Sharing our experiences

Enhanced RECOVERY
ERAS Society (UK) www.erasuk.net

Case 1

65 year old male patient

Undergoes laparoscopic anterior resection 3rd August 2015

Consultant goes on holiday on 4th Aug for 2 weeks

On 5th August, ERAS facilitator finds the patient in bed, with IV fluid and restricted oral intake

Discuss with the junior doctors, who are not aware of ERAS pathway

What should the ERAS facilitator do…….

On 6th August, patient is now complaining of abdominal pain, nausea and lacking energy to mobilise

How should this patient be managed?

In the evening, the patient begins to vomit

Slightly raised inflammatory markers and CT scan is suggestive of an ileus

What should happen next?

Patient is treated successfully with 48 hours of nasogastric tube and IV fluid

Patient makes a full recovery and is fit for discharge on day 6…..

.....but, his wife is anxious that he may be sick again and is refusing to take him home

Discuss with consultant colleague, who thinks there is no rush to discharge, as they are not convinced that ERAS is safe

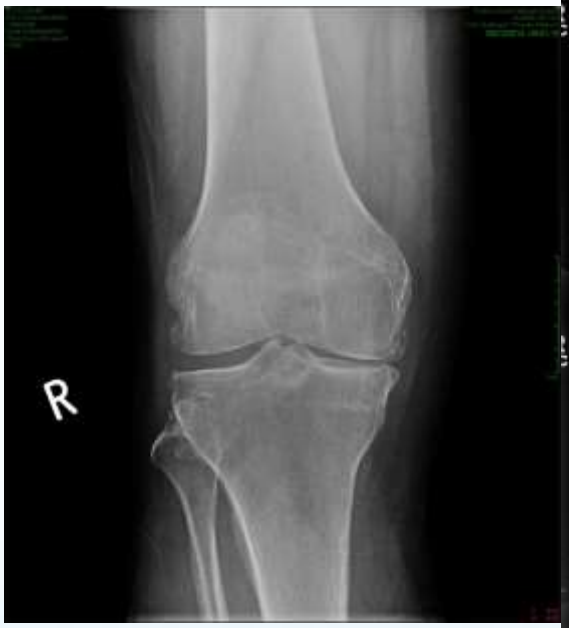
A CAUTIONARY TALE

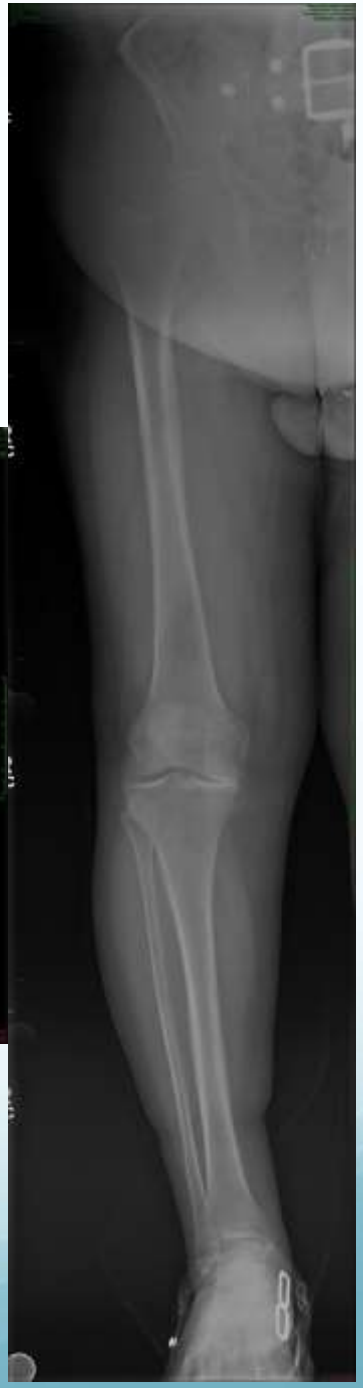
A KINNINMONTH

ER PROGRAMME

- 59 YEAR OLD WOMAN
- CONSTANT PAIN FROM ARTHRITIC KNEE
- RECURRENT SWELLING
- FEAR OF KNEE GIVING WAY
- VARUS DEFORMITY OF 15 DEGREES
- FIXED FLEXION 15 DEGREES

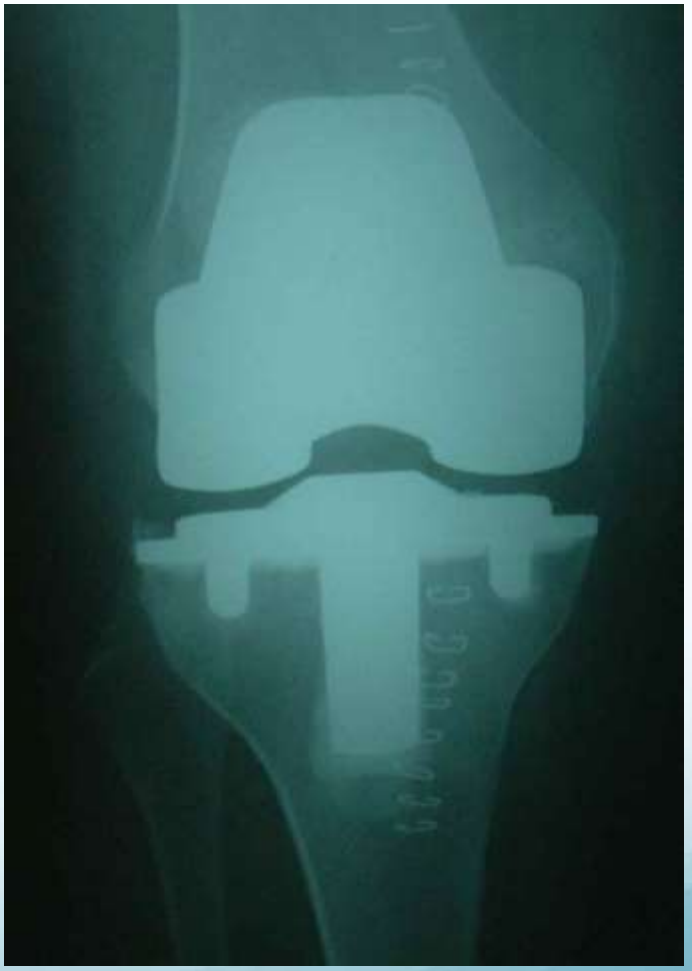
= CANDIDATE FOR KNEE REPLACEMENT





SUCCESSFUL TKR

- WOUND DRY
- MINIMAL SWELLING
- XRAY FINE
- STATED TO HAVE IMPROVING MOBILITY



ER ASSUMPTIONS

TOTAL KNEE REPLACEMENT

- MEDIAN LENGTH OF STAY = 3-4 DAYS
- MOBILISATION WITHIN 24 HOURS
- GOOD PAIN RELIEF
- NO WOUND PROBLEMS
- HOME DISCHARGE PLANNING IN PLACE

ER REALITIES

- PRE-EMPTIVE DAY OF DISCHARGE
- ASSUMED PROGRESS
- ASSUMED DAY OF DISCHARGE
- ‘NOTHING CAN GET IN THE WAY OF DISCHARGE”

PATIENT POST TKR

- DISCHARGED ON DAY 4
- STANDARD PAIN PRESCRIPTION
- NO POST DISCHARGE PHYSIO REQUIRED AS MILESTONES ACHIEVED
- “ALL IS WELL”

6 WEEK FOLLOW-UP

- CAN'T SLEEP
- PAIN +++
- ROM 25 -70 DEGREES
- ON CRUTCHES
- "WORSE THAN BEFORE OPERATION"

WHY??

HINDSIGHT

REVIEW OF NOTES

- PAIN CONTROL DIFFICULT FROM ONSET
- SUB-OPTIMAL AT DISCHARGE

- PHYSIO NOTES – SLR DIFFICULT BUT “OK”
- FLEXION - ACHIEVED 70+ DEGREES WITH DIFFICULTY
- SUB-OPTIMAL AT DISCHARGE

READMISSION AT 3 MONTHS

- INTENSIVE IN-PATIENT PHYSIO FOR 1 WEEK WITH SOME IMPROVEMENT
- LIMITED PROGRESS TO 1 YEAR
- ROM 30 -70 DEGREES
- STILL ON CRUTCHES

1 YEAR

- SURGICAL EXPLORATION WITH FIBROLYSIS
- EXCHANGE OF ARTICULATING POLYETHYLENE
- ACHIEVED IMPROVED MOTION FROM 10 -100 DEGREES
- SHORT TERM IMPROVEMENT ONLY
- CONTINUES TO HAVE PAIN

LESSONS

- POOR PAIN CONTROL
- DIFFICULTY IN ACHIEVING RANGE OF MOTION
- = PROBLEM WITH PATIENT VS SURGERY VS REGIME

- IDENTIFY EARLY AND REMOVE FROM PROGRAMME
- DELAY DISCHARGE UNTIL MILESONES EASILY ACHIEVED

Urology case study

- 73 year old lady
- Ex-smoker, no significant co-morbidity
- Not under-nourished
- Muscle invasive bladder cancer (G3T2)
- Radical anterior pelvic exenteration + extended pelvic lymphadenectomy + ileal conduit
- Straight forward with 300 ml blood loss
- ERAS protocol through journey
- Epidural working well

Post cystectomy + ileal conduit

- POD 1 - HDU
- Comfortable, with epidural
- seated for 2 hours at least
- Started with fluids and post-op ERAS drinks
- Hb 127; U/Es normal

- Would you prescribe routine anti-emetics and if so, what's your choice?

Post cystectomy + ileal conduit

- POD 2 – HDU
- Epidural
- No flatus and absent bowel sounds
- U/E normal
- Tolerating fluid intake and managed some plain soup

- Is Lignocain infusion better in reducing ileus

Post cystectomy + ileal conduit

- POD 3 - HDU
- Epidural
- No flatus and absent bowel sounds
- Nausea and abdominal distension
- WCC and U/Es normal
- Given Ondansetron

- Would you continue with oral intake?
- Chewing gum – any thoughts?

Post cystectomy + ileal conduit

- POD 4 – urology ward
- Epidural removed before transfer
- Fentanyl patch and managed by pain team (ERAS) – pain under control
- Nausea; No flatus and bowel sounds absent
- Abdomen more distended but soft
- WCC and U/Es normal
- Given more Ondansetron

- When would you insert an NG tube?

Post cystectomy + ileal conduit

- POD 5
- Pain under control (no Tramadol)
- Vomits 300ml (bilious) overnight
- No flatus and bowel sounds still absent
- Abdomen distended but soft
- WCC and U/Es normal

- NG tube now?
- Is there any value in resisting NG tube?
- Anything else?

Post cystectomy + ileal conduit

- POD 6
- HAN team do AXR – features of ileus
- NG tube inserted – 4hly aspiration and free flow
- Drains 1000ml overnight
- Abdomen less distended.
- WCC and U/Es normal

- What's the benefit of NG tube on suction as opposed to free-drainage?
- Any experience with motility agents?

Post cystectomy + ileal conduit

- POD 7
- NG tube output = 3 litres over 24 h
- Abdomen less distended; non-tender
- Phosphate enema given – no result.
- WCC and U/Es normal

- Would you try laxatives?
- Are laxatives safe after small bowel anastomosis?

Post cystectomy + ileal conduit

- POD 8
- No change
- NG output about 3 litres – replaced with IVF
- Abdominal drain still in place – about 750ml lymph per day.
- WCC and U/Es normal

- Feeling tired - how do you motivate mobilisation?

Post cystectomy + ileal conduit

- POD 9
- NG output reduced
- Tried to take in fluids – not tolerating
- Still no flatus, some slow bowel sounds
- WCC and U/Es normal
- Serum Albumin low normal

- When would you consider TPN?
- What are your triggers?

Post cystectomy + ileal conduit

- POD 10
- No change
- Still no flatus or bowel movement
- Abdomen soft and non-tender
- Drain output 500ml/ 24h = serous
- Loopogram – no leak; stents out
- WCC and U/Es normal
- CVP inserted and referred dietician for TPN
- Colorectal opinion sought - ileus

Post cystectomy + ileal conduit

- POD 11
- Commenced TPN
- Still no flatus or bowel movement
- Drain 200ml – removed
- Bowels eventually move on POD 13
- Recommenced gradual increase in oral intake supplemented by NG feeding

- How can we improve ileus post cystectomy?