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## EDITORIAL COMMENT

We congratulate the authors on the largest published prospective study of outpatient robot-assisted radical prostatectomy (RARP) to date. Through this well-designed feasibility study, authors found that outpatient RARP was not feasible in most patients, identifying postoperative nausea and vomiting (PONV) as the most frequent complication. Authors successfully standardized discharge criteria according to Post Anesthesia Discharge Scoring System (PADSS) and performed thorough assessment of perioperative and postoperative outcomes.

Prior studies have demonstrated the feasibility of outpatient RARP. One recent retrospective study found no difference in complications between patients discharged on postoperative day (POD)0 versus POD1 with the limitation that cases lacked nodal dissection.<sup>1</sup> The earliest prospective study demonstrated high satisfaction on validated surveys in a preselected cohort of 11 patients who underwent extraperitoneal RARP.<sup>2</sup> Another prospective study matched an outpatient group of 30 patients to an inpatient group who met inclusion criteria revealing no difference in patient satisfaction and short-term functional outcomes.<sup>3</sup> This current study built upon prior work by increasing sample size, utilizing an ERAS protocol, standardizing discharge criteria using PADSS, and assessing multiple outcomes including 30-day complications. A few things may be improved upon for future study including enforcement of preoperative counseling and elimination of opioids. Such improvements may increase the feasibility of outpatient discharges for select patients after RARP.

In our experience, successful outpatient RARP required 5 components: (1) extensive preoperative counseling, (2) preoperative inclusion criteria for consideration of outpatient discharge, (3) collaboration with anesthesiology department to enforce a standardized perioperative ERAS protocol, (4) early ambulation and opioid-free multimodal pain management, and (5) standardization of postoperative discharge criteria.

Routine opioid administration has been eliminated from our RARP care pathway, resulting in reduced PONV. Indeed, this study identifies PONV as the main risk factor for delayed discharge, with supporting findings that patients who met PADSS discharge criteria on POD1 experienced less PONV than those who met criteria on POD2/3. The link between opioids and PONV is well-established by the Apfel score that calculates 24-hour PONV risk based on 4 factors: gender, smoking status, history of motion sickness, and use of postoperative opioids.<sup>4</sup>

Patients benefit from greater utilization of prophylactic antiemetics and perioperative multimodal pain strategy (IV Tylenol/Ketolorac/Gabapetin/Lidocaine), which may be easily incorporated into a well-designed ERAS pathway.

Collaboration with anesthesia department is critical to create an ERAS pathway and formulate inclusion criteria that address age, American Society of Anesthesiologists score, BMI, cardiac history, hypercoagulable/bleeding disorders, and major surgical history. Outpatient RARP should be reserved for patients with low perioperative mortality risk, and we encourage preoperative patient risk-stratification as done by prior studies confirming feasibility of outpatient RARP.<sup>3</sup> Furthermore, patients meeting entry criteria should be preoperatively counseled regarding high likelihood of POD0 discharge, taking into consideration the influence of social and cultural factors on patient preferences. Effective management of patient expectations may boost patient motivation and minimize postoperative anxiety regarding discharge.

**JJ H. Zhang, Georges-Pascal Haber**, Cleveland Clinic Foundation, Cleveland, OH

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