Lumbar Drains for Aortic Endovascular or Surgical procedure: 2011 Protocol

Lumbar drains are being used in Endovascular & Surgical cases (AAA) cases to reduce the risk of spinal cord ischemia and paraplegia  (improve perfusion related to spinal cord edema)

The same Codman external drainage devise is used for the ventric & the lumbar drain.
Please be aware of the difference in care!

CONTINUOUS MONITORING with INTERMITTENT DRAINAGE

**Transduce Cerebrospinal Fluid Pressure (CSFP):**
- Position patient HOB 30°
- Level transducer to phlebostatic axis  (Yes! The right atrium)
  4th Intercostals space Mid Anterior / Posterior chest
- Level the cylinder to 10 cmH20
- Continuously transduce CSFP
  Turn stopcock off toward the cylinder
- Read waveform on end expiration
- Calculate Spinal Cord Perfusion Pressure (SCPP)
  (MAP – CSFP = SCPP)

**Intermittent Drainage**
- Maintain HOB 30° and level of transducer at phlebostatic axis
- Drain only the prescribed amount (never leave patient)
- Drains by gravity! Draining too fast may cause “spinal” headache

**Call MD /PA / NP for the following:**
1) MAP is < 80 mmHg
2) Spinal Cord Perfusion Pressure (SCPP) < 65 mmHg
3) Change in LOC or Mental Status
4) Headache / nausea
5) Numbness or change of sensation in lower extremities
6) Weakness in lower extremities
5) Change in vital signs

1) **NEVER LEAVE PATIENT UNATTENDED WHEN OPEN TO DRAIN**
2) **NEVER CONNECT A PRESSURE BAG or FLUSH SYSTEM**
3) **Never “backcock” the system  Do Not transduce & drain simultaneously**
   (may lead to accidental over drainage)
4) **Do not use Orange Swabcaps ® on Lumbar Drain**

Approved by Dr Najam May 3rd, 2011