**ENHANCED RECOVERY PROTOCOL FOR ROBOTIC CYSTECTOMY**

Adapted from BAUS and EAU Consensus statements

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**Initial assessment and outpatient preparation:**

Patient education and holistic needs assessment – CNS involvement

Setting expectations and patient education – written information + verbal

Optimise pre-operative fitness “pre-habilitation” – diet, exercise, stopping smoking

Full assessment of medical comorbidities – high risk anaesthetic clinic, POPs referral if required

Timing and impact of Oncological input if relevant – neoadjuvant chemotherapy

Stomatherapy referral for support and education

Start discharge planning – post operative support at home, aiming for day 4 discharge on average

**Pre-assessment clinic:**

Ensure seen by anaesthetist if necessary

Check all admission / discharge preparation in place

Abnormal bloods acted on / conveyed to Consultant in charge

 Hb to be above 100g/L at admission – may need Iron supplements or transfusion

Positive cultures acted on and Consultant notified

Pre-operative drinks given to patient (6x cartons Nutricia “Pre-op” drinks 200ml)

 4 evening before surgery, 2 on morning of surgery to be finished by 06.30am

 Do not substitute other drinks without discussion with surgeon

Advice on pre-operative medication esp. anticoagulation / antiplatelets

**Stomatherapy**

Meet patient and provide education and support in advance of procedure

Arrange to perform pre-operative marking of the stoma site usually within one week of surgery

**Diet advice**

 **Two days prior to surgery:**

 Low residue diet eg fish, chicken, mashed potato, white rice, no high fibre foods. Stomatherapy will visit to mark abdomen in the last week prior to operation.

 **The day prior to surgery:**

 Liquid diet eg soup, yoghurt, ice cream

 4 Pre-op drinks on evening prior to admission

**Day 0: Admission**

No solids. No milky drinks from 2 am. Clear fluids up until 06.30 including 2 pre-op drinks to be consumed before 06.30.

Arrive on ward at 07.30

Ensure all blood tests required are performed immediately on admission eg G+S, INR

Complete admission paperwork

Bowel prep not normally required unless instructed by Surgeon

Prepare patient for 08.30 collection if morning case

**Theatre / recovery**

Anaesthetic to avoid indwelling epidural unless absolutely necessary – single shot spinal

Local anaesthetic rectus sheath / TAP block given at closure by surgeon

VTE assessment completed, TEDS and clexane prescribed

Overnight Flowtron boots

Patient will have abdominal (Robinson’s) drain and urethral catheter drain each draining to a separate bag. The conduit will have ureteric stents (usually one for each kidney, not stitched in) and often a sump drain (a cut catheter, stitched to skin) all draining into the conduit bag.

HDU for selected higher risk cases, otherwise return to ward

Careful observation of vitals / fluid balance for signs of bleeding / sepsis / respiratory issues

Sips of water only post-operatively

Post-operative analgesia to minimise use of opiates – NSAIDS / paracetamol in preference with breakthrough opiates above this.

Regular prescribed medications:

 Co-amoxiclav 1.2g IV three post op doses (unless allergic)

 Metoclopramide 1mg IV tds until bowels opening and full diet

 Omeprazole 40mg IV / PO od until discharge

 Diclofenac suppository 100mg PR od unless contraindicated

 Paracetamol 1g qds po / IV

 PRN opiate

Clexane 40mg sc od for 4 weeks

**Day 1 post-op:**

Free fluids as tolerated (including soup, jelly, ice cream, supplements). Stop IVI.

FBC / U&E

Administer post-op antibiotics

Optimise pain control avoiding opiates if possible

Mobilise around bed space twice / sit in chair, exercises as per tips on recovery at end of leaflet

Chest physio exercises (see tips on recovery at end of leaflet)

Start stoma education – ward staff to continue twice daily

Leave drains in

**Day 2 post-op:**

Light diet – soft cereal / soup / soft sandwich / biscuits if no nausea / vomiting

Bloods only if clinical concerns

Mobilise around ward at least twice

Ward staff to continue stoma education twice daily

Remove Robinson’s drain. Leave Urethral drain. If output >300ml in 24 hour total, send sample for drain fluid creatinine.

**Day 3 post-op and subsequent:**

If passing flatus, increase to full diet

Glycerine suppository if not opened bowels

Remove urethral drain if < 250ml / 24 hours and no concern re possible urine leak

Remove conduit sump drain

Should be independent with stoma care if possible

Independently mobile around ward

If well and passed these hurdles, can go home with full education and advice on fluids / mobility / diet / bowels / clexane / red flag concerns / ECC back up.

Stoma team provide Monday – Friday daily support either in person or at home on discharge.

**Day 7:**

Stents removed by stoma team at 1 week post op (no routine antibiotic requirement)

Contact consultant or on call team at any time if concerns

CNS team to call patient to answer any concerns

**One month:**

Face to face clinic appointment with Surgeon for examination / results / bloods.

**Contact numbers:**

Bladder Nurse Specialist: 01227 868666 (Cancer Care Line) or ekhuft.uro-onccns@nhs.net

Kent Ward: 01227 783102

Clarke Ward: 01227 783103

**VERY IMPORTANT - Tips on a speedier recovery after surgery**

*Pain relief*

Ensuring that you have adequate pain control following surgery is essential. Some mild discomfort is normal. However, if it’s affecting your breathing or movement then ask your nurse for further pain relief.

*Walking*

The most important thing after your operation is to get up and out of bed and walk around. Walking is the best way to help to loosen your phlegm after surgery and will also help to prevent you from developing a chest infection. The nurses will help you to sit out of bed, even if you have drips and drains. You will be expected to start walking the day after your operation.

*Rest*

Although you should get up and move around as soon as possible, it’s also important to rest when you are feeling tired.

*Position in bed*

If you’re required to spend long periods in bed, ensure you are in a good position. This means sitting upright or lying on your side. Do not slump in bed.

***Breathing exercises***

Initially, due to pain and tiredness, deep breathing and coughing may be difficult. This can lead to small areas of collapse in the base of your lungs. Phlegm may also build up and can cause a chest infection. To avoid this you need to do breathing exercises every hour until you are independently mobile. These can start as soon as you are able post-operatively. Please follow the cycle of breathing exercises on the next page.



*1. Breathing control – relaxed breathing*

Start by doing breathing control. Lightly rest your hand on your stomach. Breathe in and out quietly and gently through your nose if you can. You should see your stomach rise as you breathe in. Do this for as long as you need to. If you are quite breathless you may need to do breathing control for longer until your breathing settles.

*2. Deep breaths*

Take a long, slow deep breath in through your nose, if you can. Breathe out gently through your mouth. Try to breathe right down to the bottom of your lungs, expanding your rib cage. Aim to do three to five deep breaths before returning to breathing control.

*3. Breathing control*

Return to breathing control for as long as you need to until your breathing is slow and relaxed. You may need to do a few cycles of deep breathing and breathing control before doing a huff if your phlegm is sticky.

*4. Huff*

A huff is similar to a cough but you aim to keep your mouth and throat open. Imagine you are trying to steam up a mirror held right in front of you. Take a deep breath in then exhale the air out forcefully through an open mouth. If you wheeze when you exhale you are huffing too hard.

*5. Cough*

After doing a huff you may need to do a good strong cough and bring your phlegm out into a pot or tissue. Coughing is important after an operation to clear any phlegm from your lungs and help prevent a chest infection. Coughing may feel uncomfortable, however, supporting your wound with a towel when coughing should make it more comfortable.

***Circulatory exercises***

These exercises will improve the circulation in your legs and are important to reduce the risk of blood clots. While in hospital, you should do these exercises three times a day, when you are in bed or sitting on a chair.

*Straight leg raise*

 • Lie on the bed with your legs straight or if you are sat in a chair, slowly straighten one leg.

 • Lift one leg up.

 • Keeping your leg straight, draw your foot towards you and hold for five seconds.

 • Repeat five times on each side.

*Knee bend and straighten*

Sitting on a chair or in bed, bend and straighten your leg ten times on each side.

*Ankle circles*

Move your foot in a circle, repeating ten times with each foot.

*Bottom squeeze*

Squeeze the muscles in your bottom and hold for five seconds. Repeat five times.

*Marching on the spot*

Sit on a chair and march on the spot ten times.

*Arm exercises*

These exercises will maintain the range of movement in your upper body and alleviate tension.

*Shoulder shrugs*

Shrug your shoulders upwards, quickly release and relax the shoulders so that they drop. Repeat five times.

*Shoulder circles*

Move your shoulders in a circle. Repeat five times.

*Arm raises*

Lift your arm forwards and upwards above your head. Repeat five times on each.

**Remember the most important thing is to get up and walking as soon as possible.**

If you think you’ll struggle when you get home with getting about, with personal care or with looking after yourself please ask your nurse to refer to your ward occupational therapist.