## Urinary Retention
- Supine position
- Bladder overfill during op
- Transient neuro weirdness with voiding
- Pain: abdo / inguinal wound
- Constipation (most frequent cause)
- Bladder outlet obstruction

**MGT:**
- Re-establishing fluid and electrolyte balance
- Treat constipation
- Avoiding constipation

## Urinary Tract Infection
Dysuria, frequency, unexplained pyuria / sepsis (may be silent)

**Very common post-op (esp women)**
- Catheterization
- ↓ Urine output
- Bacteremia from operation / infxn
- Poor hygiene

**Good fluid input, ABX**

## Acute Renal Failure
Oliguric Phase: sudden onset oliguria, followed by big diuresis (unconcentrated)

**Diuretic Phase,**
- If severe: ↑↑ Blood urea, Cr, K
- Acute tubular necrosis: ↓ Renal perfusion (hypoT) & hypoxia
- Toxins: aminoglycoside ABx (gentamicin etc.), myoglobin (crush syndrome)
- Hepatorenal Δ

**Prevention:** Avoid hypoT, monitor nephrotoxic drugs (if high-risk patient: IV dopamine during op = protective)

**MGT:** (Mild) fluid restriction, (severe) dialysis (wks→mths)

## Abscess
(1) Generally unwell & delayed recovery
(2) Swinging fever & local peritonitis
(3) Early septicemia

**MGT:**
- Reoperate to make a stoma from each end of failed anastomosis.
- Join up once infection gone.

## Pelvic / Subphrenic Abscess
- Following treated peritonitis
- Faecal contamination of op site

**MGT:**
- Locate with CT, U/S.
- Aspirate to classify.
- Drain.

## Bowel Fistula
- Anastomotic leak
- Bowel infarction / obstruction
- Dehydration, electrolyte disturbances, intra-abdo inflammation, skin breakdown
- Prox smal bowel fistula (↑ digestive juices)

**MGT:**
- If minimal infection / obstruction → spontaneous closure (wks-months)
- If prox smal bowel: total bowel rest (Nil by mouth, NG tube), nutrition to bypass bowel (parenteral / enteral)

## Pressure Sores
- Especially on heels & sacrum
- ↓ Pain response
- Pressure ischaemia
- Poor tissue perfusion
- Malnutrition

**Prevention:** Relieve heel pressure (heel rests, sheepskin, bean-bags), change posture often, check & massage pressure areas, manage incontinence

**MGT:** Remove necrotic tissue & control secondary infxn

## Ileus
- Nausea, anorexia, vomiting
- Ops involving bowel handling / retroperitoneum

**MGT:**
- Reintroduce fluids gradually, then solids

## Pseudo-obstruction
- No large bowel function
  - After sx (esp abdo)
  - Severe hypoK+
  - Trauma to lower spine / retroperitoneum
  - Anti-Parkinson's drugs

**Diagnosis:** Barium enema

**MGT:** Supportive

## Early Post-op Obstruction
- Vomiting, pain, constipation
  - Twisted bowel
  - Adhesions (1 wk post-op) Fibrinous
  - Mucosal oedema around anastomosis (if gastrectomy)

**Transit:** Empty bowel (NG aspiration), hydrate (IV fluids), if severe: laparotomy
- Strangulation (if toxic)
- Reoperation

## Late Post-op Obstruction
- Months / years post op
- Fibrous adhesions as per early obstruction

**Acute Ischaemic Gut**
- (sudden deterioration days post-op)
  1. Peritonitis signs
  2. AbdoXR: 'thumb-printing' & gas in bowel wall
- Inf mesenteric artery obstruction
  - Gut necrosis → Perforation

**MGT:** Immediate operation!! To avoid perforation (usually fatal)

## Peritonitis
ABDO PAIN: Severe, diffuse, RIGIDITY, GUARDING (rapid or insidious)
- Elderly get little tenderness
- Anastomosis failure
- Bowel perforation (ischaemia / obstruction)
- Peptic ulcer perforation
- Abscess burst

**MGT:**
- (1) Make well again: RESUS & ABX
- (2) Find problem: Laparotomy
- (3) Sanitize: Peritoneal toilet

## By Eleanor Curtin, GMP 3

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