**NURSING CARE OF THE CLIENT HAVING BOWEL SURGERY**

**PREOPERATIVE NURSING CARE**
- Provide routine preoperative care for the surgical client as outlined in Chapter 7.
- Arrange for consultation with enterostomal therapy (ET) specialist if appropriate. The ET nurse is trained to identify and mark an appropriate stoma location, taking into consideration the level of ostomy, skinfolds, and the client’s clothing preferences. Initial ostomy care teaching also is provided by the ET nurse during the preoperative visit.
- Insert a nasogastric tube if ordered. Although it is often inserted in the surgical suite just prior to surgery, the nasogastric tube may be placed preoperatively to remove secretions and empty stomach contents.
- Perform bowel preparation procedures as ordered. Oral and parenteral antibiotics as well as cathartics and enemas may be prescribed preoperatively to clean the bowel and reduce the risk of peritoneal contamination by bowel contents during surgery.

**POSTOPERATIVE NURSING CARE**
- Provide routine care for the surgical client (Chapter 7).
- Monitor bowel sounds and degree of abdominal distention. Surgical manipulation of the bowel disrupts peristalsis, resulting in an initial ileus. Bowel sounds and the passage of flatus indicate a return of peristalsis.
- Assess the position and patency of the nasogastric tube, connecting it to low suction. If the tube becomes clogged, gently irrigate with sterile normal saline. A nasogastric or gastrostomy tube is used postoperatively to provide gastrointestinal decompression and facilitate healing of the anastomosis. Ensuring its patency is important for comfort and healing.
- Assess color, amount, and odor of drainage from surgical drains and the colostomy (if present), noting any changes or the presence of clots or bright bleeding. Initial drainage may be bright red and then become dark and finally clear or greenish yellow over the first 2 to 3 days. A change in the color, amount or odor of the drainage may indicate a complication such as hemorrhage, intestinal obstruction, or infection.
- Alert all personnel caring for the client with an abdominoperineal resection to avoid rectal temperatures, suppositories, or other rectal procedures. These procedures could disrupt the anal suture line, causing bleeding, infection, or impaired healing.
- Maintain intravenous fluids while nasogastric suction is in place. The client on nasogastric suction is unable to take oral food and fluids and, moreover, is losing electrolyte-rich fluid through the nasogastric tube. If replacement fluid and electrolytes are not maintained, the client is at risk for dehydration; sodium, potassium, and chloride imbalance; and metabolic alkalosis.
- Provide antacids, histamine-2-receptor antagonists, and antibiotic therapy as ordered. The above medications may be ordered for the postoperative client, depending on the procedure performed. Antibiotic therapy is a common measure to prevent infection resulting from contamination of the abdominal cavity with gastric contents.
- Resume oral food and fluids as ordered. Initial feedings may be clear liquids, progressing to full liquids, and then frequent small feedings of regular foods. Monitor bowel sounds and monitor for abdominal distention frequently during this period. Oral feedings are reintroduced slowly to minimize abdominal distention and trauma to the suture line.
- Begin discharge planning and teaching. Consult with a dietitian for instructions and menu planning; reinforce teaching. Teach about potential postoperative complications, such as abdominal abscess, or bowel obstruction, their signs and symptoms, and preventive measures.

*Figure 24–12* ■ Various ostomy levels and sites.

*Figure 24–13* ■ A double-barrel colostomy. The proximal stoma is the functioning stoma; the distal stoma expels mucus from the distal colon.