High-Risk Spinal Fusion

ALGORITHM 1. Pre-Operative High Risk Spinal Fusion Care Path

Inclusion Criteria
- Neuromuscular scoliosis AND/OR other spinal deformity with underlying chronic conditions.
- Idiopathic scoliosis with co-morbidities OR high degree of curvature.
- Others designated as “High Risk” by the Orthopedic Spine Surgery team.

Exclusion Criteria
- Idiopathic Scoliosis with no co-morbidities.
- Adolescent kyphosis.
- Vertical expandable prosthetic titanium rib (VEPTR) expansion.
- Spinal diagnosis related to trauma.
- Others based on clinical judgment by Orthopedic Spine Surgery team.

Pre-Op Surgical Assessment (2-6 months prior to surgery)
- Surgeon, spine nurse, patient/family to attend
- Risk vs. benefit analysis, including ethical considerations
- Educate about pathway and surgical procedure
- Discuss possible sub-specialty consults/evaluations

Spine nurse conducts phone follow up with family to complete assessment (RN Spine Pre-op Call flowsheet in Epic)

Spine nurse communicates with care team to determine appropriate consults/evaluations and schedules appointments

Complete Pulmonary consult and other consults/evaluations as clinically indicated:
- Nutrition
- Cardiology
- Sleep Study
- Others (if indicated)

Pre-op labs:
For ALL patients:
- Complete blood count (CBC)
- Type and screen
- Basic metabolic panel (BMP)
- Serum albumin
- Prealbumin
- Venous blood gas (VBG)
- 25-OH Vitamin D

**ONLY IF clinically indicated:**
- Serum selenium, serum zinc, and serum folate

Imaging & Tests:
- Chest radiography (CXR)
- Electrocardiogram (EKG)

Other Evaluations as clinically indicated**:
- Sleep study
- Pulmonary function test
- Echocardiogram
- Metabolic

High Risk Spine Clinic/Discharge Planning Meeting/Anesthesia Evaluation
- Spine nurse, hospitalist, anesthesiologist, PT, RT, dietician, case manager, & social worker to attend
- Review the Safe for Surgery Checklist in Appendix D and initiate arrangements for any other consults/tests or post-op home equipment needs
- Patient/family education

Pre-Admission (1-2 weeks prior to surgery)
- Determine surgical antibiotic prophylaxis (consult Epidemiology/Infection control physician on-call for patients who are currently on antibiotics
- Labs: MRSA/PCR
- Pre-op scoliosis imaging
- Patient/family education
- Confirm that the Safe for Surgery Checklist in Appendix D is complete

Day of Surgery
- Skin assessment
- Labs: Urine pregnancy test for 10+ and/or post-menarchal, Type and Crossmatch, and CBC if clinically indicated
- Pre-op medications: Refer to Table 1 on page 13 and Ortho IP Spinal Fusion Admission Orderset in Epic.
**CLINICAL PATHWAY**

**ALGORITHM 2. Post-Operative High Risk Spinal Fusion Care Path**

**Orthopedics/Anesthesia team hand off patient to the PICU**

**PICU manages patient according to clinical status:**
- PICU manages ventilator, fluids, nutrition, and labs
- PICU and Surgical teams coordinate pain management
- Orthopedics team manages incision/dressing care, neurovascular assessment, and activity

**PICU - Pulmonology Consult:**
- PICU team should review pre-operative Pulmonary consult for recommendations
- PICU should consult Pulmonology within 24 hours of extubation for EVERY patient.
- If patient was on non-invasive ventilation at baseline, strongly consider Pulmonology consult PRIOR to extubating.
- Pulmonology to determine need for Respiratory Medical Equipment and begin ordering process early (if not already underway).

**PICU - Nutrition and Other Consults:**
- PICU team should review pre-operative nutrition recommendations and advance feeding (start via G-tube, NG tube, or oral as clinically indicated)
- PICU team should consult Nutrition Services within 24 hours.
- Other consults as indicated (e.g., Cardiology, Neurology, etc.)

**Patient Discharged (see criteria to the right)**
- Home care based on clinical need
- Follow up in 4-6 weeks post-op

**Hospitalist (Yellow) Team Clinical Management:**
- Hospitalist (Yellow) team is the primary team managing the patient on the floor; Orthopedics co-manages these patients.
- Inpatient Service Specialist (ISS) should call Yellow Team to notify them of the patient’s arrival on the floor.
- The Yellow Team should communicate with Pulmonology within 24 hours after arrival to the floor. If patient has had a pleural effusion and/or chest tube, Pulmonology must be consulted.
- The Yellow Team should call the Spine Nurse to co-round daily (M-F).

**Inclusion Criteria**
- Neuromuscular scoliosis AND/OR other spinal deformity with underlying chronic conditions.
- Idiopathic scoliosis with co-morbidities OR high degree of curvature.
- Others designated as “High Risk” by the Orthopedic Spine Surgery team.
**Exclusion Criteria**
- Idiopathic Scoliosis with no co-morbidities.
- Adolescent kyphosis.
- Vertical expandable prosthetic titanium rib (VEPTR) expansion.
- Spinal diagnosis related to trauma.
- Others based on clinical judgment by Orthopedic Spine Surgery team.

**Bowel Regimen:**
- See Table 2 on page 14 for Suggested Medications for the Post-Operative Period
- Senna/Occulose twice a day
- Polyethylene glycol once a day
- Fleets enema PRN

**Activity:**
- **Day of surgery- ALL patients:**
  - Elevate head of the bed up to 90° as tolerated
  - Logroll every 2 hours as and needed.
  - Physical therapy twice daily until patient is cleared

- **Postoperative day 1:**
  - **Intubated Patients**
    - Elevate head of bed up to 90 degrees as tolerated
    - Logroll every 2 hours and as needed
  - **Extubated patients:** (should be up to chair within 18 hours post-extubation)
    - Physical therapy to assist patient to dangle legs over edge of bed and/or get into chair

- **Postoperative day 2 until discharge:**
  - Ambulatory patients: Physical Therapy to assist patient with ambulation as tolerated
  - Nonambulatory patients: Up to wheelchair using Hoyer lift and/or 1 or 2 person lifts.
  - Parent/caregiver should be cleared by Physical Therapy to perform transfers
  - Nursing and parent/caregiver should get patient up to wheelchair at least 3-4 times per day, even if patient has been cleared by Physical Therapy

**Discharge Criteria:**
- Off oxygen or returned to baseline respiratory status and/or stable
- Train caregivers on new home respiratory or other medical equipment
- Tolerating oral/enteral intake
- Voiding
- Has at least one bowel movement
- Pain well controlled with oral/enteral medications and non-pharmacological approaches to pain control (i.e., cold therapy)
- Family trained and comfortable with transfers
- Cleared by physical therapy
- Home care, nursing, PT orders are placed and arranged
- Pulmonary and/or PT equipment needs are met
- Patient or caregiver can verbalize understanding of discharge teaching instructions
TABLE OF CONTENTS

Algorithm 1. Pre-Operative High Risk Spinal Fusion Care Path
Algorithm 2. Post-Operative High Risk Spinal Fusion Care Path
Target Population
Background
Pre-Operative Clinical Management (2-6 months prior to surgery)
Pre-Admission Clinical Management (1 - 2 weeks prior to surgery)
Day of Surgery Clinical Management
Intra-Operative Clinical Management
Post-Operative Clinical Management
Discharge
Follow Up
Table 1. Suggested Medications for the Pre-Operative Period
Table 2. Suggested Medications for the Post-Operative Period
Appendix A. Spine Surgery Patient Algorithm for “Expanded” Surgical Prophylaxis
Appendix B. Assessment of Eligibility for Pre-Op Sleep Study
Appendix C. Evaluation of Need for Pre-Admission Urine Analysis and/or Culture
Appendix D. Safe for Surgery Checklist
References
Clinical Improvement Team

TARGET POPULATION

Inclusion Criteria
- Patients with neuromuscular scoliosis and/or other spinal deformity with underlying chronic conditions
- Idiopathic Scoliosis with comorbidities OR high degree of curvature
- Patients undergoing or considering undergoing major spinal or chest wall deformity procedure, such as spinal fusion (primary or major revision), VEPTR insertion, or magnetic growing rod insertion
- Any other patient designated as “High Risk” by the Orthopedic Spine Surgery team

Exclusion Criteria
- Idiopathic Scoliosis with no comorbidities
- Adolescent kyphosis
- Vertical expandable prosthetic titanium rib (VEPTR) expansion
- Patients with spinal diagnosis related to trauma
- The Orthopedic Spine Surgery team may exclude a patient from this pathway if their underlying disease or planned surgery does not justify an escalated level of care.
BACKGROUND

- This clinical pathway is based on the published Care Pathway for Spine Surgery (CAPSS)1 developed by CHCO.
- Patients who require major spinal procedures, such as fusions and growing spine implants, often have many co-morbidities in addition to scoliosis.
- Scoliosis surgery requires extensive planning and coordination with the Orthopedic Surgery Team, providers in other disciplines (e.g., pulmonary, hospitalist, anesthesiology, etc.), and the patient’s family.
- Many elements of the process, from pre-operative evaluation and preparation to surgery to post-operative care, are time sensitive and need to have a formal workflow to ensure that all appropriate steps are completed.

Ethical Considerations

The goal of spine surgery for patients with progressive neuromuscular scoliosis is to maintain or improve quality of life. Because of the many associated risk factors in these complex patients, the option of surgical treatment needs to be considered carefully as surgery may not be the best option for every patient/family. The ethical issues surrounding these decisions are multi-faceted and complex. The purpose of this clinical pathway is to evaluate the patient medically, determine risks, and to assess the families’ resources and ability to care for the patient once discharged to home. The patient (if able), the parents/caregivers, and the surgeon should all come to a consensus as to whether surgical management is the best option.

PRE-OPERATIVE CLINICAL MANAGEMENT (2-6 MONTHS PRIOR TO SURGERY)

Initial Evaluation

- Surgeons and spine team will discuss ethical considerations and risk/benefit analysis with patients/families to determine candidacy for spinal surgery.
- During initial meeting/call with patient and family in orthopedic clinic, discuss the following:
  - Education on the surgical procedure and pathway
  - Ethical issues related to surgical options
  - Unique family resources and factors impacting clinical decision-making
  - Initial assessment of consults that may be needed (cardiology, neurology, pulmonology, nutrition, etc.)
- Follow-up and complete assessment by phone
  - Complete RN Spine Pre-OP Call flowsheet, including psychosocial assessment, involvement of specialty services, past medical and surgical history, current medications, previous hospitalizations, eligibility for sleep study, and history of UTI.
  - Spine nurse will communicate with surgeon, surgeon’s PA, and subspecialists to determine work up as indicated.

Consults

- Pulmonary consult is indicated for all patients.
- Nutrition assessment by registered dietician for:
  - Patients with a body mass index (BMI) less than 10% for age or greater than 85% for age
  - Patients on tube feeds or parenteral nutrition at home
  - Patients with known eating disorders, or with diagnosed gastrointestinal conditions
- Neurology consult is indicated for patients with uncontrolled seizures, severe dystonia, or if parents have questions about seizure medications
- Acute Pain Service consult is indicated for patients with baseline opioid medication use or history of chronic pain
Laboratory Studies

The following labs are indicated for all patients:

- Complete Blood Count (CBC)
- Type and screen
- Basic metabolic panel (BMP)
- Serum albumin
- Prealbumin
- Venous blood gas (VBG)
- 25-OH, Vitamin D

The following labs should be conducted only if clinically indicated:

- Serum selenium, serum zinc, and serum folate

Imaging & Tests

- Chest radiography (CXR)
- EKG

Evaluations

- Sleep Study (if clinically indicated) – to be ordered by Pulmonology 2-3 months prior to surgery.
- Pulmonary Function Tests - for patients with a thoracic scoliosis curve greater than 70°, kyphosis greater than 70°, any planned chest wall violation during surgery, or history of poorly controlled asthma.
- Cardiac Evaluation
  - For patients with a history of cardiac disease, pulmonary hypertension, or abnormal cardiovascular exam. The spine nurses or their designee will contact the patient’s cardiologist via Epic Inbox to determine whether another visit and/or EKG is indicated prior to surgery. The cardiologist will determine if an echocardiogram is needed and will place the order, arrange for any further evaluations, and make recommendations prior to surgery.
  - Patients without a history of cardiac disease will have a screening EKG performed. (Note: congenital scoliosis patients have a higher incidence of cardiac defects. Screening EKG has a high negative predictive value and was deemed appropriate by CHCO Cardiology Department).
    1. As standard CHCO procedure, a cardiologist will review the EKG and document the final interpretation in Epic.
    2. The spine nurses or designee will review the final EKG results.
    3. EKG results will guide the next step in cardiac evaluation:
       - If the EKG is normal, no further cardiac evaluation is necessary.
       - If the EKG is abnormal, call One Call at 7-3999 and ask for the outpatient cardiologist on call (aka “City Team”) to discuss whether an echocardiogram and/or cardiology consult is indicated.
         a. If there is no concern about the abnormal EKG, proceed with pathway.
         b. If a cardiology consult is done, the cardiologist’s peri-operative recommendations will be documented in a letter sent to the PCP. If risk is identified, cardiologist will consult with cardiac anesthesiologists to determine possible need for cardiac anesthesia.
c. If the City Team determines an echocardiogram only is indicated, a spine team provider (hospitalist, surgeon or anesthesiologist) should order the echocardiogram.
   - If the echocardiogram is normal, a report is documented in Epic and no further cardiac workup is needed.
   - If the echocardiogram is abnormal, the echocardiogram physician will intervene to ensure appropriate follow up and will communicate with the ordering provider.

d. Any spine team member, including the anesthesiologist, may order an echocardiogram at their discretion even if not recommended by the City Team.

e. When ordering an echocardiogram, ensure that the appropriate provider, nurse, and contact number are included in the order. These details will help the Cardiologist contact the Spine Team in case there is an abnormality.

f. For help on interpreting echocardiogram results, contact the Echocardiogram Reading Room at 720-777-4359.

High Risk Spine Clinic/Discharge Planning/Anesthesia Evaluation

- Patient/family attends High Risk Spine/Discharge Planning Meeting/Anesthesia Evaluation
  - The discharge planning meeting should be attended by representatives from: nursing, respiratory therapy, nutritional services, social work, physical therapy, case management, hospitalist, and anesthesia.
  - Provide families with the preoperative Spine book.
  - Initiate any other consults or diagnostic tests needed and coordinate with family (Refer to Appendix D, Safe for Surgery Checklist)
  - Physical therapy will order/contact DME company about new equipment needed postoperatively.

Parent | Caregiver Education

- Encourage a well-balanced diet during the pre-operative period. Adequate pre-operative nutrition has been associated with improved healing and decreased infection.

PRE-ADMISSION CLINICAL MANAGEMENT (1 - 2 WEEKS PRIOR TO SURGERY)

Preoperative visit

- Determine surgical antibiotic prophylaxis
  - Consult with Epidemiology / Infection Control physician on-call (via phone or email) for recommended surgical antibiotic prophylaxis for patients who are currently on antibiotics.
  - Anesthesiology Pre-Operative Clinic – only for patients who are not seen by an anesthesiologist during the Discharge Planning/High Risk Spine Clinic visit, unless requested by the family.

Laboratory Studies

- Nasal culture for methicillin-resistant Staphylococcus aureus (MRSA)* is recommended for all patients:
  - *Note current CHCO guideline is to test patients who will undergo spinal fusion and use results to guide surgical prophylaxis. Guideline does not recommend routine treatment of positive MRSA nasal swab results.
  - Preoperative testing and treatment of patients positive for MRSA has been shown to decrease the incidence of postoperative infections.

Imaging

- Scoliosis patients: two view spine and bending radiographs as ordered
- Kyphosis patients: AP lateral bolster radiographs of the thoracic spine
Other radiographs as clinically indicated
- Traction spine film as ordered by provider
- MRI as clinically indicated

**Parent | Caregiver Education**
- Shower and CHG cleanse guidelines - please refer to the Surgical Site Infection Spine Surgery Target Zero Bundle
- Nil per os NPO guidelines
- Patients and caregivers should receive 1:1 preoperative teaching approximately 1 week prior to surgery.
- The surgical procedure is explained and consents are obtained by the provider.
- It is suggested that patients and caregivers receive a tour of the hospital prior to surgery.

### DAY OF SURGERY CLINICAL MANAGEMENT

**Assessment**
- Skin assessment to examine skin integrity and presence of pressure ulcers or other concerns.

**Laboratory Studies**
- Urine pregnancy test: all females 10 years and older and/or postmenarchal (may be cancelled per anesthesia the morning of surgery)
- Type and crossmatch
- CBC if clinically indicated

**Pre-Operative Medications**
Please refer to Table 1. Suggested Medications for the Pre-Operative Period and refer to the Orderset in Epic: OrthoIP Spinal Fusion Admission.

**Antibiotics**
Please refer to Appendix A. Spine Surgery Patient Algorithm for “Expanded” Surgical Prophylaxis for guidance on antibiotic ordering
- Cefazolin 30 mg/kg (max of 2,000 mg) IV completion of antibiotic within 60 minutes of surgical incision OR
- Vancomycin 15 mg/kg (max of 1,000 mg) IV completion of antibiotic within 60 minutes of incision for patients with a beta-lactam allergy, patients colonized or at high-risk for colonization with MRSA, patients over the age of 13, or post-menarchal, or with acne, or with signs of maturity such as pubic hair or breast buds
  - For patients with documented hypersensitivity to vancomycin (Red Mans Syndrome), infuse over 120 minutes and pre-medicate with IV or PO diphenhydramine (see Table 1 for dosing).

**AND**
- Ceftriaxone 50 mg/kg (max of 2,000 mg) IV completion of antibiotic within 60 minutes of surgical incision.
- Levofloxacin 10 mg/kg (max of 500 mg) IV completion of antibiotic within 60 minutes of surgical incision for patients allergic to ceftriaxone.
- Clindamycin 10 mg/kg (max of 900 mg) IV completion of antibiotic within 60 minutes of surgical incision for patients allergic to vancomycin.
- Vancomycin powder for topical use (see Table 1 for dosing).
Other Medications

- For patients who can swallow pills, administer the following on arrival to the pre-op area. (Please refer to Table 1, Suggested Medications for the Pre-Operative Period for further detail).
  - Gabapentin oral capsule **AND**
  - Acetaminophen oral tablet

- For patients who can’t swallow pills, administer the following on arrival to the pre-op area. (Please refer to Table 1, Suggested Medications for the Pre-Operative Period for further detail).
  - Gabapentin oral solution and IV acetaminophen

**INTRA-OPERATIVE CLINICAL MANAGEMENT**

Please refer to the Anesthesiology Protocol for Spinal Fusion Surgeries for further detail.

- All patients will have a specialized Spine Anesthesiologist for their surgery.
- All patients will have the following lines placed: at least 2 large bore peripheral IVs, arterial line, and central venous catheter

**Medications**

- Limit use of volatile anesthetic, terminate use as soon as possible
- Antibiotics- Please refer to Appendix A, Spine Surgery Patient Algorithm for "Expanded" Surgical Prophylaxis
  - Vancomycin infusion should be started after the arterial line is established
  - Other antibiotics should be administered after the patient is flipped prone
  - Redose antibiotics for blood loss and/or elapsed time per Appendix A.
- Intrathecal morphine
  - 7.5 mcg/kg (maximum dose 500 mcg)
  - If patient has documented obstructive sleep apnea (OSA), decrease dose to 5 mcg/kg (maximum dose 350 mcg)
- Total intravenous anesthetic (TIVA) with propofol (75-200 mcg/kg/min) and remifentanil (0.05-0.3 mcg/kg/min) infusions
- Ketamine infusion 0.1-0.4 mg/kg/hr
- Tranexamic Acid: 10 mg/kg bolus over 30 minutes (maximum 1 gram), then 5 mg/kg/hr
- Ketorolac 0.5 mg/kg (maximum 30 mg) at end of surgery, if approved by surgeons
- Acetaminophen re-dose (15 mg/kg) at 6 hours after initial acetaminophen dose
- Transfusion Management
  - Hemoglobin goal is > 8-9 or hematocrit > 24-27%
  - FFP, platelets, cryoprecipitate- guide use based on thromboelastogram

**POST-OPERATIVE CLINICAL MANAGEMENT**

**Assessment | Monitoring**

Initial management following transfer from Orthopedics/Anesthesia Team to the PICU:
Upon arrival to PICU, Anesthesiology team and Surgery team give full report and handoff the patient to the PICU team.

- Admission orders to PICU done by Surgical team. Orders are reviewed and modified by PICU team as needed.
- PICU manages patient based on clinical status.
- Ventilator, fluids, nutrition, and labs- managed by PICU.
- Pain management is coordinated between the PICU and Surgical teams. Multimodal standardized pain management algorithm for spine fusion patients will be followed when appropriate. Final clinical management will be decided by the PICU team.

Incision/dressing care, neurovascular assessment, and activity- managed by Surgical team.

**Coordination of Specialty Services in the PICU:**

- **Pulmonology Consult:**
  - PICU team should review preoperative Pulmonology consult for recommendations.
  - PICU should consult Pulmonology within 24 hours of extubation for EVERY patient.
  - If patient was on non-invasive ventilation at baseline, **strongly consider** a pulmonary consult PRIOR to extubating.
  - Determine the need for Respiratory Medical Equipment and, if the patient does not have that equipment at home, begin process of ordering early.

- **Nutrition Consult:**
  - PICU should consult Nutrition Service within 24 hours.
  - See preoperative nutrition recommendations and advance feeding. Start via g-tube/NG/oral as clinically indicated.

- **Other Consults as indicated based on individual patient characteristics (e.g. Cardiology, Neurology, etc.):**

**Daily considerations that apply throughout hospital stay, both in PICU and on floor:**

- **Urinary catheter (foley):** assess for necessity every day. Reasons to keep the foley include:
  - Patient is unable to ambulate to the bathroom
  - Patient cannot return to baseline diapering
  - Accurate measurement of urine output is needed for clinical decision-making
  - Urinary retention due to opioids

- **Central line (CVC):** assess for necessity every day. Reasons to keep central line include:
  - Hemodynamic instability
  - Ongoing need for frequent laboratory draws. Consider that hematocrit and sodium may be checked with finger-stick
  - Ongoing need for medication that cannot be given through peripheral IV, such as Parenteral Nutrition (PN) and lipid emulsion (assess whether patient is tolerating enteral nutrition)
  - Lack of other intravenous access or very high level of concern (provider and parent) about losing and replacing peripheral IVs

- **VTE prophylaxis** for at risk patients in accordance with the [VTE Prevention clinical pathway](#). Discuss with surgeons the need for enoxaparin if still at risk for VTE.

- **Ez-PAP™ treatments** for extubated patients every 4 hours for 24 hours, continued 3 times/day until discharge
  - Local expert consensus supports the use of Ez-PAP™ for prevention of post-operative atelectasis. Refer to the [Lung Expansion policy](#) for more information.
Cold therapy as needed to decrease pain. Cold therapy unit belongs to the family and should be sent with the patient to floor when transferred. Cold therapy is provided to patients for comfort and not necessarily to manage swelling or drainage.

- Neurovascular checks every 2 hours for 24 hours, then every 4 hours afterward.
- Elevate head of the bed to 90 degrees as tolerated. Log roll every 2 hours. Dangle on edge of bed or transfer to chair on post-op day 1 or when extubated. Progress to ambulation and/or time in wheelchair as tolerated, minimum 3 to 4 times a day.

**Transition of patient from PICU to Hospitalist (Yellow) floor team:**
- PICU team determines when patient is medically stable for transfer to floor per usual PICU practice.
- Hospitalist (Yellow) team is the primary team when transferred out of PICU to the 6th floor. Ortho co-manages these patients.
  - Inpatient Service Specialist (ISS) should call Yellow Team to notify them of the patient’s arrival on the floor.
  - The Yellow Team will communicate with Pulmonology with 24 hours after arrival to the floor. **If the patient has had a pleural effusion and/or chest tube, then a formal Pulmonology consult should be done.**
  - Ensure Durable Medical Equipment (DME) has been ordered.
  - Call the Spine Nurse to co-round daily on Monday-Friday.

**Laboratory Studies**

The following laboratory studies generally do not vary based on patient location and may be done in the PICU and/or on the floor depending on clinical indication:

- Hemoglobin monitoring (Blood bank has requested that hemoglobin be monitored. Approximate conversion from hemoglobin to hematocrit is multiplication by 3. Hgb 7 = Hct 21%, Hgb 8 = Hct 24%, etc.)
  - POD #1: All patients have hemoglobin checked
  - POD # 2: Only check hemoglobin if the hemoglobin from POD #1 is < 10
  - POD #3: Only check hemoglobin if the hemoglobin from POD #2 is < 9

- Transfusion management:
  - Criteria for transfusion of PRBCs: Hemoglobin is < 8 **AND** the patient has symptoms of tachycardia unrelated to pain, hypotension despite euvolemsia, dizziness with ambulation, or oxygen requirement.
  - Blood product choice
    - Patient ≤ 25 kg: 10 ml/kg PRBCs
    - Patient > 25 kg: 1 unit PRBCs
  - If considering additional transfusion, recheck hemoglobin and refer to above criteria

- Other labs to be ordered as clinically indicated by the provider

**Medications**

Medications generally do not vary based on patient location and may be ordered/administered in the PICU and/or on the floor depending on clinical indication.

- Please refer to **Table 2, Suggested Medications for the Post-Operative Period** and refer to **Ortho IP Spinal Fusion PICU Post-op Orderset**

**Antibiotics**

- Antibiotic should be continued **for only 24 hours** post operatively even if drains are left in place. Please refer to **Appendix A, Spine Surgery Patient Algorithm for “Expanded” Surgical Prophylaxis**

**Pain Medications**
Patient Controlled Analgesia (PCA) for patients per Patient controlled Analgesia (PCA) Set-up, Administration and Documentation Policy:

- No basal rate should be ordered due to intrathecal morphine given in OR. Only demand dose should be ordered.
- If patient unable to utilize PCA button, then order for a PCA nurse bolus only.
- Discontinue PCA after patient has tolerated 2 doses of oral pain medications.

Acetaminophen
- Oral/NG/GT every 4 hours for 48 hours, then every 4 hours PRN

Oxycodone
- Oral/NG/GT every 4 hours scheduled for 48 hours, then every 4 hours PRN
- First post-op dose to begin first post-op day at 0900 (“Start PRN dose 4 hours after scheduled dose.”)

Gabapentin
- Oral/NG/GT- same dose as pre-op dose three times a day starting on the evening of the surgery day (2100) and continuing through until the evening of the second post-op day, for a total of 7 doses.

Ketorolac
- IV scheduled every 6 hours beginning 0900 on the first post-operative day for 48 hours (total of 8 doses), then ibuprofen every 6 hours PRN until discharge.
- Do not give Ketorolac to patients with underlying kidney disease.

Diazepam
- Oral/NG/GT - Every 6 hours PRN for spasms. Use lowest effective dose.

Other Medications
- Nalbuphine every 3 hours as needed for pruritis
- Ondansetron every 6 hours for 24 hours, then every 6 hours PRN for nausea
- Scopolamine patch every 72 hours, for patients 12 years of age and older, for nausea
- Famotidine IV every 12 hours for 24 hours, then ranitidine PO twice a day for GI prophylaxis

Bowel Regimen
- Please refer to Table 2, Suggested Medications for the Post-Operative Period
- Senna/Docusate twice a day
- Polyethylene glycol once a day
- Bisacodyl (Magic Bullet) suppository QD
- Fleets enema every day PRN

Dressing and Incision Care:
- Please refer to the Surgical Site Infection (SSI): Spine Surgery Target Zero Bundle

Activity:
- Please consult orthopedic and plastic surgeons for wound care and activity orders.
DISCHARGE

Discharge Criteria:
It is suggested that the following criteria be met prior to discharge:

- Off oxygen or returned to baseline respiratory status and/or stable
- If new home respiratory equipment needs to be ordered and obtained, caregivers need to be trained and able to use any new equipment
- Tolerating oral/enteral intake
- Voiding
- Has at least one bowel movement prior to discharge
- Pain well controlled with oral/enteral medications and non-pharmacological approaches to pain control (i.e., cold therapy)
- Cleared by physical therapy
- Family trained and comfortable with transfers and use of any new equipment
- Home care, nursing, PT orders are placed and arranged
- Pulmonary and/or PT equipment needs are met
- Patient or caregiver can verbalize understanding of discharge teaching instructions

FOLLOW-UP

- Home care: Based on clinical need.
  - Nursing- RN: 2 to 3 visits over first week or two to assess nutrition, skin, respiratory status
  - CNA: as needed or available
  - Physical therapy: 2 to 3 visits to assess and train patient/caregiver on transfers and use of new equipment
- It is suggested that patient be seen 4 to 6 weeks post-operatively, and then annually from their surgical date. May be more frequent based on provider and clinical need.
# TABLE 1. SUGGESTED MEDICATIONS FOR THE PRE-OPERATIVE PERIOD

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Maximum Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIBIOTICS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefazolin</td>
<td>Pre-operative antibiotic prophylaxis for MSSA</td>
<td>30 mg/kg</td>
<td>ONCE</td>
<td>IV</td>
<td>2,000 mg</td>
<td>Complete infusion within 60 minutes before surgical incision</td>
</tr>
<tr>
<td>Vancomycin</td>
<td>Pre-operative antibiotic prophylaxis for beta-lactam allergy, MRSA positive, <em>P. acnes</em> coverage also for age &gt; 13 years and/or postmenarchal</td>
<td>15 mg/kg</td>
<td>ONCE</td>
<td>IV</td>
<td>1,000 mg</td>
<td>Pre-op dose started within 120 minutes before surgical incision and completed prior to incision. Patients with documented Red Mans Syndrome should receive diphenhydramine pre-medication and 120 minute infusion of vancomycin</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>Pre-operative antibiotic prophylaxis for patients allergic to vancomycin</td>
<td>10 mg/kg</td>
<td>ONCE</td>
<td>IV</td>
<td>900 mg</td>
<td>Complete infusion within 60 minutes of surgical incision</td>
</tr>
<tr>
<td>Ceftriaxone</td>
<td>Pre-operative antibiotic prophylaxis for gram negative coverage</td>
<td>50 mg/kg</td>
<td>ONCE</td>
<td>IV</td>
<td>2,000 mg</td>
<td>Complete infusion within 60 minutes of surgical incision</td>
</tr>
<tr>
<td>Levofloxacin</td>
<td>Pre-operative antibiotic prophylaxis for patients allergic to ceftriaxone</td>
<td>10 mg/kg</td>
<td>ONCE</td>
<td>IV</td>
<td>500 mg</td>
<td>Complete infusion within 60 minutes of surgical incision</td>
</tr>
<tr>
<td>Topical Vancomycin</td>
<td>For topical use only in the OR</td>
<td>Short segments: 500 mg Segments that include the thoracic OR lumbar curve: 1000 mg Segments that include the thoracic AND lumbar curve: 2000 mg</td>
<td>ONCE</td>
<td>Topical</td>
<td>2,000 mg</td>
<td></td>
</tr>
</tbody>
</table>
| Diphenhydramine | Vancomycin pre-medication for patients with documented Red Mans Syndrome | 11-29.9 kg: 12.5 mg 30-50 kg: 25 mg >50 kg: 50 mg | ONCE | PO | 50 mg | For patients who cannot swallow pills give:  
• Diphenhydramine oral liquid 1 mg/kg (max dose 50 mg) OR  
• IV diphenhydramine 1 mg/kg (max dose 50 mg) |
| **PAIN MEDICATIONS** |                                                |            |           |       |              |                                                                          |
| Gabapentin       | Pre-operative pain medication                  | Capsules: 11-16 kg: 162.5 mg | ONCE | PO | 300 mg | For patients who cannot swallow pills give gabapentin oral solution 5 mg/kg (max dose 300 mg) |
| Acetaminophen    | Pre-operative pain medication                  | Tablets: 11-16 kg: 162.5 mg | ONCE | PO | 650 mg | For patients who cannot swallow pills give IV |
TABLE 2. SUGGESTED MEDICATIONS FOR THE POST-OPERATIVE PERIOD

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Maximum Dose</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ANTIBIOTICS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cefazolin</td>
<td>Post-operative antibiotic prophylaxis for MSSA</td>
<td>30 mg/kg/dose</td>
<td>Every 8 hours x 24 hours post-op (3 doses)</td>
<td>IV</td>
<td>2,000 mg</td>
<td></td>
</tr>
<tr>
<td>Vancomycin</td>
<td>Post-operative antibiotic prophylaxis for beta-lactam allergy, MRSA positive, <em>P. acnes</em> coverage also for age &gt; 13 years and/or postmenarchal</td>
<td>15 mg/kg/dose</td>
<td>Every 8 hours x 24 hours post-op (3 doses)</td>
<td>IV</td>
<td>1,000 mg</td>
<td>Patients with documented Red M ans Syndrome should receive diphenhydramine pre-medication and 120 minute infusion of vancomycin</td>
</tr>
<tr>
<td>Clindamycin</td>
<td>Post-operative antibiotic prophylaxis for patients allergic to vancomycin</td>
<td>10 mg/kg/dose</td>
<td>Every 8 hours x 24 hours post-op (3 doses)</td>
<td>IV</td>
<td>900 mg</td>
<td></td>
</tr>
<tr>
<td><strong>PAIN MEDICATIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>Mild pain</td>
<td>10-15 mg/kg/dose</td>
<td>Every 4 hours x 48 hours, then every 4 hours prn</td>
<td>Oral</td>
<td>650 mg</td>
<td>Tablet or suspension</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Moderate to severe pain</td>
<td>0.1 to 0.15 mg/kg/dose</td>
<td>Every 4 hours x 48 hours, then every 4 hours prn</td>
<td>Oral</td>
<td>10 mg/dose</td>
<td>Start on post-op day 1 at 0900. Use conservative dosing for patients with OSA (start on the low end of the dosing range)</td>
</tr>
<tr>
<td>Ketorolac</td>
<td>• Post-operative, around-the-clock analgesia • Patients on NPO status</td>
<td>0.5 mg/kg/dose</td>
<td>Every 6 hours x 48 hours, then ibuprofen every 6 hours prn pain</td>
<td>IV</td>
<td>30 mg/dose</td>
<td>Maximum duration: 48 hours. Start on post-op day 1 at 0900. Do not use in patients with underlying kidney disease</td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>• Mild to moderate pain • Adjunct for more severe pain</td>
<td>10 mg/kg/dose</td>
<td>Every 6 hours prn</td>
<td>Oral</td>
<td>800 mg/dose</td>
<td>Start 6 hours after last ketorolac dose. Do not use in patients with underlying kidney disease</td>
</tr>
<tr>
<td>Diazepam</td>
<td>Muscle spasms</td>
<td>0.05 to 0.1 mg/kg/dose</td>
<td>Every 6 hours prn</td>
<td>Oral</td>
<td>4 mg/dose</td>
<td></td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Post-operative pain</td>
<td>5 mg/kg/dose</td>
<td>Three times a day for 7 doses</td>
<td>Oral</td>
<td>300 mg</td>
<td>Capsules or oral solution. Start on evening of surgery.</td>
</tr>
<tr>
<td>Drug</td>
<td>Indication</td>
<td>Dosage</td>
<td>Administration</td>
<td>Route</td>
<td>Dose</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------</td>
<td>-------------------------------</td>
<td>----------------</td>
<td>-------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td><strong>Nacluphine</strong></td>
<td>Opioid related pruritis</td>
<td>0.05 mg/kg/dose</td>
<td>Every 3 hours prn</td>
<td>IV</td>
<td>5 mg</td>
<td></td>
</tr>
<tr>
<td><strong>ANTIEMETICS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ondansetron</td>
<td>Post-operative nausea/vomiting (PONV)</td>
<td>0.1 mg/kg</td>
<td>Every 6 hours x 24 hours, then q6h prn</td>
<td>Oral or IV</td>
<td>4 mg/dose</td>
<td></td>
</tr>
<tr>
<td>Scopolamine patch</td>
<td>Post-operative nausea/vomiting (PONV)</td>
<td>1 patch</td>
<td>Every 72 hours</td>
<td>Transdermal</td>
<td>1 patch</td>
<td></td>
</tr>
<tr>
<td><strong>ACID BLOCKERS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Famotidine</td>
<td>Stress ulcer prophylaxis</td>
<td>&lt;3 months: 0.5 mg/kg every 24 hours 3 months and older: 0.5 mg/kg every 12 hours</td>
<td>Every 12 or 24 hours x 24 hours, then ranitidine twice daily</td>
<td>IV</td>
<td>20 mg/dose</td>
<td></td>
</tr>
<tr>
<td>Ranitidine</td>
<td>Stress ulcer prophylaxis</td>
<td>2 mg/kg</td>
<td>Twice daily</td>
<td>Oral</td>
<td>150 mg/dose</td>
<td></td>
</tr>
<tr>
<td><strong>LAXATIVES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bisacodyl (Magic Bullet)</td>
<td>Constipation</td>
<td>2 to &lt;12 years: 5 mg 12 years and older: 10 mg 12 years and older: 10 mg every 24 hours 3 months and older: 0.5 mg/kg every 12 hours</td>
<td>Once daily Rectally</td>
<td>10 mg/dose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fleets enema</td>
<td>Constipation</td>
<td>2 to &lt;4 years: 33 mL 4 to &lt;10 years: 66 mL 10 years and older: 133 mL</td>
<td>Once daily Rectally 2 to &lt;4 years: 33 mL/dose 4 to &lt;10 years: 66 mL/dose 10 years and older: 133 mL/dose</td>
<td>Start on post-op day 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Senna-docusate (8.6-50mg/tablet)</td>
<td>Constipation</td>
<td>2 to &lt;6 years: ½ tablet 6 to &lt;12 years: 1 tablet 12 years and older: 2 tablets</td>
<td>Twice daily Oral 2 to &lt;6 years: 1 tablet twice daily 6 to &lt;12 years: 2 tablets twice daily 12 years and older: 4 tablets twice daily</td>
<td>Start on post-op day 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sennosides 8.8mg/5ml syrup</td>
<td>Constipation</td>
<td>2 to &lt;6 years: 4.4 mg (2.5 mL) 6 to &lt;12 years: 8.8 mg (5 mL) 12 years and older: 17.6 mg (10 mL)</td>
<td>Twice daily Oral 2 to &lt;6 years: 6.6 mg (3.75 mL) twice daily 6 to &lt;12 years: 13.2 (7.5 mL) mg twice daily 12 years and older: 26.4 mg (15 mL) twice daily</td>
<td>Start on post-op day 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyethylene glycol 3350 oral powder</td>
<td>Constipation</td>
<td>0.5-1.5 g/kg/dose Standard dosing: 4.25 g, 8.5 g, 17 g</td>
<td>Once daily Oral 17 g</td>
<td>Start on post-op day 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX A. SPINE SURGERY PATIENT ALGORITHM FOR “EXPANDED” SURGICAL PROPHYLAXIS
APPENDIX B. ASSESSMENT OF ELIGIBILITY FOR PRE-OP SLEEP STUDY

Note: This assessment is completed by the Spine Nurses as part of the RN Spine Pre-Op Call flowsheet.
CLINICAL PATHWAY

Evaluation Questions
1. Has your child had a sleep study? If yes, when and where?
2. Has your child used oxygen at home? If yes, when?
3. Does your child use CPAP or BiPAP? Have you even been told they need it?
4. Does your child snore, stop breathing at night, gasp at night?
5. Has your child had breathing or oxygen problems after surgery?

Scoring rubric for high risk spine sleep study evaluation:
□ If yes to 1: need date and results. If has sleep disordered breathing, needs to see sleep clinic if not seen in the last year. If does not have sleep disordered breathing, answer questions 2-5 and see below.
□ If no to 1, but yes to 2, 3, or 4: sleep study is indicated; Spine RN to send note to pulmonology via Epic In Basket. Pulmonology will review the note and order a sleep study if indication is confirmed.
□ If no to 1-4, but yes to 5: see pulmonary; RN to send note to pulmonology via Epic InBasket. Pulmonology will review the note and order a sleep study if indication is confirmed.

APPENDIX C. EVALUATION OF NEED FOR PRE-ADMISSION URINE ANALYSIS AND/OR CULTURE

Obtain UA and/or culture preoperatively (7-14 days preoperatively) on all patients who have ANY of the following:
- Spina bifida – UA and culture
- Routine intermittent straight cath programs – UA and only obtain culture if positive UA as described
- A history of UTI (within the past 3 months) – UA and only obtain culture if positive UA as described
- Are currently symptomatic - UA and culture

Evaluate all other high risk spinal fusion patients using the following questions:
- Do you have a history of urinary tract infections (UTIs)? If yes, when was the most recent UTI?
  Answer: NO – No urinalysis (UA) is needed
  Answer: YES – Clean catch UA and hold for culture if positive
- Do you currently have any frequency, burning or foul-smelling urine?
  Answer: NO – No UA is needed
  Answer: YES – Clean catch UA and culture

Note: If UA is suggestive of UTI, a urine culture should be obtained and appropriate antibiotic coverage should be initiated

Refer to the Urinary Tract Infection clinical pathway for guidance on interpreting UA results.

APPENDIX D. SAFE FOR SURGERY CHECKLIST
This checklist will be completed by the spine nurses as part of the pre-op assessment process. Not all items are the responsibility of the spine nurse, but spine nurses will review to ensure all have been completed prior to surgery. This checklist is included as an example and will be updated/modified per the discretion of the spine nurses.

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>MRN #</th>
<th>DOS</th>
<th>Surgeon</th>
<th>Consult</th>
<th>Completed</th>
<th>Recommendations</th>
<th>Follow up Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sleep Study</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pulmonary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cardiology/EKG: If EKG abnormal has further work up been done?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Nutrition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lab Work</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Pediatric Surgery (if chest tube is placed)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Imaging studies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Psych/mental health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Developmental Level**

<table>
<thead>
<tr>
<th>Pain Plan/Use PCA?</th>
<th>Cooperate with lung expansion?</th>
<th>Communication level</th>
</tr>
</thead>
</table>

**Home Care/Equipment**

<table>
<thead>
<tr>
<th>Home Care availability</th>
<th>Wheelchair</th>
<th>Bath Chair</th>
<th>BiPap/Cpap</th>
<th>Hospital Bed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Has family received equipment and/or family aware it has been ordered?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**D/C plan for care**

| Custody and care determined | Home assessed for current mobility | |
|-----------------------------|----------------------------------| |
|
REFERENCES


CLINICAL PATHWAY

CLINICAL IMPROVEMENT TEAM MEMBERS
Mindy Cohen, MD | Anesthesiology
Elise Benefield, RN, MSN, CPN | Program Coordinator, Orthopedic Spine Program
Suzy Evans, RN, BSN, CPN | Spine Nurse
Jason Zamkoff, MD | Hospital Medicine
Zachary Van Rhee, MD | Pediatric Critical Care
Lisa McLeod, MD | Hospital Medicine
Oren Kupfer, MD | Pulmonology
Gwen Kirby, MD | Pulmonology
Christine Baumgartner, PharmD, BCPPS | Clinical Pharmacist Specialist
Rachel Lovria, PharmD | Clinical Pharmacist
Jessica Cataldi, MD | Infectious Diseases
Sarah Nickels, PhD, MSW | Clinical Effectiveness

REVIEWED BY THE FOLLOWING EXPERTS
Elizabeth Staffieri, Parent Partner
Ada Koch, PharmD, Manager, Clinical Pharmacy Services
Kelly Capocelli, MD, Medical Director | Transfusion Medicine Services, Pediatric Pathology
Chris Nyquist, MD, MSPH | Epidemiology
Bruce Landeck, MD, Cardiology
Sumeet Garg, MD, Orthopedics
Sarah Parker, MD, Pediatric Infectious Diseases | Medical Director of Antimicrobial Stewardship
Christine MacBrayne, PharmD, Antimicrobial Stewardship
Janelle Statham, PharmD, Physical Therapy
Jessica Proctor, Physical Therapy

APPROVED BY
Clinical Pathways and Measures Committee – February 19, 2018
Antimicrobial Stewardship – January 2018
Pharmacy & Therapeutics Committee – date here

<table>
<thead>
<tr>
<th>MANUAL/DEPARTMENT</th>
<th>Clinical Care Guidelines/Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORIGINATION DATE</td>
<td>May 13, 2013</td>
</tr>
<tr>
<td>LAST DATE OF REVIEW OR REVISION</td>
<td>May 13, 2013</td>
</tr>
<tr>
<td>APPROVED BY</td>
<td>Lalit’s signature here</td>
</tr>
</tbody>
</table>

REVIEW | REVISION SCHEDULE
Scheduled for full review on (4 years from date of CGMC approval).
Clinical pathways are intended for informational purposes only. They are current at the date of publication and are reviewed on a regular basis to align with the best available evidence. Some information and links may not be available to external viewers. External viewers are encouraged to consult other available sources if needed to confirm and supplement the content presented in the clinical pathways. Clinical pathways are not intended to take the place of a physician’s or other health care provider’s advice, and is not intended to diagnose, treat, cure or prevent any disease or other medical condition. The information should not be used in place of a visit, call, consultation or advice of a physician or other health care provider. Furthermore, the information is provided for use solely at your own risk. CHCO accepts no liability for the content, or for the consequences of any actions taken on the basis of the information provided. The information provided to you and the actions taken thereof are provided on an “as is” basis without any warranty of any kind, express or implied, from CHCO. CHCO declares no affiliation, sponsorship, nor any partnerships with any listed organization, or its respective directors, officers, employees, agents, contractors, affiliates, and representatives.