Complications of Abdominal Surgery

There are many complications that can occur following any general surgery. These are listed below, and those that occur frequently following an abdominal surgery are underlined in red. Since thorough nursing assessment can often give early warning to potential complications related to the heart and lungs, use the Auscultation Assistant to practice listening and recognizing suspicious sounds:

- Postoperative hemorrhage
  - assess for increase in blood pressure, decreased heart rate
- Basal atelectasis (minor lung collapse)
  - **Low urine output** (inadequate fluid replacement intra- and post-operatively)
    - assess foley output on admission and Q4 until levels are adequate. If patient is voiding, ensure that a white hat is in the toilet/commode to properly measure output
- Acute confusion
  - exclude dehydration, blood sugar changes, hemodynamic changes, narcotic levels
  - in older adults, assess for urinary tract infection
- **Nausea and vomiting**
  - assess for ileus versus bowel instruction (see Abdominal hysterectomy)
- Fever
  - 3JPW call for typically require the nurse to call the doctor if patient temperature is > or = 38.3 c.
  - Typically, nursing will draw blood cultures, obtain a chest xray, and take a ua with micro
- Pneumonia
- Wound or anastomosis dehiscence
- Deep vein thrombosis (DVT)
- Acute urinary tract infection
- **Post-operative wound infection**
  - assess and monitor abdominal incisions/lap sites for increased redness (see Abdominal hysterectomy)
- **Bowel obstruction versus ileus**
  - assess for nausea, vomiting, constipation, inability to pass flatus (see Abdominal hysterectomy)
- Wound dehiscence
  - Wound will be closed at the bedside with either sutures, surgical tape, or staples, depending on the incision.
  - Contact doctor immediately after assessment, and place all requested supplies at the bedside. This can include a staple kit, needle driver, 3M nylon for sutures, lidocaine.
- Wound evisceration (medical emergency)
  - Wound will be covered with wet dressings. Soak ABDs or kerlix in a basin of NS or lay the dressings over the wound and irrigate them using a 60 cc sterile syringe.
  - Continuously moisten the dressings and inspect exposed viscera for signs of ischemia or necrosis.
  - Never try to push protruding viscera back into the abdomen.
  - Keep the patient in bed in a low Fowler's position. Flex the patient’s knees to reduce tension in the wound area.
  - Make sure patient has a patent IV line.
  - Monitor vital signs every 15 minutes and assess for signs of sepsis.