions when answering the test questions.

Patient: Nita Case
IDN: 123-45-6789
DOB: 9/8/1953
Date of Operation: 2/28/13
Surgery start: 10:24
Surgery end: 14:00

Procedure: Laparoscopic Roux-en-Y

Postop Progress Notes

2/28/13 20:15 - PACU Resident note

2/28/13 22:15 - Surgical Resident Note

3/1/13 06:30 - Surgical Resident Note
A/P: Routine swallow study ordered today per Dr. Smith. Check Hct this am and labs/lytes. Follow JP output. Ambulate today.

3/1/13 08:00 - Surgical Attending
- Ambulate
- Swallow study - if no leak, no obstruction then will start stage I diet.
- Check labs

3/1/13 19:30 - Nursing Note
Skin: Dressing changed by surgeon. JP dressing stained with serosanguinous drainage.
Gastric Bypass diet stage 1 started after barium swallow showed no leak.

3/1/13 23:30 - Surgery Cross-coverage Note
Called to assess 59 y/o female, POD 1 status post Lap RNY for fever to 103.8. Pt c/o epigastric pain, worse with movement. She has not been using the incentive spirometry. She has had asthma and requires CPAP at home. T 103.8, HR 94, BP 108/52, RR 15, O2 sat 95% on 2Litters nasal cannula.

Gen: fatigued, morbidly obese female Chest: coarse rales R > L on anterior exam CV: RRR, normal S1/S2

Abd: soft, diffuse tenderness all 4 quadrants, no rebound/guarding

Wounds: Removed dressing, (+) serosanguinous drainage, but no erythema, no pus, no tenderness

Ext: no calf tenderness/palpable cord, Homan’s (-)

A/P: 59 y/o female status post lap RNY with postop fever. Most likely cause is atelectasis, PMH of asthma and CPAP and lack of Incentive Spirometer use, however must also consider pneumonia. Wounds show no evidence of infection. No DVT suggested on exam. Send stat CBC w/ diff, lytes, blood & urine cultures and U/A. CXR ASAP, Tylenol for fever, incentive spirometer, Chest PT, cough & deep breath.

3/2/13 06:00 - Nursing Note

On PCA Dilaudid w/ good relief of pain. Tmax 103.8. House Officer notified. CXR done, blood work and cultures sent. Encourage incentive spirometer, cough and deep breathing, Tylenol x 1. Temp now 99.8. JP with scant serosanguinous drainage. Other VSS.

3/2/13 06:00 - Surgical Resident Note

Some c/o nausea. No emesis. Reports no flatus.


Abd: soft, nondistended, wounds with no s/s of infection. Ext: no edema


3/2/13 08:00 - Attending Note

Tmax 103.8. No n/v. Tolerating sips. Swallow study no leak, no obstruction

Abd: benign

WBC 18.7; Hct 27


3/3/13 06:00 - Surgical Resident Note

Tmax 101.6, now 99.8- 110/53- 95% room air. Abd: soft, non-tender, non-distended. One trocar site with sang stained dressing.

A/P: s/p lap RNY, check coags, lytes, CBC, f/u cx.

3/3/13 06:00 - Attending Note

T 101.6 this a.m.

No symptoms localized. No n/v. Tolerating stage 1 diet. UA/Urine Culture pending, CXR (-), blood culture pending.

Hct 22.6 Transfusions x 2. Recheck Hct.

Fever: will check abd/pelvic CT. Must use gastrographin po for study. NPO until after CT. Await urine results.

3/3/13 - Blood Bank

Blood transfusions. 2 units PRBCs transfused. First unit started at 1600 and second unit started at 2130.
3/4/13  06:00 - Surgical Resident Note
S: reports feeling well this a.m. Transfusions made her feel better.
O: Temp 100.7 yesterday afternoon. Now 99.1. 94 119/59 20 96% Abd: soft nontender, non-distended.
JP-Drain serosanguinous.
Urine Culture (-).
A/P: POD 4 s/p Lap RNY. Will check lytes and CBC.

3/4/13  08:00 - Attending Note
Tmax 100.7 88% room air.
Feels well. Looks well. No n/v.
Hct dropped to 22 yesterday. Transfused x 2 u PRBC.
Abd/Pelvic CT: small amount blood, no evidence of leak or obstruction
Plan: full liquid diet, ambulate > 4x/day. Check Hct.

3/5/13  06:00 - Surgical Resident Note
Pain controlled. No n/v.
Tmax 99.4 -116/55 -83 -96% on room air. Hct - 31
Abd: soft, non-tender, non-distended, incisions c/d/i. JP site c/d/i.
A/P: check labs in a.m., continue stage 2 diet, if labs okay, d/c home with JP in place.

3/6/13 - Discharge Summary
Principal Diagnosis: s/p laparoscopic RNY for morbid obesity
Associated diagnoses: Diabetes, HTN, Asthma, obstructive sleep apnea, GERD
Operations and procedures: laparoscopic RNY
Allergies: IV contrast

History and reason for hospitalization and significant findings
HPI: Preoperative for laparoscopic Roux-en-Y gastric bypass with wedge liver biopsy. She has been doing well. No fevers or chills. No nausea or vomiting. No recent illnesses. She has seen Dr. Jones with regards to her essential thrombocythemia. His recommendations include perioperative Lovenox and resumption of her aspirin soon after the operation. Comorbid conditions otherwise unchanged.

PE:
Chest: clear to auscultation.
Heart: regular rate and rhythm.
Abdomen: soft, nontender with a well healed right upper quadrant incision, which extends her entire right upper quadrant, Kocher type, and an infraumbilical trocar site from a tubal ligation. No hernia is palpated. Extremities: with no edema. Pulses 2+.
Her preadmission testing labs were reviewed. Her platelet count was 592,000.

Admission labs and other studies
2/28/13 – Iron 102, TIBC 338, Ferritin 128
2/10/13 – Hct 36.1, WBC 9.9, Plt 592 (h), Sodium 139, Potassium 4.3, Chloride 101, CO2 29.7, BUN 30 (h), Creatinine 1.1, Glucose 136 (h), Alb 4.9

Hospital course and treatment
Patient taken to the OR and underwent laparoscopic Roux-en-Y gastric bypass on 2/28/13. Please see the separately dictated operative report for details of the procedure. Postop the patient did well. Vital signs remained stable. Mobilized OOB and ambulated first postop night. Pain well controlled with PCA Dilaudid, transitions over to PO pain medication when tolerating diet. POD 1 swallow study indicated contrast passing easily through the esophagus, into the gastric pouch and into the Roux limb. Sips of Stage 1GBP diet started and tolerated. The patient then had a drop in Hct on POD 3. She was CT scanned emergently and transfused 2 units PRBC. CT scan showed a hematoma so lovenox and ASA were stopped. She also had a temp elevation to 103.8. WBC 11.7. She was able to void with no problems. By POD 4 she was doing better and was advance to a stage 2 diet. Her pain was well controlled with PO pain med and she was deemed ready for discharge to home.

**Most recent labs and other studies**

3/3/13 – Abd CT – s/p gastric bypass. 1. No evidence of anastomotic leak identified. No evidence of contrast within the excluded portion of the stomach. 2. Moderate intra-abdominal hematoma seen adjacent to the gastrojejunostomy site and extending into the lesser sac. A small amount of blood is also noted within the pelvis. 3. Small bibasilaratelectasis.

3/1/13 – Barium Swallow – no evidence of extravasation or obstruction.

**Condition of discharge:** stable

**Discharge medications:** levothyroxine, lisinopril, advair, dilaudid, prilosec. Also atenolol for 1 month per bariatric protocol.

**3/13/13 - Bariatric Surgery – 1 week postop visit**

Ms. Olsen is 1 week s/p Lap RNY for morbid obesity, HTN, GERD, sleep apnea. She is feeling fatigued and not wanting to eat much. Reporting some incisional pain when moving ‘a certain way’. VSS. She is tolerating a Stage III diet with minimal dumping and no n/v. Trocar incisions-left quadrant site with small amount of pus and minimal opening at right corner. Upon inspection appears to be superficial. Will start on po Keflex for superficial infection. Sites cleansed. Instructed on wound care. Other trocar sites healing well and no signs of infection. JP drain with very small amt drainage – d/c’d. Site w/out s/s of infection. Pt to come to Bariatric Center for f/u on 3/30/13.

John Smith, MD

**03/30/13 - Bariatric Center Post-Surgery Visit**

**Height:** 64 Inches  
**Preop Weight:** 273 lbs  
**BMI:** about 45  
**Today’s Weight:** 234 lbs  
**Wt loss to date:** 39 lbs  
**Date of surgery:** 2/28/2013  
**Surgeon:** Smith  
**Type of Surgery:** Lap roux-en-y gastric bypass  
**Complications:** Needed 2 units of blood post op  
**Liver Biopsy:** Moderate steatosis with mild ballooning degeneration predominantly in zone three. Extra Medullary Hematopoiesis. Note: No iron or d-pas globules are seen. Trichrome
stain reveals minimal sinusoidal fibrosis. The extra medullary hematopoiesis is consistent with the history of essential cythemia.
- Just started the aspirin. Ecotrin.
- Was sent home without ASA or lovenox because of low HCT and hematoma on CT, question bleeding.
- Feels fatigued, not wanting to eat much, eats by the clock, wants to be curled up into a ball. Legs feel heavy, walks shuffling, head is heavy and lightheaded (not orthostatic not vertiginous).
- Eating protein ok: cottage cheese, eggs, and fish.
- Food adversions to meat.

**Tolerance of foods, N/V/dumping sx:** dumping x1. **Protein sources/intake:** eggs, cottage cheese, fish

**Hunger/satiety:** no hunger fills quickly. **Constipation/diarrhea:** no

**Hydration:** Fluid intake: 48 oz. **Lightheaded?** Yes **Urine dark?** No

**Abdominal pain or sx suggestion ulcer, stenosis, hernia, or gallstones:** No

**Legs/VTE sx:** No LE swelling, pain, erythema, numbness/tingles; no SOB, CP, pleuritic symptoms

**Exercise:** walking every day

**Excess skin complications** (1 yr and after); no

**PMH r/t obesity complications:**

**Obesity:** Gastric bypass 2/28/13.

**Hepatic:** Fatty liver by biopsy done with GBP.


**Respiratory:** Asthma: Advair 250 bid. Sleep apnea. Had sleep study 1/3/2012; Index 11 (more during REM), desat nadir 66. Did not tolerate CPAP at sleep study. Now is able to tolerate CPAP.

**GI:** GERD/HH. Prilosec 40 started in 6/11, symptoms now resolved on medication. Occasional dysphagia when not chewing well.

**MS:** Ankle swelling, related to Achilles tendonitis from injury 2008.

**Nutrition:** Vitamin D deficiency. Now taking MVI and 1000 mg of calcium daily. She has had bone density.

**Other PMH/PSH:**

**ENT:** Environmental allergies

**Endocrine:** Hypothyroidism 2004 Levothyroxine 75.

**Hematology:** Essential Thrombocytethemia (had earlier dx of Polycythemia Vera, but, per Dr. Jones, only essential thrombocytopenia now) Anagrelide in the past. ASA 81 qd. Enlarged spleen.

**GI:** Esophageal spasm. Occasional pain/dysphagia. UGI was normal. No symptoms since surgery.

**Medications:** Lisinopril 10, Atenolol 50, levothyroxine 75, ASA 81, Prilosec 40, MVI, Viactiv 3 a day, Advair 250 bid

**Med Allergies** Contrast dye Æ asthma attack, throat close, eyes swelled

**Family History**

CAD: Father had MI and died from it at age 72

DM: uncle aunt grandmother
HTN: Mother
Stroke: Mother at 45 “caused by blood pressure”
Cancer: Brother
DVT/PE/clotting: Parent had DVT, Sister had clot when had a cast on leg, (Mother had stroke but may have been bleed, was told it was caused by high BP)

**Social History** Never tobacco. 2 wine per weekend ETOH. No recreational drugs. Married with 2 adult children. 4 grandchildren. Work: ICU Nurse

**ROS:**
Diabetes: No polyuria, no polydipsia, no blurry vision
Cardiovascular Disease: No CP w/ exertion, no DOE, no claudication
Liver Disease: No history or risk factors other than obesity
Skin: No rashes. No cellulitis.
Neuro: No headaches, no h/o head trauma correlated with obesity onset, no numbness/tingling, no seizures. Psychiatric: No depression, no anxiety
Genitourinary: No history of DVT/ PE, no varicose veins

**Cancer Screening:** PAP (yes) Mammography (yes) Colon (yes)

**PHYSICAL EXAM:**
BP: 122/56 (138/56) HR: 72 (90)
Gen: Appears well in NAD. Mood good.

Lungs: CTA
CV: RRR no murmur.
Abd: Soft, obese, NTND. Trocar incisions-left quadrant site with small amount of pus and minimal opening at right corner. Upon inspection appears to be superficial. No hernia. Extrem: No edema
Skin: No rashes.
Vitals: BP: 144/60 HR: 78 Neck circumference 14.75”

**ASSESSMENT AND RECOMMENDATIONS:**
- 59 yo female with preop BMI 45, s/p gastric bypass 2/28/2013, and complications of obesity complications as reviewed above. Lost 39 lb so far. Doing well.
- Multiple small meals, protein in each.
- Ok to increase calcium to 1500/day
- Sleep apnea. Continue CPAP.
- GERD: Recommend continuing PPI for now.
- ASA use: Has restarted.
- Discontinue atenolol per completion of hospital protocol.
- ID use: Recommend against NSAID use post-op INDEFINITELY to prevent anastomotic ulcers. If necessary, should be taken for short courses only and premedicate with a proton pump inhibitor.
- Nutritional supplements: As discussed in pre-op nutrition groups, patient is expected to remain on lifelong daily multivitamin and at least 1000mg of calcium, in 2 divided closes. These does may be adjusted subsequently.

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