Kidney Transplant Clinical Practice Guideline

Phase II: Post-Op Management

Original: 2017
Updated: 2018
Updated: 7/8/21

Timeline	Day of Surgery	Post-op Day 1	Post-op Day 2	Post-op Day 3	Post-op Days 4-7
Unit	**PICU**	**PICU/6 East**	**PICU/6 East**	**6 East**	**6 East**
Assessment & Monitoring	Vital Signs Post Procedure ICU: BP, HR, RR, CVP, every 30 min x6 hrs, then Q1H; Temp Q4H, Cardiac Monitor, Continuous Pulse Ox, Weigh QAM, Strict I&O Q 30 min x 6H, then QH	**PICU:** BP, HR, RR, Q1H; Temp Q4H, Cardiac Monitor, Continuous Pulse Ox, Weigh QAM, Strict I&O QH **6E:** Vital Signs Q4H, Strict I&O Q2H, Weight QAM	**PICU:** BP, HR, RR, Q2H; Temp Q4H, Cardiac Monitor, Continuous Pulse Ox, Weigh QAM, Strict I&O QH **6E:** Vital Signs Q4H, Strict I&O Q2H, Weight QAM	Vital Signs Q4H, Strict I&O Q2H, Weight QAM	Vital Signs Q4H, Strict I&O, Weight QAM
Laboratory	Draw Renal Function Panel, HHP and Heparin Assay at 1800, 0000, 0600, CBC with Diff QAM	Draw Renal Function Panel, Heparin Assay and CBC with Diff at 0600, 1800	Renal Function Panel, Tacrolimus (trough level), CBC with Diff *(Draw all labs at 0600)*	CMP (Don't draw RFP on day CMP drawn), Tacrolimus (trough level), Phosphorous, Uric Acid, UA Reflex to Culture, CBC with Diff *(Draw all labs at 0600)*	Renal Function Panel, Tacrolimus (trough level), CBC with Diff *(Draw all labs at 0600)*
Radiology	As medically indicated (Chest X-ray and US)	As medically indicated (Chest X-ray and US)			
Lines & Drains	**Foley Catheter:** To closed drainage. May flush with 5-10 ml NS PRN. If unable to flush or bladder distention identified, notify MD. **Art Line (as needed):** art line, continuous monitoring x 24 hrs then DC unless otherwise indicated **CVL (as needed)**	**Foley Catheter:** To closed drainage. May flush with 5-10 ml NS PRN. If unable to flush or bladder distention identified, notify MD. **Art Line (as needed):** art line, continuous monitoring x 24 hrs then DC unless otherwise indicated **CVL (as needed)**	**Foley Catheter:** To closed drainage. May flush with 5-10 ml NS PRN. If unable to flush or bladder distention identified, notify MD. **CVL (as needed)**	**Foley Catheter:** Remove POD #3 and as indicated by Transplant Surgeon *Observe and palpate bladder distention, or if suspected catheter obstruction, bladder scan.*	
IVF Therapy	**Art Line/CVL:** NS with 2 units/ml heparin IV continuous at 2 ml/hr **Insensible Loss Replacement:** D5 1/2NS **Urine Output Replacement:** (NS or 1/2NS) Replace urine output mL:mL every 30 min x6 hrs, then Q1H	**Art Line/CVL:** NS with 2 units/ml heparin IV continuous at 2 ml/hr **Insensible Loss Replacement:** D5 1/2NS **Urine Output Replacement:** (NS or 1/2NS) Replace urine output mL:mL Q1H for total 24 hours post-op	**Maintenance Fluids:** D5 1/2NS		
Nutrition/ GI	NPO	Advance Diet per Surgery Recommendations	Advance Diet per Surgery Recommendations *(Convert IV Meds to PO)*	Regular Diet	Regular Diet
Activity	Fall Risk Assessment per Nursing	Out of Bed at least 3 times daily and as tolerated	Out of Bed at least 3 times daily and as tolerated	Out of Bed at least 3 times daily and as tolerated	Out of Bed at least 3 times daily and as tolerated
Consults	Critical Care, Pharmacy	Physical Therapy			
Discharge Planning		Case Management *(Once trasferred to 6E)*	Case Management *(Once trasferred to 6E),* Pharmacy Education (If appropriate)	Pharmacy Education (If appropriate)	

See Medication Table and Discharge Box On Back

Medication Table

Medication	Dosage	Max Dose	Comments
Pediatric Dose: <35 kg | Adult Dose: >35 kg			
trimethoprim-sulfamethoxazole (Bactrim)	**Peds Dose**: 5 mg/kg PO suspension - Start POD 4 **Adult Dose**: 5 mg/kg PO tablet - Start POD 4	160 mg/dose	Give every Monday, Wednesday, Friday
morphine	0.05-0.1 mg/kg IV Q2H PRN pain	10 mg/dose	Discontinue if patient on PCA
hydrocodone -APAP (lortab, hycet liquid) (norco tablets)	0.05-0.2 mg/kg PO Q4H prn pain	10 mg hydrocodone-325 mg APAP per dose (based on hydrocodone component)	Not to exceed 75 mg/kg/day of APAP from all sources
oxycodone	0.1-0.2 mg/kg PO Q4H prn pain	10 mg/dose	
famotidine (Pepcid)	0.25 mg/kg IV Q12h	20 mg/dose	Convert to PO when no longer NPO
methylprednisolone (Solu-Medrol)	10 mg/kg IV x1 - Give POD 1	500 mg/dose	
prednisolone sodium phosphate (Orapred) **prednisone (Deltasone)**	**Peds Dose**: POD 2-3: 20 mg/m2 PO BID POD 4-6: 25 mg/m2 PO QAM POD 7-13: 15 mg/m2 PO QAM POD 14-20: 10 mg/m2 PO QAM POD 21-Ongoing: 5 mg/m2 PO QAM **Adult Dose**: POD 2-3: 30 mg PO BID POD 4-6: 40 mg PO QAM POD 7-13: 20 mg PO QAM POD 14-20: 10 mg PO QAM POD 21-Ongoing: 5 mg PO QAM	60 mg/day	
tacrolimus (Prograf)	0.1 mg/kg PO Q12H - Start POD 1	5 mg/dose	Daily Tacrolimus blood level should be drawn before AM dose is given and 12 hours after PM dose. Pediatric nephrologist will adjust dose.
basiliximab (Simulect)	**Peds Dose**: 10 mg IV x1 - Give POD 4 **Adult Dose**: 20 mg IV x1 - Give POD 4	Peds: 10 mg Adult: 20 mg	
mycophenolate mofetil (Cellcept)	400 mg/m2 IV BID	1000 mg/dose	Convert to PO when no longer NPO
valganciclovir (Valcyte)	**Peds Dose**: 15 mg/kg PO suspension QD - Start POD 4 **Adult Dose**: 900 mg PO tablets QD -Start POD 4	900 mg/dose	Do not give to patients where both donor and recipient are CMV negative
heparin drip	5 units/kg/hr IV continuous	500 units/hr	Do not titrate unless directed by nephrology and transplant surgery