DUKE ENHANCED RECOVERY

Radical Cystectomy

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 POST-“ERAS Protocol” in procedure description
3. PROVIDE instructions for individual care pathway and expected hospital stay
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. DISTRIBUTE 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 in PREOP HOLDING
   a. Alvimopan 12 mg PO (provider specific)
   b. Acetaminophen 975 mg PO
   c. Gabapentin 600 mg PO
   d. Epidural or other block

INTRAOPERATIVE PHASE

1. ADMINISTER VT PROPHYLAXIS
    a. Heparin 5000 Units SC
    b. SCD's in place
2. ADMINISTER ANTIBIOTIC PROPHYLAXIS
    a. First line- Cefoxitin; order in place from preop
    b. Second line, Ancef if allergic to Cefoxitin or Cipro and Flagyl
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 for neobladder cases
    b. Pelvic drains at pelvic surgeons discretion
    c. Maintain ureteral stents as ordered
    d. Remove NG prior to transfer to PACU

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. ALLOW a diet immediately- Post Surgical Bland
5. AMBULATE immediately and 4 times daily until discharge
6. HOB elevated at 30 degrees at all times
7. OUT of BED at least 6 hours daily in addition to walks
8. MINIMIZE IVF to less than 1L/POD 0-1, then none thereafter.
9. INITIATE VT prophylaxis at 8a POD 1
10. Remove JP drains and stents after POD5
11. TRANSITION from epidural/block to oral narcotics once diet is tolerated.
12. ENFORCE multimodal, non-narcotic pain management as first line
13. MAINTAIN euglycemia. 24h q6H BS, with intervention and on-going surveillance if >150
14. ENCOURAGE Incentive Spirometry
15. CONTINUE appropriate Entereg until first BM, then D/C
16. CONTINUE laxative for all non-stoma patients until first BM
17. ENFORCE defined discharge criteria
    a. Discuss from POD 0 with patient, family, resident team, and nurse staff
    b. Reinforce expectations and discuss regularly with PATIENT, RN staff, PRM, and family
    c. Anticipate discharge needs
        i. HHN for stoma/urostomy care
        ii. Lovenox for VT prophylaxis for 30 days.
        iii. Follow-up appointments with Oncology/GU.