Perioperative Management of the Radical Cystectomy Patient.

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MAYO CLINIC

Financial Disclosures

- I have no Intuitive stock
- I am not an employee

- I have functioned as a proctor and speaker in the past.

Overview

- ERAS and the current state
- Pre-op Considerations
- Peri-op Considerations
- Post-op Considerations

ERAS?

- ERAS is the fad
- Many things we currently and have done are now en vogue
  - Bowel prep avoidance
  - Narcotic avoidance
  - pathways

Pre-op Considerations

- Unhealthy population
- Use Neoadjuvant chemo – cisplatin based if possible
  - Can use split-dose if cT3 or higher and gfr 50 to 60
- Assess the current Thromboembolic risk and use anticoagulation if high even pre-op

Pre-op Considerations

- Pre-op anemia
  - Often found
  - Especially in chemo patients
- A hgb of 11 or high preferred
  - All cystectomy patients drop at least 2 grams or more (robotic or open)
- Vit C and Iron Sulfate used in all if anemic

Pre-op Considerations

- Nutritional Status
  - Most of the time can't do pre-op IV nutrition but in rare cases can do enteral
  - Most case education with respect to supplements is key
  - If already losing weight and appetite, likely very advanced disease

Pre-op Considerations

- Social situation
- Should be thinking disposition prior to surgery
- Educate the patient
- We have a social work consult to work out any insurance and home health issues

Peri-op

- No old fashioned Nichols prep
  - Just NPO
  - In XRT history cases can do enema night before and in pre-op as well as a bottle of MgCitrate
- Everyone that can should get alvimopan in pre-op
- ?Use of Amicar intra-op

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- Heparin or Lovenox SQ in pre-op

Post –op Care

- No NGT necessary
- Sit in chair evening of surgery
- Ambulate >5 times POD #1
- NPO except meds with sips
- Alvimopan
- Gum chewing

Post –op Care

- Abx for only 24 hours
- Flatus either evening of POD#2 or AM of POD#3
- If tolerate clears then give regular diet
  - Some people will give clears earlier
- Drains and stent per surgeon discretion
- Plan for discharge on POD#4 or #5

Post –op Care

- Fluid boluses rarely if ever needed
- Discharge date should be decided with the patient in pre-op setting
  - Tell them they will be d/c'd on day 3 to 4
- Consider $NaHCO_3$ in patients with neobladders and/or CO_2 <21 post-op

Post –op Care

- I do f/u q48 hours 2 times after DC and check labs
- By that time their stents are out on day 7-10
- Can see them for failure to thrive
- Can intervene early
- Question remains on anticoagulation

Thank you for your attention!