# DUKE ENHANCED RECOVERY

## Gyn Oncology- Open Cases

**PREOPERATIVE PHASE**

EDUCATION in SURGICAL CLINIC

1. DEFINE EXPECTATIONS-Preoperative Counseling and Training-
    a. Exercise
    b. Quit Smoking
    c. Quit drinking alcohol
    d. Healthy Diet and Nutritional supplements

2. LABEL the patient in case request (Check box for ERAS and ± Epidural)
3. COMPLETE Preoperative order set prior to surgery date
4. DEFINE DISCHARGE criteria
    a. Medical criteria that the MD and team will monitor
    b. Ambulating and self-care
    c. Tolerating liquids enough to stay hydrated and to tolerate PO pain regimen

CONFIRMATION of OPTIMIZATION and READINESS-Pre Anesthesia Testing (PAT)

1. IDENTIFY the ERAS patient
2. SCREEN for anesthetic risk and OPTIMIZING opportunities
3. DISTRUBUTE carbohydrate drink (Clearfast-12oz) and instructions
4. DISTRIBUTE CHG sponges and instructions
5. PROVIDE written reinforcement of fasting guidelines- No food after midnight prior to surgery, Clear liquids until 2 hours before surgery and CHO drink prior to arriving at hospital

DAY of SURGERY, PREOP HOLDING

1. IDENTIFY ERAS patient and initiate protocol
2. DOCUMENT CHO drink was taken and document time
3. DOCUMENT if bowel prep completed or not-
4. ADMINISTER and DOCUMENT multimodal drugs
    a. Acetaminophen 975 mg PO
    b. Gabapentin 600 mg PO
    c. Epidural T10-12 in preop holding

**INTRAOPERATIVE PHASE**

1. ADMINISTER VT PROPHYLAXIS
    a. Heparin 5000 Units SC- after epidural is placed
    b. SCD's in place
2. ADMINISTER ANTIBIOTIC PROPHYLAXIS
    a. Ancef 1-2 Gm IV- indicated for Hysterectomy only,
    b. Ertapenem 1g IV- Only for bowel surgery;
    c. No antibiotic indicated for "clean procedure"
3. ADMINISTER MULTIMODAL PAIN MGT during surgery
4. AVOID intraoperative IV opioids (attending anesthesiologist approval required)
5. OPTIMIZE intraoperative fluids with GOAL DIRECTED FLUID THERAPY
6. MAINTAIN normothermia (Temp >36)
7. MINIMIZE tubes, lines, and drains
    a. Foley out except when an epidural is in place or for low pelvic cases
    b. No intra-abdominal drains; pelvic drains at pelvic surgeons discretion

**POSTOPERATIVE PHASE**

1. IDENTIFY patient as ERAS protocol
2. ENFORCE continuous SCD usage from PACU arrival until discharge
3. CONTINUE epidural use from intraop through PACU to ward
4. CONTINUE PONV medications- Zofran 1st line
5. ALLOW a diet immediately- Post Surgical Bland
6. ENCOURAGE Gum Chewing at least 3 times per day
7. AMBULATE immediately and 4 times daily until discharge
8. HOB elevated at 30 degrees at all times
9. OUT of BED at least 6 hours daily in addition to walks
10. MINIMIZE IVF to less than 1L/POD 0-1, then none thereafter
11. INITIATE VT prophylaxis at 8a POD 1
    a. Heparin SC if epidural in place
    b. Lovenox SC after epidural remove
12. REMOVE any remaining Foley on POD 1, unless indicated otherwise
13. OBTAIN routine labs on POD 1 only
14. TRANSITION from epidural/block to oral narcotics once diet is tolerated
15. ENFORCE multimodal, non-narcotic pain management as first line
16. MAINTAIN euglycemia. 24h q6H BS, with intervention and on-going surveillance if >150
17. ENCOURAGE Incentive Spirometry
18. CONTINUE laxative for all non-stoma patients until first BM- Colace and MOM

19. ENFORCE defined discharge criteria
    a. Discuss from POD 0 with patient, family, resident team, and nursing staff
    b. Reinforce expectations and discuss regularly with PATIENT, RN staff, PRM, and family
    c. Anticipate discharge needs
        i. HHN for stoma care
        ii. Lovenox for VT prophylaxis X 28 days
        iii. Follow-up appointments, staple removal, Gyn Onc