ASPAN
American Society of PeriAnesthesia Nurses

Clinical Practice: Frequently Asked Question

Q: Does ASPAN have any recommendation for bladder scanning on:

- **Post-op urology patients**
- **Outpatients prior to discharge**
- **Patients who have received spinal anesthesia**

Do you have clinical guidelines for a postop bladder protocol which evaluates a patient's post-void residual/what volume straight catheterization or foley catheterization is indicated?

A: Intake and output is an important component of assessment in the postoperative patient.[1] Postoperative urinary retention (POUR) is the inability to urinate following a surgical procedure despite having a full bladder, and is a common problem associated with risk of overdistention and damage to the detrusor muscle. Opioids, anesthetics (especially spinal anesthetics), certain surgical procedures such as pelvic/urologic surgery, a lengthy time in surgery, benign prostatic hyperplasia, and surgical pain increase the risk of POUR. Placing an indwelling catheter to decompress the distended bladder is a frequently used intervention; however, there is a risk of urinary infection with catheterization.[2]

Bladder scanning is a non-invasive technological tool that is increasingly being used in the PACU as an effective means for assessing POUR. It may also be used to monitor bladder volume to determine if interventions are needed before the bladder becomes distended. [2,3] And, it can help to determine if a patient at risk for POUR is able to be discharged without voiding.

The American Society of PeriAnesthesia Nurses (ASPAN) does not currently have a clinical guideline for a POUR protocol. The best treatment for postoperative urinary retention is prevention and should involve the entire treatment team in identifying and optimizing preoperative, intraoperative, and postoperative risk factors so that a preventative plan could be developed. The patient's intake and output should be monitored during surgery. If the patient was not catheterized in surgery, the bladder should be scanned prior to leaving the OR, and a catheter placed if the bladder volume is greater than 400-600ml. In the PACU, patient assessment should include checking the suprapubic area for swelling and asking the patient if they are experiencing pain when they try to void. The patient should be encouraged to try and void. A soothing warm compress could be placed over the suprapubic area. The bladder should be scanned every 2-3 hours for extended stay

patients. If the bladder volume exceeds 400ml-600ml, the physician should be notified so the bladder can be decompressed.

References:

1. American Society of PeriAnesthesia Nurses.2023-2024 perianesthesia nursing standards, practice recommendations and interpretive statements. Cherry Hill, NJ; ASPAN.
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3. Pincus,E, Ng,S, et al. Decreasing Post-operative Urinary Retention in Patients. J PeriAnesth Nurs .2024 Aug;39(4):e21.
4. Wolfe RC, Portell J, Maamari JA. Pharmacologic Management of Postoperative Urinary Retention. J Perianesth Nurs. 2023 Aug;38(4):667-670. doi: 10.1016/j.jopan.2023.05.006. Epub 2023 Jun 14. PMID: 37318437.
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