Cystectomy ERAS Pain Protocol

Exclusions -  
Daily pre-op opiates for >2 months (opiate tolerance).  
Abnormal LFTs, coags, or Creatinine

Immediately Pre-op -  
1000 mg Acetaminophen po (and then po or IV – depending on NPO status - q6h till discharge) (if no liver abnormalities)

Alvimopan 12 mg po q12h until first bowel movement per surgeons (only approved for Colectomy and Cystectomy for cost reasons)

Thoracic Epidural aimed at upper level of incision (tested with 3 cc 1.5% Lidocaine w/ Epi 1:200K). (No epidural if laparoscopic)

Intra-op
1/16% Bupivicaine plus Fentanyl 2 micrograms/cc infused at 10 cc/hr started ASAP after anesthesia induction. Avoid systemic opiates (especially Morphine and Dilaudid)

NO FLUID MANAGEMENT SPECIFICS YET

PACU
Changed to PCEA with 6 ml/hr infusion in PACU.

For breakthrough pain:
Epidural Fentanyl (25-50 micrograms bolus) and increase infusion by 2ml/hr, followed by increased Bupivicaine concentration (1/8%) if BP okay.
For pain when BP low or pressors ongoing: talk with surgeons about Toradol (i.e., bleeding & nephrotoxic risks). If BP unable to be controlled with low dose pressors or fluid boluses (500 cc) “split” epidural (take fentanyl out of epidural infusion and add IV opiate PCA) in preparation for, or as start of, stopping epidural.

PostOp Day 1
PCEA and acetaminophen (PO) continued and Ibuprofen 600 mg po q6h after clear liquid lunch (if Creatinine normal). If NPO and pain and/or nausea are slowing progress discuss Toradol (ketorolac 15 mg q6h IV X <48h) with surgeons if no h/o gastric, bleeding or renal impairment until tolerating diet.

PostOp Day 3
Cap epidural and start oral analgesics (usually oxycodone) after full liquid or regular diet breakfast (pull epidural 4 hours later if pain well controlled).