

Provincial Clinical Knowledge Topic

ERAS Cystectomy Surgery, Adult – Inpatient

V 1.2

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Revision History

Version	Date of Revision	Description of Revision	Revised By
1.0	March 2018	Topic Complete	Dr. Eric Hyndman
1.1	April 2018	Acknowledgements amended	Candice Healey
1.2	August 2019	Pre-operative Order Set, Intra-operative Guidance and Post-operative Order Set amended; updates to linked documents	Christine Fantuz

Important Information Before You Begin

An Alberta Health Services (AHS) Provincial Clinical Knowledge Topic is the evidence-informed clinical best practice standard for a specific patient population. Enhanced recovery after surgery (ERAS) Topic content is based on recommendations from published international guidelines and other evidence, with consideration for current practices at ERAS sites and other clinical standards. Topic information strives to adhere to [Institute for Safe Medication Practices \(ISMP\)](#) safety standards, and align with provincial and national Quality and Safety initiatives and standards, e.g. [Health Quality Council Alberta \(HQCA\)](#), [Choosing Wisely](#), [Safer Healthcare Now](#), and [Accreditation Canada](#). The Topic will be reviewed periodically and updated according to best practice evidence and other clinical recommendations and guidelines.

Clinicians using this Topic should, in consultation with the patient, use independent medical judgement in the context of individual clinical circumstances to direct care.

Guidelines

This Topic is based on the following guidance:

- 1) [Guidelines for perioperative care after radical cystectomy for bladder cancer: Enhanced Recovery After Surgery \(ERAS®\) Society recommendations](#)¹
- 2) [Enhanced Recovery After Surgery \(ERAS\) for gastrointestinal surgery. Part 1: pathophysiological considerations](#)²
- 3) [Enhanced Recovery After Surgery \(ERAS\) for gastrointestinal surgery. Part 2: consensus statement for anaesthesia practice](#)³

Keywords

- ERAS
- Enhanced recovery
- Cystectomy
- Urinary diversion
- Surgery
- Adult

ERAS Cystectomy Surgery, Adult – Inpatient

Rationale

International ERAS guidelines were developed to improve patient outcomes, accelerate recovery after surgery, and reduce healthcare costs. ERAS is a multimodal approach, with interventions across all stages of surgical care. Refer to [Enhanced Recovery After Surgery: A Review⁴](#).

The international ERAS guidelines were used in the refinement of provincial care pathways for enhancing recovery after surgery. There are AHS ERAS care pathways developed for Breast Reconstruction (not applicable outside of Foothills Medical Centre, Misericordia Community Hospital and Grey Nuns Community Hospital), Colorectal, Cystectomy, Gynecologic Oncology (not applicable outside of Foothills Medical Centre and Royal Alexandra Hospital), Liver, Major Gynecology, Major Head and Neck (not applicable outside of Foothills Medical Centre and University of Alberta Hospital), and Pancreas surgery. These care pathways are detailed in surgery-specific ERAS Topics.

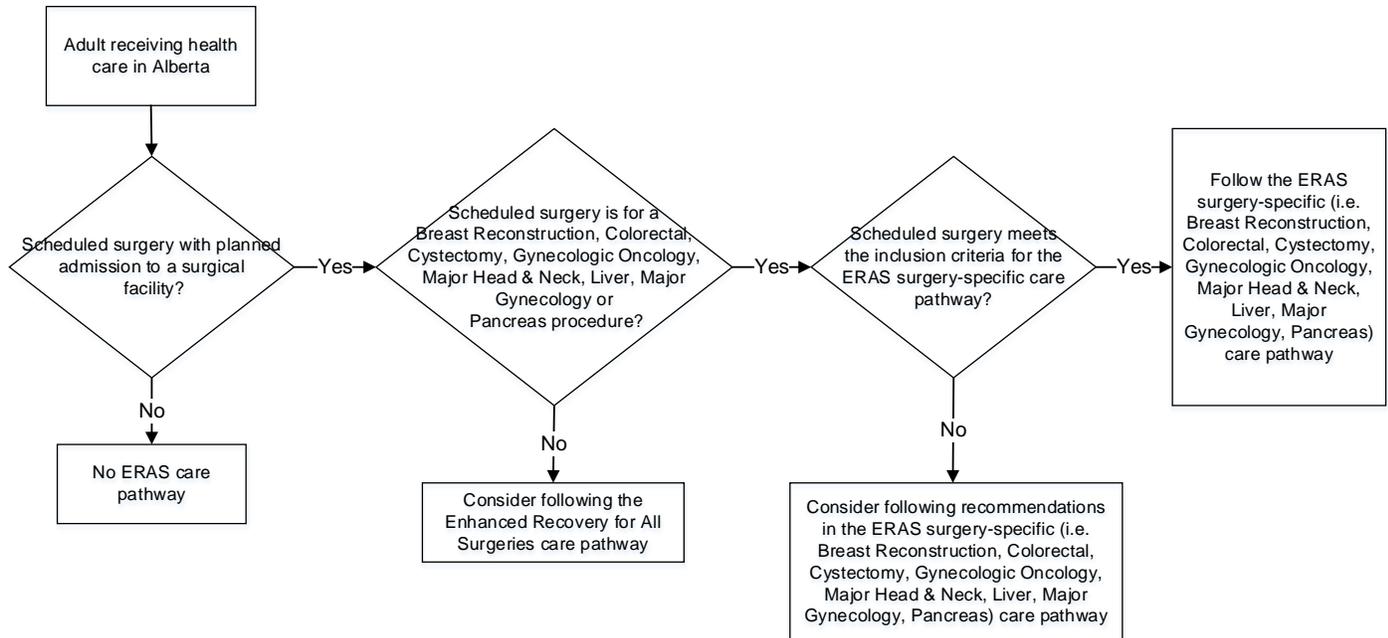
Certain criteria must be met for a patient to be considered for inclusion in an ERAS care pathway. See the Rationale section in each ERAS Topic for specific surgical procedures appropriate for inclusion.

The inclusion criteria (applicable as of July 1, 2017) for the ERAS Cystectomy Surgery, Adult - Inpatient care pathway are

- Adult surgical inpatient undergoing scheduled cystectomy surgery (open or laparoscopic) within Alberta for radical cystectomy with ileal conduit or neobladder

While all eligible patients should be started on the ERAS Cystectomy Surgery, Adult - Inpatient care pathway, individual patient care plans may need to be modified based on surgical findings or additional procedures. Cystectomy surgery patients who do not meet the inclusion criteria (e.g., those undergoing a partial cystectomy procedure) may still be considered for applicable recommendations in the ERAS Cystectomy Surgery, Adult - Inpatient care pathway.

Figure #1 ERASAlberta Care Pathway Inclusion Flowchart



Goals of Management

The goals of clinical management for enhancing the recovery of adult patients after scheduled surgery are to

1. Decrease
 - surgical care length of stay (acute and total) with no increase in readmissions or use of emergency, specialty or primary care related to the post-surgical care
 - surgical complications delaying discharge
 - serious surgical complications including reoperations
2. Increase
 - positive surgical care experiences for patients and families, and providers
 - compliance with ERAS recommendations

This can be achieved by engaging patients and families, clinicians and staff in a multidisciplinary evidence-informed ERAS care pathway focused on

- patient preparation that includes pre-operative optimization, an explanation of the surgical procedure, as well as post-operative expectations and goals to maximize patient participation in their surgical care journey
- Pre-operative fasting and carbohydrate loading following national anesthesia guidelines
- appropriate prophylaxis to prevent or reduce surgical complications including venous thromboembolism (VTE), surgical site infections, nausea and vomiting

- multimodal, opioid-sparing analgesic approaches to improve the management of perioperative pain, nausea and vomiting
- management of physiological surgical stress response
- maintenance of normothermia
- minimally invasive surgical approaches
- balanced fluid management
- avoidance of tubes
- surgical site drains may be used but should be removed as early as clinically appropriate
- mobilization soon after surgery
- stimulation of gut motility
- offer of food and drinks soon after surgery with appropriate nutritional supplements

ERAS Cystectomy Surgery, Adult – Inpatient: Recommendations

ERASAlberta recommendations are based on published international ERAS guidelines and other evidence, with consideration for current practices at ERAS sites and other clinical standards. ERAS[®] Society recommendations are from the Table of Recommendations within [ERAS[®] Society Guidelines](#). The GRADE⁵ methodology was used to determine quality of evidence and strength of recommendation for each ERAS[®] Society recommendation.

Note: Careful consideration should be taken with elderly and/or frail patients, particularly in the area of medication management.

Pre-operative information, education and counselling

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

- **ERAS[®] Society Recommendation:** Patients should receive routine dedicated preoperative counseling and education (surgical details, hospital stay and discharge criteria in oral and written form, stoma education, patient's expectations).
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Pre-operative optimization

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below with the following additions: anemia should be actively identified, investigated, and corrected pre-operatively. Patients should be screened for nutritional status including weight loss within the previous 6 months. All patients at nutrition risk need an assessment to confirm malnutrition. If a patient is malnourished, an in-depth nutrition assessment, along with treatment, is required by a registered dietitian.

Note: Patients with alcohol dependency should wean consumption under the recommendation of a qualified healthcare professional.

- **ERAS[®] Society Recommendation:** Preoperative optimization of medical conditions should be recommended (correction of anemia and co-morbidities; smoking cessation and reduction of alcohol intake 4 weeks prior to surgery; encouraging physical exercise).

Preoperative nutritional support should be considered, especially for malnourished patients.

- **ERAS[®] Society Recommendation - Quality of Evidence:** Anemia/co-morbidities correction (Not available but Rectal Surgery evidence is Moderate), Nutritional support (Not available but Rectal Surgery evidence is High), Smoking cessation and alcohol reduction (Not available but Rectal Surgery evidence is Moderate), Exercise (Not available but Rectal Surgery evidence is Very Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Pre-operative bowel preparation

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

- **ERAS[®] Society Recommendation:** Preoperative bowel preparation can be safely omitted.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Moderate (Rectal Surgery evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Pre-operative fasting and carbohydrate load treatment

ERASAlberta Recommendation: Before scheduled procedures, the minimum duration of pre-operative fasting should be 8 hours after a meal that includes meat, fried or fatty foods, 6 hours after a light meal (such as toast and a clear fluid), and 2 hours after clear fluids as per the [Canadian Anesthesiologists' Society Guidelines to the Practice of Anesthesia - Revised Edition 2019⁶](#). Carbohydrate load treatment should occur between 2 and 3 hours prior to the administration of anesthesia.

Note: The AHS Provincial Clinical Knowledge Topic: [Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient](#) provides recommendations for patients with diabetes mellitus.

- **ERAS[®] Society Recommendation:** Intake of clear fluids up until 2 hours before induction of general anesthesia is recommended. Solids are allowed up until 6 hours before anesthesia. Preoperative oral carbohydrate loading should be administered to all non-diabetic patients.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Preoperative fasting (Not available but Rectal Surgery evidence is Moderate), Preoperative carbohydrate loading (Not available but Rectal Surgery evidence is Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Pre-anesthetic medication

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

- **ERAS[®] Society Recommendation:** Avoidance of long acting sedatives.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Moderate)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Venous thromboembolism prophylaxis

ERASAlberta Recommendation: Patients should have a sequential compression device (SCD) applied, and receive pre-operative or intra-operative pharmacological prophylaxis with heparin. Extended prophylaxis with low molecular weight heparin (LMWH) should be given for an additional 28 days post-discharge to patients with cancer or other patients with increased risk of venous thromboembolism (VTE). Risk assessment is required in accordance with the AHS-Wide Policy Suite – Venous Thromboembolism Prophylaxis ([Policy](#) and [Guideline](#)).
Note: Refer to the AHS Provincial Clinical Knowledge Topic: *VTE Prophylaxis, Adult – Inpatient* ([link to be added once available](#)).

- **ERAS[®] Society Recommendation:** Patients should wear well-fitting compression stockings, and receive pharmacological prophylaxis with LMWH. Extended prophylaxis for 4 weeks should be carried out in patients at risk (note: cystectomy patients are considered at risk so prolonged prophylaxis should therefore be administered). 12 hour interval between injections and epidural manipulation.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Antimicrobial prophylaxis and skin preparation

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below with antibiotic provision as per [AHS Recommended Drug Regimens for Surgical Prophylaxis in Adult Patients](#).

- **ERAS[®] Society Recommendation:** Patients should receive a single dose antimicrobial prophylaxis 1 hour before skin incision. Skin preparation with chlorhexidine-alcohol prevents/decreases surgical site infection.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Antimicrobial prophylaxis (Not available but Rectal Surgery evidence is High), Skin preparation (Not available but Rectal Surgery evidence is Moderate)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Prophylaxis (Strong), Cleansing (Strong)

Prevention of post-operative nausea and vomiting (PONV)

ERASAlberta Recommendation: All patients need to be pre-operatively assessed for risk⁷ and provided with perioperative PONV prophylaxis accordingly. A multimodal approach to PONV prophylaxis should be adopted in all high risk patients.⁸

- **ERAS[®] Society Recommendation:** A multimodal PONV prophylaxis should be adopted in all patients with ≥ 2 risk factors.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Very Low (Rectal Surgery evidence is Low except in high-risk patients where evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Standard anesthetic protocol

ERASAlberta Recommendation: Emphasis is placed on using short acting anesthetic agents with consideration for the use of total intravenous anesthesia (TIVA) instead of inhalation anesthetic. Opioids should be used sparingly and if needed, short acting opioids are recommended.

- **ERAS[®] Society Recommendation:** To attenuate the surgical stress response, intraoperative maintenance of adequate hemodynamic control, central and peripheral oxygenation, muscle relaxation, depth of anesthesia, and appropriate analgesia is recommended. Fast acting agents (recommendation unknown).
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Moderate)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Prevention of intra-operative hypothermia

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.
Note: Suitable warming devices should be used.

- **ERAS[®] Society Recommendation:** Normal body temperature should be maintained pre-and postoperatively (especially relevant for cystectomy patients since operative duration is prolonged).
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Perioperative fluid management

ERASAlberta Recommendation: Very restrictive or liberal fluid regimes should be avoided in favour of euvoemia. The use of advanced hemodynamic monitoring to facilitate individualized fluid therapy during the perioperative period should be considered, especially for high risk patients and patients for which significant intravascular volume loss is anticipated. Balanced crystalloid solutions are preferred to sodium chloride 0.9%. The enteral route for fluid post-operatively should be used as early as possible, and intravenous fluids should be discontinued as soon as clinically appropriate.

- **ERAS[®] Society Recommendation:** Fluid balance should be optimized by targeting cardiac output using the esophageal Doppler system or other systems for this purpose and avoiding overhydration (high-risk patients need close and individualized goal directed fluid management. There are several ways to achieve this and all must be used together with sound clinical judgment). Judicious use of vasopressors is recommended with arterial hypotension.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Low (Rectal Surgery evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Minimally invasive surgery (MIS)

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

- **ERAS[®] Society Recommendation:** Laparoscopic/robotic cystectomy is not recommended outside a trial setting until long term results are available.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Low (Rectal Surgery evidence is Moderate)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Nasogastric intubation

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

- **ERAS[®] Society Recommendation:** Postoperative nasogastric intubation should not be used routinely (early removal is recommended).
- **ERAS[®] Society Recommendation - Quality of Evidence:** Low (Rectal Surgery evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Surgical site drains

ERASAlberta Recommendation: Surgical drains are indicated for cystectomy patients.

- **ERAS[®] Society Recommendation:** Perianastomotic and/or pelvic drain can be safely omitted (because of urine leak, drainage might be required in cystectomy patients).
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Weak

Urinary drainage

ERASAlberta Recommendation: Ureteral stents, ileoconduit or transurethral neobladder catheter should be used. Transurethral neobladder catheter should be discontinued when clinically indicated.

- **ERAS[®] Society Recommendation:** Transurethral catheter can be removed on postoperative day (POD) 1 after pelvic surgery in patients with a low risk of urinary retention (ureteral stents and transurethral neobladder catheter should be used. The optimal duration of ureteral stenting [at least until POD 5] and transurethral catheterization is unknown).
- **ERAS[®] Society Recommendation - Quality of Evidence:** Very Low (Rectal Surgery evidence is Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Weak

Prevention of post-operative ileus

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

- **ERAS[®] Society Recommendation:** A multimodal approach to optimize gut function should involve gum chewing and oral magnesium.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Moderate (Rectal Surgery evidence is Moderate)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Post-operative analgesia

ERASAlberta Recommendation: The use of multimodal opioid-sparing strategies is recommended including thoracic epidural analgesia (TEA). When TEA is contraindicated, transversus abdominis plane (TAP) catheters or rectus sheath blocks are acceptable options for post-operative analgesia.

- **ERAS[®] Society Recommendation:** Thoracic epidural analgesia (TEA) is superior to systemic opioids in relieving pain. It should be continued for 72 hours. A multimodal postoperative analgesia should include TEA.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is High)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Post-operative glucose control

ERASAlberta Recommendation: ERAS elements that reduce metabolic stress should be employed to reduce insulin resistance and the development of hyperglycemia. Insulin therapy to maintain normoglycemia is recommended, if applicable.

Note: The AHS Provincial Clinical Knowledge Topic: [Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient](#) provides recommendations for patients with diabetes mellitus.

- **ERAS[®] Society Recommendation:** None
- **ERAS[®] Society Recommendation - Quality of Evidence:** N/A
- **ERAS[®] Society Recommendation - Strength of Recommendation:** N/A

Post-operative nutritional care

ERASAlberta Recommendation: Patients should be allowed a normal diet as tolerated after surgery. They should be cautioned to begin carefully and increase intake according to tolerance over 3 to 4 days. Oral nutritional supplements (ONS) should be used to supplement total caloric and protein intake.

- **ERAS[®] Society Recommendation:** Early oral nutrition should be started 4 hours after surgery.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Moderate)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Early mobilization

ERASAlberta Recommendation: Same as the ERAS[®] Society recommendation below.

Note: Mobilization to start the evening of post-operative day (POD) 0.

- **ERAS[®] Society Recommendation:** Early mobilization should be encouraged (2 hours out of bed POD 0 and 6 hours out of bed POD 1)
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Audit outcomes and compliance

ERASAlberta Recommendation: A systematic audit is essential to determine clinical outcomes and measure overall compliance with clinical recommendations. Reporting on patient experience and functional recovery using validated tools may also be useful. Using more evidence-based elements of perioperative care from an ERAS guideline are likely to improve outcomes further.

- **ERAS[®] Society Recommendation:** All patients should be audited for protocol compliance and outcomes. Routine audit should include outcomes, cost-effectiveness, compliance and changes in protocol.
- **ERAS[®] Society Recommendation - Quality of Evidence:** Not available (Rectal Surgery evidence is Low)
- **ERAS[®] Society Recommendation - Strength of Recommendation:** Strong

Clinical Decision Support

The ERAS Cystectomy Surgery, Adult - Inpatient Topic is intended to guide clinicians in enhancing surgical care for all patients who meet the inclusion criteria for the ERAS care pathway. The ERAS clinical knowledge and patient information contained within this Topic are intended to be used as a comprehensive package applied to a surgical care population. All recommendations should be applied to all eligible patients. The anticipated benefits of care management are reduced if the care pathway is applied selectively.

Clinical decision support tools relevant to the ERAS Cystectomy Surgery, Adult - Inpatient care pathway include the following

[AHS Pre-Operative Fasting and Carbohydrate Loading Prior to Surgical Interventions - Adults Guideline](#)

[AHS Recommended Drug Regimens for Surgical Prophylaxis in Adult Patients](#)

[AHS Safe Surgery Checklist](#)

[AHS Use of Aprepitant \(Emend[®]\) for Prevention of Postoperative Nausea and Vomiting \(PONV\) in Adults](#)

[AHS Venous Thromboembolism Prophylaxis Guideline](#)

AHS VTE Prophylaxis Weight-Band Table – *please see AHS internal website*

[Canadian Anesthesiologists' Society Guidelines to the Practice of Anesthesia - Revised Edition 2019⁶](#)

[Canadian Nutrition Screening Tool \(CNST\)](#)

[Choosing Wisely Canada: Drop the Pre-Op Toolkit](#)

[Choosing Wisely Canada: Recommendations and Resources, by Specialty](#)

[Consensus Guidelines for the Management of Postoperative Nausea and Vomiting⁸](#)

[Eating and Drinking Before Surgery: Patient Instructions](#)

Preoperative ERAS Cystectomy care pathway - [Appendix A](#)

Other important clinical information relevant to the ERAS Cystectomy Surgery, Adult - Inpatient care pathway can be found in [References](#) and [Additional Information](#).

ERAS Cystectomy Surgery, Adult – Inpatient Pre-operative Order Set

Order Set Components

Order Set Keywords: ERAS, Cystectomy, Pre-admission, Pre-operative, Surgery

Before Day of Procedure

Patient Teaching

- Teach: provide ERAS material and discuss perioperative patient goals
 - [Your Surgery Journey – Patient Guide](#)

Refer to [AHS Pre-Operative Fasting and Carbohydrate Loading Prior to Surgical Interventions - Adults Guideline](#). Refer to [MyHealth.Alberta.ca](#) for specific patient instructions.

- Teach: Eating and Drinking Before Surgery: Patient Instructions – *Non-Diabetic*

OR

Choose ONE:

- Teach: Eating and Drinking Before Surgery: Patient Instructions – *Non-Diabetic, Fasting Only*
- Teach: Eating and Drinking Before Surgery: Patient Instructions - *Diabetic*
- Instruct patient to hold _____ medication(s) _____ days prior to scheduled surgery

Consults and Referrals

- Physician: Anesthesia
- Physician: Internal Medicine
- Nurse Specialized in Wound, Ostomy and Continence (NSWOC)
- Physiotherapy
- Screen for nutrition risk: use [Canadian Nutrition Screening Tool \(CNST\)](#)
 - Refer to Registered Dietitian if CNST score equals 2 Yes answers

Laboratory Investigations

- Complete Blood Count (CBC) with differential
- PT INR
- PTT
- Albumin
- Creatinine/eGFR
- Electrolytes (Na, K, Cl, CO₂)
- Hemoglobin A1C: if not performed within last 3 months
- Urea
- Type and Screen
- Urine Bacterial Culture

Diagnostic Investigations

- GR Chest, 2 Projections (Chest X-Ray PA and Lateral)
- Electrocardiogram

Day of Procedure

Patient Care

Discuss Goals of Care with patient or alternate decision-maker and complete or update Goals of Care Designation. Refer to AHS Provincial Clinical Knowledge Topic: [Advance Care Planning and Goals of Care Designations, All Ages – All Locations](#).

- Apply sequential compression device (SCD)
- Apply forced-air warming device

Monitoring

- Vital Signs: AM of surgery
- Weight: AM of surgery
- Blood Glucose Monitoring Point of Care Testing (POCT): AM of surgery

Diet/Nutrition

Refer to [AHS Pre-Operative Fasting and Carbohydrate Loading Prior to Surgical Interventions - Adults Guideline](#).

The minimum duration of pre-operative fasting prior to the administration of anesthesia should be 8 hours after a meal that includes meat or fried or fatty foods, 6 hours after a light meal (such as toast and a clear fluid), 2 hours after clear fluids.⁶

Pre-operative eating and drinking

- Clinical Communication: Final snack 8 hours prior to scheduled surgery
- Clinical Communication: Clear fluids until 3 hours prior to scheduled surgery
- NPO 2 hours prior to scheduled surgery

Refer to AHS Provincial Clinical Knowledge Topic: [Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient](#). The recommendation is to avoid carbohydrate loading³ patients with diabetes mellitus until prospective trials have been completed.

Clinicians should use independent medical judgement in the context of individual clinical circumstances and delete the following order if required.

Pre-operative carbohydrate loading

- Clear apple juice or cranberry cocktail (refer to [Appendix B](#)) 500 mL PO 3 hours prior to scheduled surgery. Must be consumed by 2 hours prior to scheduled surgery
 - If patient's admission is greater than 3 hours prior to scheduled surgery, provide carbohydrate load
- Assess and document last consumption of food and fluids (including carbohydrate load)

Intravenous Therapy

- Intravenous Cannula: insert intra-operatively
- Intravenous Cannula: insert pre-operatively, apply saline lock

Medications

VTE Prophylaxis

Refer to AHS Provincial Clinical Knowledge Topic: [VTE Prophylaxis, Adult – Inpatient](#) (link to be added once available). Refer to [AHS Venous Thromboembolism Prophylaxis Guideline](#).

- heparin 5000 units SUBCUTANEOUSLY once pre-operatively

Antibiotic Prophylaxis

Antibiotics should be given within 60 minutes prior to incision.

Choose ONE option:

Option 1:

- ceFAZolin 2 g IV once pre-operatively

AND

- metroNIDAZOLE 500 mg IV once pre-operatively

Option 2 if patient has ceFAZolin allergy or severe non-IgE mediated reaction to any β -lactam:

- gentamicin (1.5 mg/kg) _____ mg IV once pre-operatively

AND

- clindamycin 600 mg IV once pre-operatively

Analgesics

Consider dose reduction if patient is elderly.

- acetaminophen 975 to 1000 mg PO once pre-operatively, to be given 1 hour prior to surgery. Maximum of 4000 mg acetaminophen in 24 hours from all sources
- gabapentin 300 mg PO once pre-operatively, to be given 1 hour prior to surgery

Antiemetics

If patient has 3 or 4 of the following risk factors for post-operative nausea and vomiting (PONV)⁷

- female gender
- non-smoker
- history of PONV or motion sickness
- post-operative use of opioids

AND patient meets one of the following criteria

- High risk of developing PONV within 24 hours after surgery AND history of being refractory to other antiemetic treatments
- Risk of medical sequelae of vomiting (i.e. jaw wiring, neurosurgery, upper gastrointestinal surgery)

Choose aprepitant:

- aprepitant 80 mg PO once pre-operatively, to be given 1 hour prior to surgery

Glycemic Management Medications

Refer to AHS Provincial Clinical Knowledge Topic: [Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient](#).

ERAS Cystectomy Surgery, Adult – Inpatient Intra-operative Guidance

Normothermia

- Operating Room temperature at least 20°C
- Monitor patient's temperature intra-operatively

- Use forced-air warming device for all procedures lasting longer than 30 minutes to achieve/maintain a temperature between 36°C to 38°C throughout the perioperative period
- Use fluid warmers for procedures in which greater than 1 litre fluid is expected to be administered

Post-operative Nausea and Vomiting (PONV) Prophylaxis

- Provide multimodal prophylaxis with consideration to patient's PONV risk score and administration of pre-operative PONV prophylaxis⁸

Pain Management

- Consider the use of regional anesthesia (transversus abdominis plane [TAP] block or rectus sheath block) or thoracic epidural analgesia (TEA) if applicable, and discuss decision with surgical team
- Use opioids sparingly. If needed, short acting opioids are recommended. Long acting opioids should be avoided. Patients with pre-operative chronic pain may require additional assessment based on their Best Possible Medication History (BPMH). Consider non-opioid analgesia or appropriate opioid-sparing adjuncts

Additional Guidance

- Consider the use of total intravenous anesthesia (TIVA) instead of inhalation anesthetic
- Avoid routine nasogastric intubation
- Fluid therapy goal is to maintain euvolemia. If appropriate, use goal-directed fluid management to guide fluid therapy especially for high risk patients and for patients undergoing surgery with significant intravascular volume losses anticipated
- Use surgical site drains judiciously

ERAS Cystectomy Surgery, Adult – Inpatient Post-operative Order Set

Order Set Components

Order Set Keywords: ERAS, Cystectomy, Post-operative, Surgery

Admit, Transfer, Discharge

- Anticipated Date of Discharge: _____

Patient Care

Discuss Goals of Care with patient or alternate decision-maker and update Goals of Care Designation, if applicable. Refer to AHS Provincial Clinical Knowledge Topic: [Advance Care Planning and Goals of Care Designations, All Ages – All Locations](#).

- Sequential compression device (SCD): discontinue when ambulating well

Monitoring

- Vital Signs: assess as per local institutional practices
- Opioid Monitoring: monitor as per local institutional practices
- Pain Score and Nausea Score: assess at least every 4 hours x 3 days **and then** every 8 hours
- Blood Glucose Monitoring Point of Care Testing (POCT): QID

Activity

- Activity as tolerated
 - Post-operative day (POD) 0: stand at bedside, up in chair, walk to doorway and back; activity goal is 2 hours
 - POD 1: up in chair each meal, ambulate at least 3 times daily; activity goal is 4 hours
 - POD 2 until discharge: up in chair each meal, ambulate at least 3 times daily; activity goal is 6 hours
- Notify physiotherapist if pre-operative mobility concerns or if patient requires more than one-person assist

Intake and Output

- Intake: assess intake every 8 hours x 4 days, include strict oral intake
- Output: assess urine output every 2 hours x 3 days **and then** every 8 hours. Notify most responsible health practitioner if less than 30 mL/hour for 2 consecutive hours
- Indwelling Urinary Catheter: connect to straight drainage
- Suprapubic Urinary Catheter: connect to straight drainage
- Neobladder – Indwelling Urinary Catheter: irrigate with 60 mL of sodium chloride 0.9% every 6 hours
 - Irrigate gently and slowly, may aspirate if needed. Passive drainage is acceptable. Do not deflate urinary catheter balloon
- Ileal Conduit Stoma Care: connect to straight drainage
- Weight: assess daily x 3 days, start on POD 1
- Active Suction Drain(s): reprime every 8 hours and PRN, record output
- Remove Stents (on or before POD 8) on: _____ as per local institutional practices

Only if clinically indicated and non-fenestrated stents used choose Irrigate Non-Fenestrated Stents:

- Irrigate Non-Fenestrated Stents: use sodium chloride 0.9% 10 mL once daily and PRN

Diet/Nutrition

- Clear Fluids Diet: start on POD 0
- Post-Surgical Transition Diet: start after assessment by most responsible health practitioner, goal is on or before POD 2
- Regular Diet: start after assessment by most responsible health practitioner, goal is on or before POD 2
- Regular Diabetic – Adult Diet: start after assessment by most responsible health practitioner, goal is on or before POD 2

Protein/Calorie Dense Oral Nutritional Supplements

Appropriate when patient is on any type of oral diet including Gluten-free and Diabetic – Adult. Suitable for lactose intolerance but NOT appropriate for dairy allergy. Achieve a supplement intake of 300 kcal/day on POD 0 and 600 kcal/day on POD 1 until discharge.

- Ensure Protein Max: 90 mL PO 3 times daily, start on POD 0 **and then** 90 mL PO 5 times daily, start on POD 1 until discharge

Wound Care

- Surgical Incisions: assess every 8 hours and PRN
- Wound Dressing Instructions: _____

- Active Surgical Drain(s) Care: assess and change dressing daily and PRN
- Remove Staples on: _____

Respiratory Care

- Incentive Spirometry: perform every 1 hour while awake
- Oxygen Therapy: titrate to saturation, maintain SpO₂ greater than 92%
- Head of Bed: elevate to at least 30 degrees while patient on opioids or epidural

Laboratory Investigations.

- Complete Blood Count (CBC) with differential on POD 0 at _____ hours
- Creatinine on POD 0 at _____ hours
- Electrolytes (Na, K, Cl, CO₂) on POD 0 at _____ hours

- Complete Blood Count (CBC) with differential, start on POD 1 in AM and repeat daily x 5 days

If patient is receiving VTE prophylaxis choose repeat CBC with differential:

- Complete Blood Count (CBC) with differential, start on POD 1 in AM and repeat every 3 days x 5 times

- Creatinine, start on POD 1 in AM and repeat daily x 5 days
- Electrolytes (Na, K, Cl, CO₂), start on POD 1 in AM and repeat daily x 5 days
- Magnesium (Mg) on POD 1 in AM
- Phosphate on POD 1 in AM

Special Fluids

- Fluid Creatinine: collect from Active Suction Drain

Intravenous Therapy

- sodium chloride 0.9% lock when patient tolerating oral fluid intake
- lactated ringer's infusion IV at 100 mL/hour if patient **not** tolerating oral fluid intake, lock when patient tolerating oral fluid intake

Medications

VTE Prophylaxis

Refer to AHS Provincial Clinical Knowledge Topic: VTE Prophylaxis, Adult – Inpatient (link to be added once available). Refer to AHS VTE Prophylaxis Weight-Band Table (see AHS internal website) if patient has reduced renal function or is less than 40 kg or greater than 100 kg.

If patient is at increased risk of VTE (refer to [AHS Venous Thromboembolism Prophylaxis Guideline](#)) consider extended prophylaxis (up to 4 weeks post-discharge) with low molecular weight heparin (LMWH).

Choose ONE:

- tinzaparin 4500 units SUBCUTANEOUSLY once daily at _____ hours (hh mm), start on POD _____ until discharge
- tinzaparin 4500 units SUBCUTANEOUSLY once daily at _____ hours (hh mm), start on POD _____ and extend therapy for 28 days
- Teach LMWH self-injection in preparation for discharge

Antilucer Agents and Acid Suppressants

- pantoprazole EC tab 40 mg PO daily before breakfast until discharge
- ranitidine 150 mg PO BID until discharge

Bowel Stimulation

- Chew gum 3 times daily (minimum 30 minutes each time), as tolerated

Choose ONE:

- magnesium gluconate 1000 mg PO BID, start on POD 1, discontinue after first bowel movement
- magnesium hydroxide 30 mL PO BID, start on POD 1, discontinue after first bowel movement
- polyethylene glycol 3350 powder 17 g PO daily until discharge, start when patient able to resume oral intake

Analgesics

Consider non-opioid analgesia or appropriate opioid-sparing multimodal analgesia. If needed, short acting opioids are recommended. Long acting opioids should be avoided.

- Follow Anesthesia/Acute Pain Service orders for continuous regional epidural, nerve block therapy and/or patient controlled analgesia (PCA)
- Follow Surgery orders for patient controlled analgesia (PCA)

Prophylaxis Analgesics

Consider dose reduction if patient is elderly.

- acetaminophen 975 to 1000 mg PO every 6 hours x 48 hours **and then** acetaminophen 975 to 1000 mg PO every 6 hours PRN for pain.
Maximum of 4000 mg acetaminophen in 24 hours from all sources

Use caution if patient has renal impairment or is at high risk of acute kidney injury.

- ibuprofen 400 mg PO every 6 hours x 48 hours **and then** ibuprofen 400 mg PO every 6 hours PRN for pain

OR

If patient is NPO choose BOTH:

Use caution if patient has renal impairment or is at high risk of acute kidney injury.

- ketorolac 10 mg IV every 6 hours x 48 hours

AND THEN

Use caution if patient has renal impairment or is at high risk of acute kidney injury.

- ibuprofen 400 mg PO every 6 hours PRN for pain

PRN Oral Opioids (for pain not controlled by non-opioid analgesia)

Consider dose reduction if patient is elderly or opiate-naïve.

- oxyCODONE 5 to 10 mg PO every 4 hours PRN for pain not controlled by non-opioid analgesia

PRN Parenteral Opioids (for pain not controlled by oral opioids, or oral analgesia is contraindicated)

Consider dose reduction if patient is elderly or opiate-naïve.

Choose ONE:

- morphine 1 to 5 mg IV/SUBCUTANEOUSLY every 4 hours PRN for pain not controlled by oral opioids

- HYDROmorphine 0.5 to 2 mg IV/SUBCUTANEOUSLY every 4 hours PRN for pain not controlled by oral opioids

Antiemetics⁸

Consider dose reduction if patient is elderly or has reduced renal function.
Choose ONE option:

Option 1:

Choose ALL:

- ondansetron 8 mg PO/NG (or ODT if difficulty swallowing or active vomiting with no IV access) every 8 hours x 48 hours **and then** ondansetron 4 mg PO/NG every 8 hours PRN
- ondansetron 4 mg IV every 8 hours x 48 hours **and then** ondansetron 4 mg IV every 8 hours PRN if oral dose is **not** tolerated

AND

- metoclopramide 10 mg PO/NG/IV/IM every 6 hours PRN

Option 2:

Choose BOTH:

- metoclopramide 10 mg PO/NG/IV/IM every 6 hours x 48 hours **and then** metoclopramide 10 mg PO/NG/IV/IM every 6 hours PRN

AND

- ondansetron 4 mg PO/NG/IV (or ODT if difficulty swallowing or active vomiting with no IV access) every 8 hours PRN. If nausea and vomiting persist after first PRN dose, notify prescriber

Glycemic Management Medications

Refer to AHS Provincial Clinical Knowledge Topic: [Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient](#).

Patient Teaching

- Teach: ileal conduit self-management
- Teach: indwelling urinary catheter self-management for neobladder

Consults and Referrals

- Nurse Specialized in Wound, Ostomy and Continence (NSWOC), if applicable
- Physiotherapy
- Registered Dietitian
- Social Work
- Transition Services

Rural Considerations

The ERAS clinical knowledge and patient information contained within each Topic are intended to be used as a comprehensive package to maximize the anticipated benefits of care management. Considerations for application of ERAS care pathways (developed for Breast Reconstruction, Colorectal, Cystectomy, Gynecologic Oncology, Liver, Major Gynecology, Major Head and Neck, and Pancreas surgery) in rural surgical facilities within Alberta include

- Surgical procedure criteria must be met (see the Rationale section in each ERAS Topic).

- Adult patients scheduled for Breast Reconstruction, Colorectal, Cystectomy, Gynecologic Oncology, Liver, Major Gynecology, Major Head and Neck, or Pancreas surgery who do not meet the inclusion criteria for the ERAS care pathway may still be considered for applicable recommendations of that pathway (see the Recommendations section in each ERAS Topic)
- Adult patients scheduled for any other type of surgery may be considered for the Enhanced Recovery for all Surgeries, Adult – Inpatient, Ambulatory care pathway
- Clinical expertise (e.g., surgeon, anesthesia and nursing), clinical support services (e.g., nutrition services, pharmacy, physiotherapy, laboratory, diagnostic imaging), and additional resources (e.g., medications, nutritional supplements, sequential compression devices, active warming devices) are available for the duration of clinical care from admission to discharge (see the Recommendations section in each ERAS Topic)
 - There must also be site physician and operations leadership, a site team focused on learning and collaboration, and processes and resources to audit outcomes and compliance

Disposition Planning

Discharge

Prior to patient discharge from the ERAS care pathway, the following should be considered

- Patient is medically stable
- Patient is functioning close to or at pre-operative level for activities of daily living
- Patient is passing gas or stool
- Patient is tolerating solid food
- Patient's pain is well controlled on oral analgesia
- Patient's nausea is well controlled with no vomiting
- Patient's incisions and/or wounds are healing and managed with appropriate wound care products
- Patient is able to self-catheterize, if appropriate
- Patient is able to manage ileal conduit or indwelling urinary catheter, if appropriate
- Patient is able to manage drains and/or self-injection, if appropriate

- Discharge medication list and prescription(s) have been provided to patient
- Discharge teaching is complete and a copy has been provided to patient
- Transition Services/Home Care Services have been arranged, if required
- Nurse Specialized in Wound, Ostomy and Continence (NSWOC) appointment has been arranged, if required
- Wound care/negative-pressure wound therapy supplies have been arranged, if required

- Patient has been referred to the following education resources
 - [Your Surgery Journey – Patient Guide](#)
 - [Bladder Cancer Canada: Patient Guidebook for Patients Facing Radical Cystectomy](#)
 - MyHealth.Alberta.ca
 - [Care for an Indwelling Urinary Catheter](#) (male and female)
 - [Patient Care Webpages](#) including After Surgery and [Incision Care After Surgery](#)

- [Patient Care Handouts](#) including Before and After Surgery - Adult - [What to Expect at Home](#)
- [Patient Care Videos](#) including Before and After Surgery – [Preventing Problems After Surgery](#)

Outpatient follow-up

- If applicable, patient to have staples removed in 7 to 10 days by family physician or in surgeon’s clinic
- Patient to follow up with family physician or surgeon in 4 to 6 weeks

Analytics

Outcome Measure #1

Name of Measure	ERASAlberta coverage rate
Definition	Number of surgeries performed that were verified ERAS surgeries divided by the total surgeries performed that were eligible ERAS surgeries, multiplied by 100. Calculated provincially, by zone, by site.
Rationale	Intended to measure the ability of ERASAlberta to provide enhanced recovery after surgery.

Outcome Measure #2

Name of Measure	ERASAlberta length of stay (LOS) rates
Definition	Number of surgeries performed that were verified ERAS surgeries and resulted in <ul style="list-style-type: none"> • acute LOS less than or equal to acute LOS benchmark • ICU LOS less than or equal to ICU LOS benchmark • readmission LOS less than or equal to readmission LOS benchmark • total LOS less than or equal to total LOS benchmark divided by the total surgeries performed that were verified ERAS surgeries, multiplied by 100. Calculated provincially, by zone, by site.
Rationale	Demonstrates how ERAS impacts patient care by decreasing post-operative complications and accelerating recovery, thereby allowing for earlier discharge.

Outcome Measure #3

Name of Measure	ERASAlberta readmission rate
Definition	Number of surgeries performed that were verified ERAS surgeries and resulted in greater than or equal to 1 unplanned readmission to acute care within 30 days of discharge date divided by the total surgeries performed that were verified ERAS surgeries, multiplied by 100. Calculated provincially, by zone, by site.
Rationale	Demonstrates how ERAS impacts patient care by decreasing post-operative complications and accelerating recovery, thereby reducing the risk of readmission.

Outcome Measure #4

Name of Measure	ERASAlberta compliance rates
Definition	<p>Number of surgeries performed that were verified ERAS surgeries in which specific</p> <ul style="list-style-type: none"> • ERAS pre-operative care • ERAS intra-operative care • ERAS post-operative care <p>was provided in compliance with ERASAlberta recommendations divided by the total surgeries performed that were verified ERAS surgeries, multiplied by 100. Calculated by site.</p>
Rationale	Compliance with ERASAlberta recommendations is an indicator of the appropriateness of the ERAS care pathway in achieving desired patient outcomes.

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Additional Information

AHS Enhanced Recovery after Surgery (ERAS)

www.ahs.ca/ERAS

AHS Knowledge Resource Service ERAS Subject Guide: Surgery Subject Guide

<https://krs.libguides.com/surgery/eras>

AHS Pre-Operative Fasting and Carbohydrate Loading Prior to Surgical Interventions - Adults Guideline

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-preop-fasting-carb-load-hcs-237-01.pdf>

AHS Provincial Clinical Knowledge Topic: *Advance Care Planning and Goals of Care Designations, All Ages – All Locations*

<https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-advance-care-planning-goals-of-care-designations-all-ages-all-locations.pdf>

The AHS Provincial Clinical Knowledge Topic: *Perioperative Management of Patients with Diabetes Mellitus, Adult – Inpatient*

<https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-perioperative-diabetes-guidelines-adult-inpatient.pdf>

AHS Provincial Clinical Knowledge Topic: *VTE Prophylaxis, Adult – Inpatient*
(link to be added once available)

AHS Recommended Drug Regimens for Surgical Prophylaxis in Adult Patients

<https://www.albertahealthservices.ca/assets/info/hp/as/if-hp-as-surgical-prophylaxis.pdf>

AHS Safe Surgery Checklist

<http://www.albertahealthservices.ca/assets/about/scn/ahs-scn-surg-ssc-checklist.pdf>

AHS Safe Surgery Checklist Policy

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-safe-surgery-checklist-ps-04-policy.pdf>

AHS Use of Aprepitant (Emend®) for Prevention of Postoperative Nausea and Vomiting (PONV) in Adults

<https://www.albertahealthservices.ca/assets/Infofor/hp/if-hp-phys-aprepitant-emend-ponv-summary-statement.pdf>

AHS Venous Thromboembolism Prophylaxis Guideline

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-venous-thromboembolism-prophylaxis-ps-09-01-guideline.pdf>

AHS Venous Thromboembolism Prophylaxis Policy

<https://extranet.ahsnet.ca/teams/policydocuments/1/clp-venous-thromboembolism-prophylaxis-ps-09-policy.pdf>

AHS Weight-Band Dosing for Subcutaneous Tinzaparin or Enoxaparin for Venous

Thromboembolism (VTE) Prophylaxis in Acute Care Adult Inpatients

(please see AHS VTE Prophylaxis Weight-Band Table on the AHS internal website)

Bladder Cancer Canada: Patient Guidebook for Patients Facing Radical Cystectomy

<https://bladdercancer canada.org/wp-content/uploads/2017/05/Patient-Guidebook-Radical-Cystectomy-Greyscale-EN-May-2016.pdf>

Bugs & Drugs

<http://www.bugsanddrugs.org/>

Canadian Nutrition Screening Tool (CNST)

<http://nutritioncareinCanada.ca/sites/default/uploads/files/CNST.pdf>

Choosing Wisely Canada: Drop the Pre-Op Toolkit

<https://choosingwiselycanada.org/perspective/preop-toolkit/>

Choosing Wisely Canada Recommendations and Resources, by Specialty

<https://choosingwiselycanada.org/recommendations/>

Eating and Drinking Before Surgery: Patient Instructions

<https://myhealth.alberta.ca/alberta/Pages/Your-Surgery-Resources.aspx>

MyHealth.Alberta.ca Health Information and Tools, Care for an Indwelling Urinary Catheter

<https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=tv7406spec>

MyHealth.Alberta.ca Health Information and Tools, Patient Care Handouts

<https://myhealth.alberta.ca/health/aftercareinformation/Pages/default.aspx>

MyHealth.Alberta.ca Health Information and Tools, Surgery – Incision Care After Surgery

<https://myhealth.alberta.ca/health/pages/conditions.aspx?Hwid=tc4128spec>

MyHealth.Alberta.ca Health Information and Tools, Surgery – What to Expect

<https://myhealth.alberta.ca/health/Pages/conditions.aspx?hwid=tw9795>

MyHealth.Alberta.ca Patient Care Videos including Before and After Surgery: ERAS – Your Surgery Journey (videos 1 – 14)

<https://myhealth.alberta.ca/Alberta/Pages/learning-surgery-journey-video-series.aspx>

Safer Healthcare Now! Prevent Surgical Site Infections

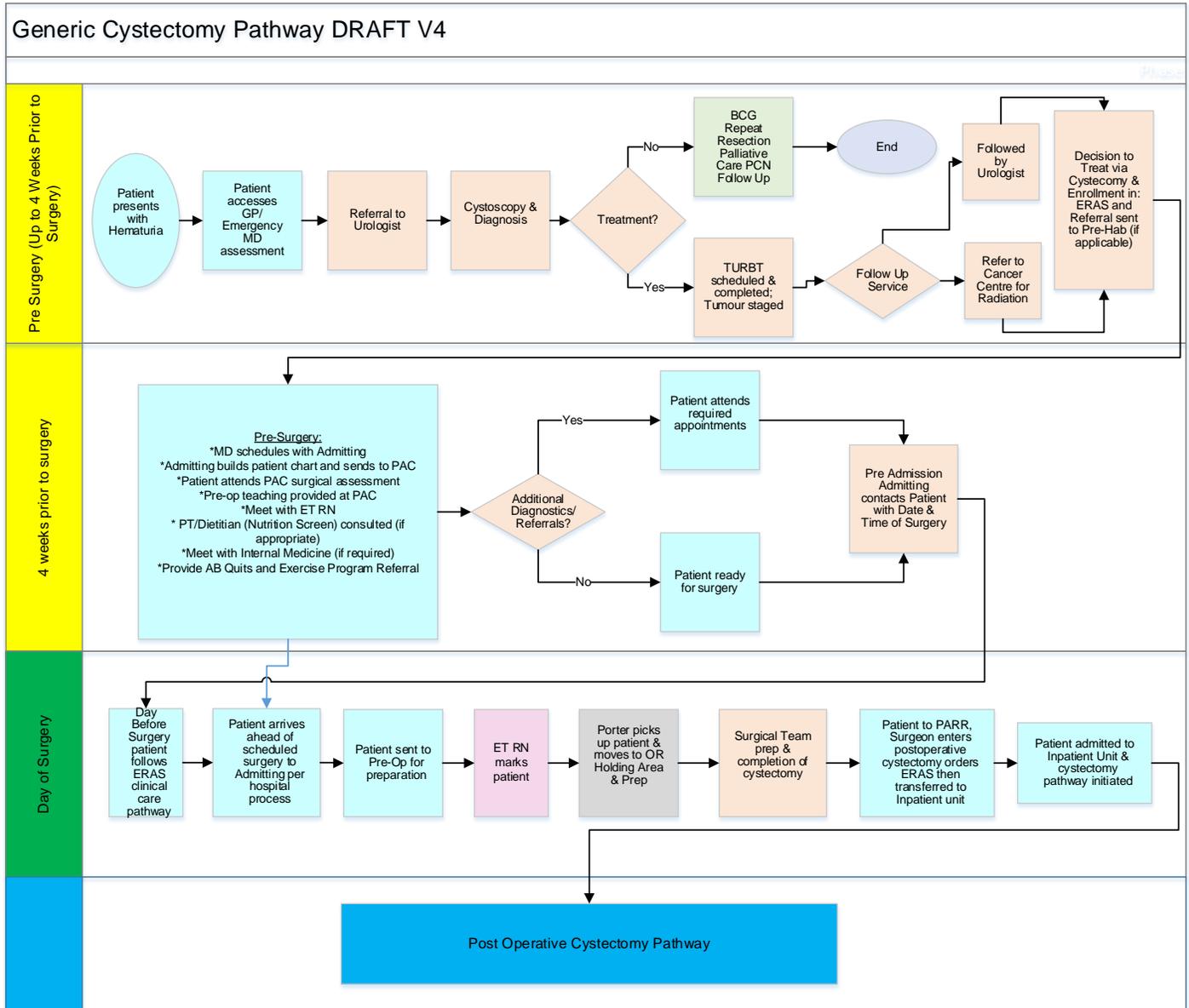
<http://www.patientsafetyinstitute.ca/en/toolsResources/Documents/Interventions/Surgical%20Site%20Infection/SSI%20Getting%20Started%20Kit.pdf>

Your Surgery Journey – Patient Guide

<https://myhealth.alberta.ca/YourSurgeryJourney>

Appendix A – Preoperative Cystectomy Workflow

Figure #3 Preoperative Cystectomy Workflow



Appendix B – ERAS Nutrition Working Group Consensus: Juice as Carbohydrate Loading Products

Drawing from the best practices around the world, ERAS has been implemented in Alberta to enhance perioperative patient care, support patient recovery and reduce health care costs. Carbohydrate (CHO) loading is one of about 24 ERAS protocol elements and is an integral part of the preoperative care process^{1, 2}. The main purpose is to attenuate postoperative insulin resistance, which contributes to negative nitrogen balance, leading to muscle mass loss and reduced muscle strength.¹⁻⁶ In addition, CHO loading hinders preoperative stress, hunger and thirst in surgical patients.^{1, 2, 7, 8} According to ERAS guidelines, CHO loading involves ingestion of clear fluids that contain complex CHOs, mostly of maltodextrins. These products have been extensively researched and are recommended for preoperative use by the ERAS guidelines.⁹⁻¹⁹

ERAS and The European Society of Anaesthesiology Guidelines recommend the ingestion of CHO-rich beverages that are specifically developed for preoperative consumption up to two hours before surgery.^{1, 2, 9-20} No specific guidelines are given regarding the type and/or brand of products to be used; however, it is suggested that not all CHOs are safe.²⁰ Gastric emptying is the major concern preoperatively, therefore beverages with lower osmolality assumed to be safer for preoperative consumption.²¹ In addition, it was suggested that the insulin response to the beverage should reach 60 µIU/mL to achieve appropriate fed state that is believed to improve postoperative insulin resistance.^{2, 21} All research that has been done involve only commercial products. The preoperative CHO loading product most often studied is Nutricia Preop® that contains 12.5% CHO from maltodextrin and has low osmolality (260 mOsm/kg H₂O) to induce faster gastric emptying.²² Nutricia Preop®, is in liquid form and is only available in Europe.²²

PREcovery™ is a new CHO-containing product commercially available in Canada that contains 12.5% CHO from maltodextrin and has low osmolality (114 mOsmol/kgH₂O).²³ Although it is a potential commercial product that can be used for ERAS, more studies are needed to explore the effectiveness of PREcovery™. As well, this product is in powder form and needs to be mixed with 400 mL of water²³, which may lessen the practicality of using this product for ERAS. Decisions will need to be made on access and availability of the product, who will prepare the product, the process of preparing this product for patient safety and who will cover the product's cost.

Because of the limited availability and research of commercial CHO-containing products in Canada, the ERAS Nutrition Working Group (WG) continues to recommend the use of apple juice and cranberry cocktail juice. Although there are no published studies on the safety of juice as a preoperative CHO-loading product, no adverse effects have been reported on using juice for this purpose since ERAS was first implemented in Alberta in 2013. As well, based on an ERAS nutrition and environmental scan, Canadian sites using juice as the ERAS preoperative CHO-loading product reported no adverse effects.

The ERAS Nutrition WG recommendation continues to be based on the following criteria: availability, palatability, clinical considerations, volume needed, ease and process of administration, cost of product, infection control and simplicity (for patient use and nurses and physicians to discuss with and teach patients). Juice meets most of the beverage criteria as it is conveniently available and palatable, can be used at home or in hospital for minimal cost

compared to CHO-containing products, is already pre-packaged, simple to consume, and easy for physicians and health professionals to discuss with and teach patient as part of ERAS preoperative teaching. However, this WG's consensus may be updated once new research and products that meet the criteria are available.

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