OB/GYN

Gynecology
Antibiotics given in surgery discuss post op use
SCD's & early ambulation ask GYN team Re heparin

Hemorrhage: serial exams & visualize vaginal bleeding every Q2H

Sepsis Antibiotics: 48hrs Amp/Gent/Clindamycin or Levo/Flagyl
Avoid LMW heparin as may go back to OR

Gynecology Oncology
Hemorrhage:
-Tx Hct < 24, -Tx Hct > 30 prior to chemotherapy or XRT
-Albumin: 5% 250cc Q6 for large volume ascites drainage or hypoalbuminemia (< 2)
-Antibiotics: 24 hrs of cefoxitin/flagyl for GI surgery
-SCD's Heparin to start POD #1 5000 U TID SQ, often will consider Pearlman drip if large surgery or if sarcoma debulk. PTT goal 35-45, no bolus
-New DVT: Therapeutic Fragmin superior to Coumadin in cancer patients
- NPO, NGT / LIWS (due to LOA, bowel surgery)
-Wound: often will have wicks to change BID, if intubated with packing or
-open fascia we prefer to keep them intubated and paralyzed.

Radical vulvectomy
- bed rest/low residue diet

Total pelvic exenteration
- large fluid shifts with 50% peri-operative morbidity close communication between all involved is vital

OB
Antepartum patients:
increase blood volume 2 x by 28-30 weeks, vitals BP 80/50, HR 90-100, Sp02 >92% (fetal needs)
exceptions: preeclampsia, co-morbid HTN
Confirmed pregnancy consult OB service early
8-3441 Maternal Fetal Medicine fellow,
8-3447 attending
Plan of care may include discussion of
-potential fetal effects from any Rx or diagnostics
-acceptance of care for the patient/family unit
-termination pregnancy (threat to maternal life/pre-viable)
-avoid fluoroquinolones, ACEI, ARBs, alkylating agents/MTX
-other agents should be reviewed by MFM for concerns
Diagnostic studies -most can be performed, including iv contrast, minimize radiation exposure through shielding

Postpartum patients

typically tolerate lower BP / higher HR if healthy prior
Lactation -avoid"pump and dump" consult MFM
DVT prophylaxis -high risk of VTE