Post-Operative Monitoring

This is done is to ensure there is not a recurrence of colic signs, for signs of pain and to ensure there are not any changes in the patient’s demeanour and attitude. Depending on the how critical the patient is post-surgery, colic checks and physical exams are done every two hours for the first 24 hours. During every check all parameters measured should be recorded so changes will be easy to spot.

On physical examination, you monitor:

1. Heart Rate
2. Respiratory rate and effort
3. Perfusion i.e. mucous membranes, CRT, jugular refill time
4. GI Motility
5. Temperature i.e. both core and extremities
6. Digital Pulse
7. Hydration Status i.e. moist/ tacky mucous membranes/ skin turgor
8. PCV & TP every 6- 24hrs

For Colic Check:

1. General demeanour
2. Pain Assessment
3. Faecal Output
4. Urination
5. IV catheter site
6. +/- gastric reflux
7. Water/ food intake
8. Incision Site
9. Fluid input/ output

**IV Catheters:**

The type of colic before surgery and the severity of the patient post-surgery determines how long a catheter may stay in for. Ideally, all colic patients should have a long-term polyurethane IV catheter in case they require analgesia, antimicrobials & IV fluid therapy. The polyurethane catheter is less thrombogenic. They should be flushed with heparinized saline every four/ six hours to ensure that it is patent. It should also be monitored for signs of heat, swelling, pain and thrombophlebitis. It is removed immediately if there are any abnormalities. If an infection is suspected, then the tip of the catheter should be tested for bacterial culture and sensitivity.

**IV Fluid Therapy:**

Most colic patients may have compromised hydration status and water is withheld post-surgery or until normal gut motility returns therefore IV fluid are given. Normally isotonic crystalloids are given with the daily maintenance = 2ml/kg/hr- 3ml/kg/hr. Electrolytes can be added but depends on the daily blood electrolyte measurements. The hydration status of the patient is also important due to the patient actively refluxing. The amount of gastric reflux produced determines the IV fluid therapy adjustments.

**PCV and Total Protein:**

How these parameters are checked depends on the patient’s stability, severity of disease and duration of time after surgery. It is used as a guide for adjusting rate of fluid administration. The jugular and facial vein can both be used for blood sample collection. A 23G/ 21G 1-inch needle is used.

**Check for Gastric Reflux:**

If a patient is refluxing and may need to be refluxed every 2-4 hours and depends on the amount obtained and patient comfort. The heart rate should be taken before and after because a distended stomach might be the source of pain. Also, the amount and character of the reflux should be noted as it is important for IV fluid therapy.

**Incisional Care:**

An abdominal bandage can be used for 5-14 days and they function to keep the incision clean and dry and to reduce the peri-incisional oedema. Both the incision and bandage must be checked at twice daily for discharge, oedema and incision dehiscence. The site should be palpated for evidence of pain which may indicate infection. Stallions and geldings’ bandages should be checked to see if they slipped caudally as it can be easily contaminated with urine.

**Medication:**

Antimicrobial therapy ay be continued for 3-5 days post-op using broad spectrums.

**Analgesia:**

Flunixin meglumine at 1.1mg/kg is most often used to reduce endotoxaemic effects. Lidocaine constant rate infusions can also be used as an anti-inflammatory and as a prokinetic to help with GIT motility. CRI rates need to be monitored as overdosing can cause stupor or collapse.

**Post-op Feeding:**

There should be a customised food plan for each patient depending on the type of colic they were diagnosed with. Patients with simple displacement or obstruction of the large colon can tolerate food quickly after surgery. But those recovering from caecal and small colon impactions, small intestinal strangulation require slower food re-introduction. Patients can be offered small amounts of water followed by wet, sloppy, high fibre mashes/ handful of grass-soaked hay every four hours. The amount is increased gradually if the patient can tolerate it and no relapse occurs. During this time the patient should be monitored for inappetence, colic, tachycardia, faecal output and borborygmi.