Abdominal Surgery Protocol

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COMMON INDICATIONS (elective surgery):

- *High priority*
  - Abdominal colorectal
  - Hysterectomy – total abdominal
  - Large ventral hernia or multiple hernias
  - Nephrectomy, prostatectomy
- *Low priority*
  - Inguinal and umbilical hernias
  - Supracervical ("partial") hysterectomy
  - Cholecystectomy
  - All other minor laparoscopic procedures

PAA:

- Scopolamine patch per ERAS Summary (hold for females over 70 and males over 55 years old)
- Initiate glucose control protocol for diabetics, and for non-diabetics with blood sugar > 140 in PAA
- Tylenol 1g PO
- Carbohydrate loading (maltodextrin) for colorectal surgery

INTRAOPERATIVE:

- GA maintained with a propofol infusion and up to 1 MAC of sevoflurane or isoflurane
- No nitrous for colorectal surgery
- Intubation narcotic minimization:
  - LTA kit
  - Sympathetic modulation PRN (Precedex or beta blocker)
- Bilateral truncal blocks after induction for all high priority cases
  - TAP blocks and supraumbilical rectus sheath blocks
  - 20-30ml of .375-.5% Ropivicaine with 1:200K epi on each side (Maximum dose 3mg/kg)
- Multimodal analgesia:
  - High-dose Decadron (10 mg IV) at induction except for colorectal surgery or for diabetics
  - Ketamine 25-50 mg IV mg prior to incision for high priority cases. Decrease or eliminate the dose in the elderly. May repeat dose q1hr in younger patients
  - Toradol 30 mg IV at closure if creatinine < 1.2. Decrease dose to 15 mg IV if over 80 years
  - Precedex
  - Judicious use of narcotics is preferable to a narcotic-free approach
- Additional anti-emetics per ERAS Summary:
  - Droperidol 0.625-1.25mg
  - Zofran 4-8mg
- Nimbex infusion always preferrable to multiple Zemuron doses
- If increased anesthetic depth is required, instead of narcotics consider:
  - Propofol bolus and/or infusion increase
  - Second dose of ketamine
  - Sympathetic modulation (Precedex or beta-blocker)
  - Ultiva infusion
  - Lidocaine infusion if blocks were not performed
  - Remember that hypertension of pneumoperitoneum is primarily from increased SVR, not light anesthesia
- Fluid management – avoid both hypovolemia (AKI) and overhydration (bowel edema)
- Removal of OG/NG tube as determined by surgeon