mvsu
melbourne vascular surgery unit

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POST OP - FEM-POPLITEAL BYPASS

POST OP SUMMARY:

NB: Instructions are attached to Operation Record.

First 24 hrs post procedure bed rest is compulsory unless otherwise instructed.

Synthetic bypass: there will be an oblique incision in the groin with a single incision either above or below the knee.

Autologous vein bypass, there will be additional thigh incisions to enable ligation, or for vein harvesting.

The suture lines often become somewhat congested and red with lymph leak common in association with limb oedema which produces a clear yellow discharge. Any suspicious discharge can be managed by a swab for culture with antibiotics initiated if virulent pathogens are found.

After revascularisation oedema in the lower limb is very common and is most prominent for approximately six weeks. This is associated with erythema of reperfusion. Although suggesting infection, this should not be diagnosed unless there is concomitant fever and/or serology.

The patient is normally discharged from hospital in a tube shaped stocking which produces graduated compression from the ankle to the knee. It is rare to require more compression but a lymph leak above the knee may benefit from compression above the knee.

THE BEST GUIDE TO BYPASS PATENCY IS WARMTH

Post-op day one:
Rest in bed with the leg flexed on one pillow. Some thromboprophylaxis will be prescribed.

Post-op day two:
Slowly begin to mobilise patient. If there is an incision below the knee it is expected that the patient will find the calf muscle very uncomfortable when mobilising. It is important that you give analgesia as prescribed. Mr.Milne may remove dressings – wounds are left open, and shaped stocking put on from toe to knee. As a result of oedema following the procedure lymph or blood stained fluid may leak from any incisions. Plain combine should be used to manage this. In the groin it can be tucked into underwear, on the thigh it is to be secured with a 15cm crepe bandage and below the knee it can be held in place by the tubigrip. Replace combine as often as necessary.

Post-op day three:

Patient can increase mobility. All dressings should be removed by this day and a shaped stocking is to be put on from the toe to the knee.

DO NOT USE AN OCCLUSIVE DRESSING
- Increases risk of infection -

On post-op days five to seven:
Limb swelling is normal. The foot on the operated side is normally warmer than the non-operated side. Because of oedema following the procedure lymph discharge from any one of the incisions may occur. This is normally clear and can be managed with a dry dressing as described above. The suture lines often become somewhat congested and red with lymph leak common in association with limb oedema.

This produces a clear yellow discharge. Any suspicious discharge can be managed by a swab for culture with antibiotics initiated if virulent pathogens are found.

After revascularisation oedema in the lower limb is very common and is most prominent for approximately six weeks. This is associated with erythema of reperfusion. Although suggesting infection, this should not be diagnosed unless there is concomitant fever and/or serology to support same.

The patient is normally discharged from hospital in a shaped tube stocking. This produces graduated compression from the ankle to the knee. It is rare to require more compression but a lymph leak above the knee may benefit from above knee compression.

THE BEST GUIDE TO BYPASS PATENCY IS WARMTH

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