

PROTOCOL FOR: Head and Neck: Myocutaneous Flap Reconstruction, Care of the Patient

SUPPORTIVE DATA: A myocutaneous flap reconstruction is performed in the head and neck cancer patient to reconstruct surgically resected areas that cannot be closed, primarily due to the amount of tissue removed or to poor tissue quality as a result of radiation treatment. The procedure involves the transposition of a section of surrounding tissue and often restores functional and cosmetic defects. Muscles commonly used for the flap reconstruction include the temporalis, pectoralis major, trapezius, latissimus dorsi and sternocleidomastoid. A split thickness skin graft (STSG), which involves the transposition of a layer of epidermis, may also be performed.

Care of the patient post myocutaneous flap reconstruction focuses on assessment of flap viability and the prevention of injury.

**DESIRED
PATIENT OUTCOMES:**

The patient will have minimal to no complications following myocutaneous flap reconstruction.

**CLINICAL
ASSESSMENT
AND CARE:**

1. Assess vital signs every 4 hours for 24 hours. Advance vital signs to every 8 hours when stable.
2. Assess the patient's pain level on a scale of zero to ten at least every four hours. Medicate as ordered for pain and assess the patient's response to analgesia.
3. Assess flap perfusion, noting color, temperature, and capillary refill every two hours for 24 hours, every four hours for 24 hours, then every eight hours.
4. Assess for edema or signs of hematoma formation.
5. Assess the flap incisions and the donor site incisions for signs of bleeding, hematoma, dehiscence, necrosis, and infection.
6. Provide wound care if ordered by the physician.
7. Avoid pressure on flap caused by tracheostomy ties and oxygen collar. The patient should be positioned so as not to be lying on the flap.
8. Drain Care:
 - a. Assess that the drain is functioning as evidenced by maintenance of suction and the drainage of fluid into the drain reservoir.

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- b. Assess the area surrounding the drain insertion site for drainage, edema and/or signs of infection.
 - c. As ordered, while the drain is in place, and with cotton-tipped applicators, cleanse the drain insertion site with a solution of half strength hydrogen peroxide and normal saline followed by a normal saline rinse and a light application of bacitracin ointment.
 - d. Empty, measure and record the drain output every eight hours.
9. If an STSG is present, assess the graft for signs of rejection or infection. Assess the donor site for signs of bleeding or infection. Provide wound care to the donor site as ordered by the physician.
10. Notify the physician for:
- a. poor flap perfusion, edema of flap or hematoma, any areas of dehiscence, necrosis, or signs/symptoms of infection.
 - b. any problems with the wound drainage system.
 - c. complications of the STSG or donor site.

PATIENT

- EDUCATION:
1. Instruct the patient not to lie on the flap.
 2. Instruct the patient and family in the signs and symptoms of flap rejection and wound infection.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/01

REVISION DATES: 12/02, 10/03