Vancouver CoastalHealth

VA: VGH / UBCH / GFS
VC: BP / Purdy / GPC

ORDERS

ADDRESSOGRAPH

COMPLETE OR REVIEW ALLERGY STATUS PRIOR TO WRITING ORDERS

RADICAL CYSTECTOMY POST-OP: ENHANCED RECOVERY AFTER SURGERY ORDERS

(items with check boxes must be selected to be ordered)

Time Processed
RN/LPN Initials
Comments

Date: _____ Time: _____

DIET:

- Encourage gum chewing for 15 minutes PO TID (when awake until day of discharge)
- Post-op day 0: NPO
- Post-op day 1 and 2: full fluid diet and one Boost Plus Tetra BID to a maximum total oral fluid intake of 454 mL or 16 ounces as tolerated. Deliver tray to nursing station.

☐ NPO

☐ Other: _____

ACTIVITY: Activity progression as per clinical pathway

☐ Other: _____

CONSULTS: Stoma nurse to see patient

☐ Other: _____

MONITORING:

- Initiate ERAS clinical pathway for Radical Cystectomy
- Initiate ICOUGH protocol
- Monitor vital signs as per protocol (Notify physician if new fever greater than 38.5 °C)
- Urine output Q2H overnight. Call physician if urine output less than 100 mL per 4 hours
- Capillary blood glucose (glucometer) TID and at HS x 24 hours if non-diabetic and blood glucose levels are normal

LABORATORY:

CBC, electrolytes, urea, Creatinine, on POD # 1, 2, 3, and 5

☐ Other: _____

TREATMENTS:

Wound Management:

Leave dressings to primary closed wounds until POD # 3 (reinforce PRN). Change if saturated

Check stoma each shift for WCR (pink, warmth, raised)

☐ Hemovac to suction

Studer/Indiana Pouch:

☐ Post-op day 1 and onward: Irrigate and aspirate pouch BID with 120 mL sodium chloride 0.9% (NS) via:

☐ suprapubic catheter

☐ foley catheter

_____ _____ _____

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INTRAVENOUS:

- ☐ dextrose 5% - sodium chloride 0.45% (D5W-½NS) at 100 mL/h *OR*
- ☐ _____ at _____mL/h
- ☐ add potassium chloride 20 mmol/L post-op day_____

Post-op Day 1: Saline lock IV when drinking well
If CVC *in situ*, remove and insert a saline lock

MEDICATIONS:

Analgesia:

- ☐ See POPS orders

Antiemetics:

ondansetron 4 mg IV Q8H x 24 hours (approved by POPS)

GI Prophylaxis: ranitidine 50 mg IV Q8H until taking Diet As Tolerated, then discontinue.

Bowel Protocol:

- ☐ sennosides 24 mg PO QHS when able to take PO
- ☐ bisacodyl suppository 10 mg PR daily PRN starting POD 3

VTE Prophylaxis: see page 3

Antibiotic Use:

Antibiotic prophylaxis is provided and completed pre-op.
There is no indication to continue antibiotic prophylaxis into post-op period

DISCHARGE INSTRUCTIONS:

See ERAS clinical pathway for discharge criteria

☐ Patient going home on LMWH. Discharge prescription may be for either ☐ dalteparin *OR* ☐ enoxaparin for total duration of 28 days from start date of dalteparin in hospital. Patient/family to be taught how to inject LMWH using dalteparin (start POD #2), and to be given Sharps Container and appropriate LMWH teaching sheet.

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RADICAL CYSTECTOMY POST-OP: ENHANCED RECOVERY AFTER SURGERY ORDERS

(items with check boxes must be selected to be ordered) **(Page 3 of 3)**

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Date: _____ Time: _____

VTE Prophylaxis Refer to VTE Risk Assessment And Thromboprophylaxis Recommendations on reverse

RISK ASSESSMENT:

LOW RISK:

☐ Early ambulation; no anticoagulant or mechanical prophylaxis

MODERATE OR HIGH RISK: Order anticoagulant prophylaxis unless contraindicated

CONTRAINDICATION(S) TO ANTICOAGULANT PROPHYLAXIS (check all that apply):

☐ Active bleeding of clinical significance requiring intervention

☐ High risk of serious bleeding or bleeding into a critical site (e.g. intracranial, intraspinal, pericardial, intraocular, retroperitoneal, intra-articular)

☐ Known major bleeding disorder or acquired coagulopathy (consider Hematology consult)

☐ Platelet count less than 50 x 10^9/L (consider Hematology consult)

☐ History of heparin-induced thrombocytopenia (HIT) see Footnotes and Precaution 7 on reverse

☐ Patient already receiving therapeutic anticoagulation

Other contraindication (specify): _____

Reassess daily to start anticoagulant prophylaxis when contraindication resolves

ANTICOAGULANT PROPHYLAXIS: see Footnotes and Precautions 6 to 9 on reverse

Give first post-op dose at (time): _____ on (date): _____

☐ dalteparin 5000 units subcutaneous daily at 10:00 until discharge ∗OR∗

☐ for patients with severe renal impairment, heparin 5000 units subcutaneous Q12H until discharge ∗OR∗

Other: _____

Reason: _____

Monitor patients with epidural catheter receiving anticoagulant prophylaxis for symptoms and signs of spinal hematoma

Epidural catheter should not be removed within 18 hours of a dose of dalteparin or 10 hours of a dose of heparin.
After epidural catheter removal, dalteparin or heparin should not be given for at least 2 hours

MECHANICAL PROPHYLAXIS: (only when anticoagulant prophylaxis contraindicated)

☐ Sequential compression device (SCD)

Apply to lower limb(s) continuously until anticoagulant prophylaxis starts or discharge

Interrupt for skin care, assessments, toileting and ambulation only

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VTE RISK ASSESSMENT AND THROMBOPROPHYLAXIS RECOMMENDATION

Patient Risk Groups (satisfaction of any one or more of the listed criteria)	Thromboprophylaxis Recommended
Low Risk Group • Day surgery[1] without any VTE risk factors (see below) • No reduction in mobility compared to usual state • Surgical procedure with a total anesthetic and surgical time of less than 60 minutes with no risk factors for VTE (see below)	Early ambulation
Moderate or High Risk Group • Any medical or surgical patient having had or are expected to have significantly reduced mobility for 3 days or more[2,3] • Medical patients with ongoing reduced mobility (compared to their usual state) AND have one or more risk factors for VTE (see below)[2,3] • Surgical procedure with a total anesthetic and surgical time of 60 minutes or longer[3-6] • Acute surgical admission with an inflammatory or intra-abdominal condition[3-6] • Surgical patients with one or more risk factors for VTE (see below)[3-6]	LMWH (heparin if eGFR less than 10 mL/min)[4-9]

Obstetrical Patients with Increased Risk
• Having one or more risk factors for VTE (see below)
• Pregnancy-related risk factors:
  • Ovarian hyperstimulation
  • Hyperemesis gravidarum
  • Multiple pregnancy
  • Preeclampsia
  • Emergency caesarean section
	Consider LMWH (heparin if eGFR less than 10 mL/min)[4-9]

RISK FACTORS FOR VTE

- Age 60 years or over
- Active cancer and cancer treatment
- Previous VTE
- Critical Care admission
- Obesity (BMI over 30 kg/m^2)
- Known thrombophilia
- First degree relative with VTE
- Varicose veins with phlebitis
- Estrogen-containing oral contraception
- Hormone replacement therapy

One or more significant medical conditions:

- Sepsis or severe acute infection
- Heart disease
- Respiratory pathology
- Inflammatory condition
- Rheumatological disease
- Nephrotic syndrome
- Antiphospholipid syndrome
- Acute stroke

CONTRAINDICATIONS FOR MECHANICAL PROPHYLAXIS

- Acute stroke with immobility (unable to walk independently to the toilet)
- Peripheral vascular disease with absent pedal pulses
- Severe peripheral neuropathy
- Skin breakdown, ulcers, gangrene, cellulitis, or dermatitis
- Skin grafting within last 3 months
- Allergy to stocking or compression cuff materials
- Unable to size or apply properly due to deformity, recent surgery or trauma

FOOTNOTES AND PRECAUTIONS

1. Day surgery includes patients admitted and discharged within 24 hours for an elective surgical or invasive procedure.
2. In medical patients receiving anticoagulant prophylaxis, the NNT to prevent symptomatic DVT is 212 and non-fatal PE is 300; the NNH for major bleed is 430. There is no evidence for mechanical thromboprophylaxis in medical patients.
3. In surgical patients receiving anticoagulant prophylaxis, the NNT to prevent symptomatic DVT is 20-106 and non-fatal PE is 110-150; the NNH for major bleed is 70-100. There is weak evidence for using mechanical thromboprophylaxis alone and weaker evidence for combining anticoagulant and mechanical prophylaxis to improve efficacy.
4. First post-op dose of anticoagulant should be given after hemostasis is achieved and as soon as it is safe to do so (usually 12 -24 hours after surgery). This should take into account the risks of bleeding, thrombosis and timing of subsequent surgery.
5. Prophylaxis for up to 30 days after surgery is recommended in those having hip replacement or hip fracture surgery, and up to 14 days after total knee replacement. Consider prophylaxis for up to 30 days after abdominal or pelvic surgery for cancer and in patients with multiple risk factors for VTE.
6. Heparin 5000 units subcutaneous Q12H should be used if patient is awaiting urgent surgery and is a candidate for neuroaxial blockade. Refer to Peri-operative Pain Service or Anesthesia regarding timing of epidural catheter insertion and removal.
7. LMWH and heparin should not be given in patients with HIT. Consider consulting Hematology/Internal Medicine regarding the use of alternative agents (e.g. fondaparinux or argatroban).
8. If eGFR is 10 to 30 mL/min AND expected LOS is longer than 10 days, consider using heparin instead of dalteparin.
9. Suggested dosing for dalteparin and heparin in patients with extremes of weight and/or severe renal impairment:

Weight range	dalteparin (if eGFR 10 mL/min or above)	heparin (if eGFR less than 10 mL/min)
40 kg or less	2500 units subcutaneous once daily	2500 units subcutaneous Q12H
41 kg to BMI 40 kg/m^2	5000 units subcutaneous once daily	5000 units subcutaneous Q12H
BMI over 40 kg/m^2	5000 units subcutaneous Q12H	5000 units subcutaneous Q8H