# POSTOPERATIVE MANAGEMENT Anticoagulation

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To minimise the risk of graft thrombosis in the early post operative period anticoagulation is indicated for all patients. Every centre has its specific protocol: the exact details are less important than the balance between adequate anticoagulation to minimise thrombosis and over-anticoagula tion leading to bleeding and the need for further surgery . Intravenous unfrac tionated heparin, dextran or epoprostenol are examples of preparations used; monitoring of their e ff ect can be achieved by measuring prothrombin time (PT) and/or thromboelas tography (TEG). TEG is a real-time bedside test that gives a numerical value for overall coagulation. The heparin dose or infusion rate of therapy can be amended according to the TEG or PT results. TEG has an advantage over PT as the r esult is immediate and analysis incorporates the entire clotting cascade and platelet function. Patients usually require 24–48 hours of high-dependency care (high-dependency unit or intensive care unit) and close blood glucose monitoring is essential. Insulin secreted by the transplant pancreas drains directly into the IVC and straight into the systemic circulation without passing through the liver, thereby avoiding first-pass metabolism. This is unlike normal physiology where insulin drains via the portal vein through the liver. As a result of high systemic insulin levels the patient may require intravenous glucose supplementation to maintain blood glucose levels. This phenomenon usually accommodates within 48 hours. If blood glucose levels rise above 8 /uni00A0 mmol/L, then cross-sectional imaging with arterial phase contrast is usually performed to assess for thrombosis. The presence of a small volume of thrombus in the distal ligated end of the SMA is considered normal. However, thrombus propagating from the stump into the SMA, SA thrombus or PV thrombus should be treated with full anticoagulation. The indication for surgery is limited to complete thrombosis of the arterial inflow or PV; thrombectomy usually fails, resulting in graft pancreatectomy .

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