Anesthesia Guidelines for Gynecological Robotic Surgery Cases

Surgeons:
Goff, Gray, Liao, Norquist, Swisher, Urban (Gyn Onc), Hipps, Chiang, Lentz (Gynecology)

Indications:
- Endometrial/Uterine cancer
- Pelvic/ovarian mass
- Cervical cancer
- Uterine fibroids
- Uterine/vaginal prolapse

Antibiotics:
cefazolin & metronidazole (levofloxacin & metronidazole if PCN allergic)

Case Duration:
1-3 hours

Positioning:
- Patients will be in dorsal lithotomy during the case - please check that IVs are running, pulse oximetry is reading well and there is a good EKG tracing before the patient is prepped.
- Both arms will be tucked and inaccessible during the case
- We will ask for maximum Trendelenberg during the case. Once the robot has been docked, the patient CANNOT be taken out of T-berg without removal of the robot arms. Do not change the T-berg positioning without discussing with surgical team
- To prevent the patient from slipping on the bed, there is a gel pad over the bed and underneath the patient. Prior to intubation, please have the patient positioned on the bed with the buttocks over the "V" at the end of the bed - once the patient is on the gel pad it is very tough to move them again. If the patient cannot be intubated in the correct surgical position because of a difficult airway or other concerns then the patient must be physically lifted up off the gel pad to move her and this requires a lot of man power in the room. We have found that anesthesia providers become more comfortable with intubation further down on the bed with the more robot cases that they do.
- In the setting of an extremely obese patient, we can request shoulder pads from the OR staff to maintain patient position. These pads are more mobile than prior pads, such that there is much less likelihood of a brachial palsy.
- During the case, a Mayo stand will be placed at the head of the bed over the patient's face. Once we place the patient in T-berg, the Mayo stand is lowered such that is just above the patient's face and provides a protective surface to prevent injury from the robotic arms

Requests to Anesthesia:
- Oro-gastric tube: given that our first trocar placement is often several centimeters above the umbilicus, an OGT decompresses the stomach to prevent gastric injury with direct laparoscopic entry
- During paraaortic lymphadenectomy, please minimize respiratory excursions by decreasing tidal volume if possible - any movement of the diaphragm leads to movement of the small bowel directly into our field of operation
- Be aware that due to the T-berg positioning, urine output is lower than expected. Similarly, patients will develop periorbital and facial edema.

Medications:
- Please inform the surgical team if a scopolamine patch is placed
- Do not give Toradol unless discussing with surgical team 1st; depending on intraoperative blood loss and findings, Toradol should potentially be avoided

June 1st, 2013