UNIVERSITY HOSPITAL WISHAW
ENHANCED RECOVERY FOR MAJOR GYNAECOLOGICAL PROCEDURES

NHS Lanarkshire

BACKGROUND

This guideline has been developed to minimize morbidity, provide adequate analgesia, promote early patient mobilization and return to independent care and earlier hospital discharge. Consider applying most/all of the following elements to most/all patients undergoing major gynaecological procedures if clinically appropriate.

PREOPERATIVE

1. Patients will be seen at the preoperative ERAS clinic. They will be educated on the ERAS process. This education will involve information regarding having general anaesthesia +/- spinal anaesthesia.
2. Appropriate patients will be given carbohydrate loading drinks to take the night before and the morning of surgery.
3. Avoid long fasting periods: Unrestricted water intake until 2 hours before surgery. Morning tea and toast for afternoon cases (no later than 0600hrs).

ANAESTHESIA

1. Spinal Anaesthesia in addition to general anaesthesia may be advantageous in the perioperative period, for both laparoscopic and open procedures, to reduce opiate requirement, reduce postoperative nausea and vomiting and reduce time to mobilization. Spinal anaesthesia may involve heavy bupivacaine and diamorphine or diamorphine only (recommended dose of diamorphine 300micrograms).
2. TAP blocks or inguinal field blocks may be beneficial in those women who have not received a spinal.
3. Give IV Paracetamol (dose as per NHSL ‘Paracetamol adults’ dosing guideline)
4. Give NSAIDS if no patient contraindications
5. Give prophylactic antiemetics (Ondansetron 4mg or Granisetron 1mg and Dexamethasone 3.3- 6.6mg).

PERIOPERATIVE FLUIDS

1. Shortest fluid fast possible – encourage clear fluids until 2 hours preop.
2. Offer drink of water in recovery. Intra-operative IV fluids should be titrated to replace intraoperative fluid losses.
3. Only prescribe postoperative IV fluids if clinically indicated. If patient is stable and drinking, discontinue IV fluids in recovery room. (Default is to take down IV fluids prior to leaving recovery room).

SURGICAL TECHNIQUE

1. An increasing number of surgical procedures are being carried out laparoscopically.
2. Consider surgical infiltration of the port sites or the laparotomy wound (rectus sheath blocks) with local anaesthetic, if TAP blocks or inguinal field blocks have not been performed (see other considerations for local anaesthetic dosing)
3. Remove as much CO_2 gas as possible from the abdomen prior to closure in laparoscopic cases.

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Approved by: Gynaecology ERAS team
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POSTOPERATIVE ANALGESIA

1. Oxycodone MR 10mg twice daily –
    i. laparoscopic procedures: give a dose on night of surgery and a second dose on the morning of day 1 (2 doses total).
    ii. open procedures: give a dose on night of surgery and then twice daily for a further 24hrs (3 doses total).

2. Oxycodone 5mg 2 hourly as required for pain.

3. Regular paracetamol (dose as per BNF)

4. Regular NSAID if no contraindication (e.g Ibuprofen 400mg three times daily)

5. If rescue analgesia is required (and patient cannot take oral analgesia e.g due to nausea and vomiting) use subcutaneous morphine as per the NHSL WGH subcutaneous analgesia protocol.

6. Prescribe antiemetic as required (e.g Ondansetron 4mg eight hourly as required)

7. Prescribe Naloxone as required for itch (200 micrograms subcutaneously as per WGH Spinal/Epidural Opioid Observation chart).

8. If the patient was taking regular analgesia prior to admission consider restarting this regime in the post operative period.

Consider discussion with the acute pain team or on call anaesthetist if patient has poor analgesia.

STEP DOWN AND TAKE HOME ANALGESIA

1. Patients should be stepped down to regular Codeine Phosphate (30-60mg four times daily) following cessation of oxycodone MR, in addition to regular analgesia as above.
2. Continue Oxycodone 5mg 2 hourly as required for pain until discharge.
3. Take home analgesia:
    i. If no contraindication to NSAIDS: regular Paracetamol, NSAID and Codeine Phosphate.
    ii. If NSAIDs contraindicated: regular Paracetamol and Codeine Phosphate as above.
    iii. Only in exceptional circumstances should Oxycodone preparations be prescribed as take home medication.
4. Consider prescribing lactulose 10ml 2 or 3 times daily for constipation.

OTHER CONSIDERATIONS

1. Approx. 1:200 -1:500 patients who have a spinal will develop a post dural puncture headache. The typical feature of this headache is its postural nature i.e worse on sitting or standing. If any patient develops a postural headache this should be discussed with the pain team or on call anaesthetist.
2. If administering local anaesthetic the maximum recommended safe dose is 2mg/kg for levo-bupivacaine (Chirocaine). 0.25% Chirocaine contains 2.5mg Chirocaine per ml. It is safe to use up to 50mls of 0.25% Chirocaine if your patient weighs >62kg. This could be 10mls for port site infiltration and 20mls each side for TAP blocks.

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