LARGE VOLUME PARACENTESIS PROTOCOL

Patient selection: Large tense ascites or diuretic failure/ resistance
Exclude spontaneous bacterial peritonitis

Do not perform total paracentesis (LVP) if infection is present or if patient is in hepato-renal failure (renal function will worsen)- but up to 3 litres could be removed to ease discomfort and lower abdominal pressure.

1. Exclude SBP with diagnostic tap within 48 hrs. See SBP protocol.
2. Check recent INR: if > 1.5 discuss with consultant
3. Explain procedure and risks to patient : infection, punctured viscera, bleeding, hypovolaemia.
4. Examine abdomen to select optimum site for drain insertion.
    a. Left or right lower quadrant. Ideally: 2 finger breadths cephalad and 2 finger breadths medial to the anterior superior iliac spine
    b. Alternatively in midline 3cm below umbilicus
5. Aseptic precautions:
    Wash hands
    Sterile gloves
    Skin prep with betadine or equivalent
6. Infiltrate skin with 2% lignocaine down to peritoneum.
7. Make small skin incision with scalpel.
8. Inserting the drain:
    Use a Safe-T-Centesis catheter.
    Alternatively peritoneal dialysis catheter can be used.
    Read manufactures instructions.
    Suture the drain in place (this allows the patient to get up).
    Connect to catheter drainage bag.
9. Send repeat microbiology samples (esp. cell count)

10. **Albumin cover**
    Use 100mls of 20% human albumin solution (H-A-S)
    8g for every litre drained. i.e. 1 bottle for each 2.5l drained

11. Do not clamp drain (unless respiratory function is compromised from very tense ascites – then drain 2-3litres initially, checking for any deterioation)
12. Remove the drain
    When dry
    After a maximum of 8 hours
13. Use a single stitch if required to close the hole.
14. Nursing observations
    15 min pulse and BP for first hour then hourly whilst drain is in place and 3 hourly post removal.
    Record amount drained.
    Continue daily weights.

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