VPoster: 552

LSH and TLH in the Free Standing ASC

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ABSTRACT

Traditionally the majority of both LSH and TLH have been coupled with an overnight convalescence. At the Women's Specialty Surgery Center, a free standing ASC, these procedures are performed with as little as a four hour recovery to discharge time. The necessary modifications in treatment plans and coordinating efforts to effectuate this rather rapid ambulatory transition are presented. The goals of of cost savings, patient safety, and general satisfaction are easily attainable with proper preparation, counseling, preoperative instructions, and incorporating special tips and certain techniques.

Study Objective: Our experience with outpatient LSH and TLH and helpful hints for day surgery discharge are presented.

Methods: Retrospective Case Series of all TLH and LSH procedures preformed in the first year of operation at WSSC between October 22, 2009 to Sept 22, 2010

Setting: Women's Specialty Surgery Center at Texas Health Resources - Presbyterian Dallas, TX. 75231

Patient Demographics: All females undergoing LSH or TLH with an ASA of 3 or below and weight < 350 pounds and BMI < 40. Ages ranged between 31-61 years old.

Interventions: Preparation, Anesthesia Tips, Operative Technique, and Recovery Room Pearls

PREPARATION

Starts with the in office consultation by presenting the TLH or LSH as a "day surgery" procedure.

Surgery Center nurse calls patient at home the day prior to surgery to review events as planned for surgery and discharge.

Post-operative prescription given at preoperative scheduling and filled prior to day of surgery.

Friendly and relaxed nurses in the Preoperative area to comfort the patient and provide open communication.

Bair Paws to provide warmth and comfort in pre and post operative holding areas.

ANESTHESIA TIPS

Preemptive strikes for post operative nausea
- At induction, give 10mg IV Decadron and 10mg IV Reglan
- Prior to extubation give 8mg IV Zofran
- Avoid/Limit sedating antiemics such as Phenergan if possible
- Give Emend (Aprepitant) for patients with a history of postoperative emesis. The recommended oral dosage of Emend is 40mg PO within 3 hours prior to induction of anesthesia

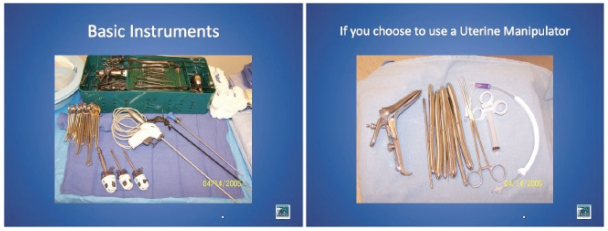
Induce with Propofol and use nerve stimulator to titrate Rocuronium as muscle relaxant. Avoid using reversing agents.

Avoid preloading with crystalloid during the 1st half of case. Preloading causes cerebral edema while in steep trendelenburg, which exacerbates postoperative nausea and somnolence. Concentrate hydration in 2nd half of case and in PACU. Goal ≤ 1.5 – 2 Liters IVF.

Avoid using long acting narcotics such as Fentanyl and Morphine to decrease somnolence. Instead use short acting systemic agents such as Sufentanil and long acting local anesthetics. Give Torodol 30mg IV at skin closure for additional pain control.

Give first dose of home pain meds in PACU to ensure it is well tolerated

OPERATIVE TECHNIQUE



Deep infiltration of trocar sites with 0.5% Bupivacaine.
- 5cc prior to skin incision and 5cc at skin closure at each of the 3 port sites for a total of 30cc of plain Bupivacaine

Use optical blunt dissecting trocars (11mm or less)
- Decreases sharp or penetrating intra-abdominal injuries seen with bladed trocars
- Better maintenance of pneumoperitoneum compared with open technique
- Fewer fascial stitches translates to decreased postoperative pain

The ideal dissection technique requires an energy modality that can accomplish meticulous hemostasis and will be tissue selective without causing inadvertent tissue damage.
- Bipolar Enseal to minimize blood loss (Infundibulopelvic ligament, Utero-ovarian ligament, Fallopian tube and Round ligament)
- Harmonic Scalpel for bladder flap dissection, uterine artery isolation, and uterine corpus amputation

It is crucial to release all intraperitoneal CO_2 by venting or breathing the abdomen through open trocars.

Use Endo Close device to loosely reapproximate fascia at the morcellation trocar site to decrease pain while still preventing hernia formation.

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RECOVERY ROOM PEARLS

- Allow adequate rest in first 1-2 hrs of recovery.
- Recovery in stretcher with head elevated at 45 - 75 degrees to reduce cerebral edema from steep trendelenburg position
- Reiterate preoperative counseling, assuring a 3 - 6 hour in center convalescence
- Early ambulation and attempt first void and diet at 3 hr time mark.
- Transfer to reclining chair once ambulating and voiding for remainder of recovery period.

MEASUREMENTS AND RESULTS

	LSH	TLH
NUMBER OF OPERATION	70	7
AVERAGE AGE	44	47
AVERAGE OPERATION TIME	98 MINUTES	156 MINUTES
AVERAGE UTERINE WEIGHT	149 GRAMS	174 GRAMS
AVERAGE BLOOD LOSS	117 MILLILITERS	237 MILLILITERS
AVERAGE TIME IN PACU	55 MINUTES	63 MINUTES
AVERAGE TIME IN RECOVERY	302 MINUTES	291 MINUTES
OVERNIGHT STAYS IN ASC	9	4
COMPLICATIONS	1 *	NONE
TRANSFERS TO HOSPITAL	2**	NONE

* Hemorrhage requiring transfusion. Pt was discharged on the same day.
** One transfer was precautionary secondary Pt on plavix, the second transfer was for hypotension with increased blood loss that resolved with crystalloid resuscitation.

FOLLOW UP AND FEEDBACK

- Nursing staff makes a postoperative phone call 24hrs after discharge
- Develop quality assurance protocols and recover patient survey cards about surgery center experience
- Tracking your data is imperative:
  - Offers patient reassurance
  - Enhances surgeons confidence

CONCLUSION

The average time to discharge for LSH and TLH was 6 hours after the completion of the operation. 87% of the LSH patients were able to be discharged on the same day of surgery. All patients who were observed at either the WSSC or in the hospital were discharged the next morning without further intervention or complication. There were also no readmissions to report following either procedure.

Minimally invasive surgical technique has transformed the most commonly performed gynecologic surgical operation into a day surgery procedure. It provides the patient with a safe alternative to traditional open hysterectomy, and improves the postoperative quality of life by accelerating the recovery phase.