Kidney Transplant Clinical Practice Guideline

Phase II: Post-op Management

Timeline	Surgical Day	Post-op Day 1	Post-op Day 2	Post-op Day 3	Post-op Day 4	Post-op Day 5	Post-op Day 6	Post-op Day 7
Unit	**PICU**	**PICU/6 East**	**PICU/6 East**	**6 East**	**6 East**	**6 East**	**6 East**	**6 East**
Assessment & Monitoring	Vital Signs Post Procedure ICU: BP,P, RR, CVP, every 30 min x6 hrs, then Q1H; Temp Q4H, Cardiac Monitor, Continuous Pulse Ox, Weigh QAM, Strict I&O	**PICU:** BP,P, RR, Q1H; Temp Q4H, Cardiac Monitor, Continuous Pulse Ox, Weigh QAM, Strict I&O **6E:** Vital Signs Q4H, Strict I&O Q2H, Weight QAM	**PICU:** BP,P, RR, Q2H; Temp Q4H, Cardiac Monitor, Continuous Pulse Ox, Weigh QAM, Strict I&O **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	Vital Signs Q4H, Strict I&O, Weight QAM	Vital Signs Q4H, Strict I&O, Weight QAM	Vital Signs Q4H, Strict I&O, Weight QAM
Laboratory	Draw Renal Function Panel and HHP at 1800, 0000, 0600, CBC with Diff QAM	Draw Renal Function Panel, CBC with Diff at 0600, 1800	Renal Function Panel, Tacrolimus (trough level), CBC with Diff *(Draw all labs QAM)*	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 QAM)*	Renal Function Panel, Tacrolimus (trough level), CBC with Diff *(Draw all labs QAM)*	Renal Function Panel, Tacrolimus (trough level), CBC with Diff *(Draw all labs QAM)*	Renal Function Panel, Tacrolimus (trough level), CBC with Diff *(Draw all labs QAM)*	Renal Function Panel, Tacrolimus (trough level), CBC with Diff (*Draw all labs QAM)*
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 irrigate gently with 5-10 cc NS PRN for suspected clots/obstructions **Art Line (as needed):** Continuous monitoring x24 hrs then D/C **CVL (as needed)**	**Foley Catheter:** To closed drainage. May irrigate gently with 5-10 cc NS PRN for suspected clots/obstructions **Art Line (as needed):** D/C after 24 hrs **CVL (as needed)**	**Foley Catheter:** To closed drainage. May irrigate gently with 5-10 cc NS PRN for suspected clots/obstructions **CVL (as needed)**	**Foley Catheter:** Remove POD #3 and as indicated by Transplant Surgeon *(Patient remains Strict I&O Q2H while Foley in place)*				
IVF Therapy	**Art Line:** Artline 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 cc:cc every 30 min x6 hrs, then Q1H	**Art Line:** Artline 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 cc:cc every 30 min x6 hrs, then Q1H	**Art Line:** Remove after AM labs, unless otherwise indicated **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	Regular Diet	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	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							

See Medication Table 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
lortab (liquid 7.5 mg hydrocodone-325 mg APAP per 15 mL)	0.05-0.2 mg/kg PO Q4H prn pain	10 mg/dose (based on hydrocodone component)	Not to exceed 75 mg/kg/day of APAP from all sources
norco	0.05-0.2 mg/kg PO Q4H prn pain	10 mg hydrocodone-325 mg APAP per dose	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	
ranitidine (Zantac)	1 mg/kg IV Q8H	50 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 14-27: 10 mg/m2 PO QAM POD 28-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 14-27: 10 mg PO QAM POD 28-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)	300 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