PE63 "Enhanced" recovery program after robot-assisted radical cystectomy: A single center experience after 30 cases

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Introduction & Objectives:

Robot-assisted radical cystectomy (RARC) is still associated with significant morbidity and prolonged hospital stay, despite improvements in surgical technique and perioperative care. Enhanced recovery after surgery (ERAS) protocols are multi-modal perioperative care pathways designed to achieve early recovery after surgical procedures by maintaining preoperative organ function and reducing the stress response following surgery. The key elements of ERAS protocols include preoperative counselling, optimization of nutrition, standardized analgesic and anesthetic regimens and early mobilization. The aim of this study was to present our initial experience with the use of ERAS protocols after RARC.

Materials & Methods:

We retrospectively reviewed our prospectively maintained database of RARC. We extracted the data of 30 patients who underwent robot-assisted radical cystectomy and urinary diversion (i.e. Bricker intervention [Brl], 18 patients, or Y neobladder [Ynb], 12 patients) and ERAS protocol, from December 2016 to March 2018. Our protocol included: no oral bowel preparation, combined anesthesia [general+epidural without opioids], removal of naso-gastric tube at the end of the surgery, oral clear fluids on day of surgery, parenteral and enteral nutrition in post operative Day –(POD) 1, mobilization in -POD2. Intraoperative surgical variables, peristalsis recovery, time to flatus and length of hospital stay, restored oral intake, mobilization and complications (classified according to Clavien-Dindo classification) were recorded and compared. For the purpose of this study stable health status was defined as follows: no drain, complete and free mobilization, standard oral intake and regular bowel function.

Results:

Mean age at surgery, BMI and Age Adjusted Charlson Index were 64.5 years, 25.8 kg/m2 and 5, respectively. Mean time of surgery was 280 minutes, with mean blood loss of 489.7 ml. Drain was removed after 3.8 days, while time to flatus and to normal bowel function restoring were 2.6 and 4.8, respectively. Time to full oral intake was 3.5 days and mobilization was recorded after 1.3 days. The median day in which patients were fit for discharge was 8. Only 1 patient did not complete fast track protocol for recurrent emesis. We recorded 4 complications with Clavien Grade >2. No significant differences were recorded between Bricker and Neobladder group for all the variables considered ($p<0.05$).

Conclusions:

Our preliminary experience showed that ERAS protocol applied to RARC allowed a fast return to bowel function and a short time to stable health status with no increase of complications. Due to the limited sample size, further data have to be collected to confirm these results.