INTERDISCIPLINARY TEAM APPROACH: ISSUES AND PROCEDURES KARLIND T. MOLLER pdf

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1. By using evidence-based protocols for perioperative and postoperative care, surgical stress can be reduced, healing optimized, and the patient experience improved. Traditional components of perioperative care include bowel preparation, cessation of oral intake after midnight, liberal use of narcotics, patient-controlled analgesia use, prolonged bowel and bed rest, the use of nasogastric tubes or drains, and gradual reintroduction of feeding. However, many of these commonly implemented interventions are not evidence-based, and their use frequently does not promote healing and recovery 2. With this in mind, ERAS pathways were developed with the goal of optimizing patient outcomes by introducing interventions that are data supported and have been proved either to decrease surgical stress or help the body mitigate the negative consequences of such stress 2. Background It is well known that surgical stress induces a catabolic state that leads to increased cardiac demand, relative tissue hypoxia, increased insulin resistance, impaired coagulation profiles, and altered pulmonary and gastrointestinal function 3. This response can lead to organ dysfunction with increased morbidity and delayed surgical recovery 4. The consequences of delayed postoperative recovery may include nosocomial infections, development of venous thromboembolism VTE , long term diminishment of quality of life 5 , and increased health care costs. The goals of decreasing surgical stress and helping the body mitigate the consequences of such stress with ERAS pathways are achieved by the implementation of a combination of multiple elements, which when bundled together, form a comprehensive perioperative management program. Colorectal surgery was the first subspecialty to implement ERAS programs. When ERAS pathways have been implemented for benign gynecologic and gynecologic oncology surgeries using open and minimally invasive approaches , results have been encouraging 13â€” Benefits of ERAS pathways include shorter length of stay 16, 20 , 21 , decreased postoperative pain and need for analgesia, more rapid return of bowel function, decreased complication and readmission rates, and increased patient satisfaction Implementation of ERAS protocols has not been shown to increase readmission, mortality, or reoperation rates 20, Multiple studies also have demonstrated significant cost-savings associated with implementation of ERAS pathways. However, differences exist between ERAS protocols among institutions performing gynecologic surgery; thus, there is a need to develop standardized, evidence-based and specialty-specific guidelines 16, Preoperative Enhanced Recovery After Surgery Components Preoperative Management Planning and Risk Assessment Patient involvement and engagement are key, and patient education is associated with improved outcomes 6. Counseling should start as early as the initial preoperative visit, with an explanation of the rationale behind ERAS and a discussion of patient expectations. Patient-tailored handouts may be helpful in communicating the goals of ERAS and helping patients understand the active role they may play in their care. Preoperative risk assessment should include identification of tobacco and alcohol use, overweight status and obesity, anemia, and sleep apnea. These factors should be considered when choosing the appropriate preoperative and postoperative care. The perioperative period is a critical window of opportunity for surgeons to influence behavior and encourage smoking cessation. Smoking-related impairment in wound healing decreases and pulmonary function improves within 4â€”8 weeks of smoking cessation Although the benefits of smoking cessation increase proportionally with the length of cessation, and there has been concern about short-term smoking cessation immediately before surgery, emerging research suggests that shorter-term perioperative smoking cessation does not cause harm 25â€” A Cochrane Review suggested that intensive preoperative alcohol cessation interventions could significantly reduce complication rates A discussion regarding planned length of stay is crucial to ensuring availability of appropriate support and managing patient expectations. Patients should be provided the opportunity to discuss surgical planning and pain control with the surgical team and the anesthesia team as desired. Designated nurses specializing in ERAS care may be helpful A key strategy for successful implementation of an ERAS program is the active engagement of all parties. In addition to partnering with the patient, a central component of a successful program is the cooperation of an interdisciplinary team, including the surgeon, preoperative nurse, anesthesiologist, office nurses, and other important staff Fig. Appropriate risk stratification is an important component of enhancing surgical recovery. The Caprini VTE risk assessment model and the Rogers score may be used to provide individual risk

assessment, although more extensively validated models for specific patient populations are needed 31 , Systemic hormone therapy and oral contraceptive use have been associated with increased risk of VTE; however, the overall risk remains quite low. No trials exist to demonstrate a reduction in postsurgical VTE with preoperative discontinuation of hormone therapy, and this practice should not be routinely recommended. In women using combined oral contraception, prothrombotic clotting factor changes persist 4â€”6 weeks after discontinuation, and risks associated with stopping oral contraception a month or more before major surgery should be balanced with the very real risk of unintended pregnancy. It is not considered necessary to discontinue combination oral contraceptives before laparoscopic tubal sterilization or other brief surgical procedures. In current users of oral contraceptives who have additional risk factors for VTE having major surgical procedures, heparin prophylaxis should be considered Lastly, preoperative anemia is associated with postoperative morbidity and mortality and should be actively identified and corrected Diet and Bowel Preparation The goal of the preoperative phase of ERAS is for patients to obtain the energy necessary for the body to accommodate the high metabolic demands imposed by surgery. The traditional fasting requirements of surgery deplete liver glycogen and are associated with impaired glucose metabolism and increased insulin resistance, which have been shown to adversely affect perioperative outcomes. This strategy has been shown to reduce preoperative thirst and anxiety and reduce postoperative insulin resistance in colorectal surgery, ultimately reducing length of stay and improving patient satisfaction 30, 34 , Data from the anesthesia literature have demonstrated that intake of clear fluids up until 2 hours before surgery does not increase gastric content, reduce gastric fluid pH, or increase complication rates Thus, clear fluids should be allowed up to 2 hours before induction of anesthesia and solids up to 6 hours prior. Integration of a multidisciplinary approach is important to ensure buy-in and compliance with these guidelines from all members of the surgical team. Evidence that preoperative mechanical cleansing of the bowel improves surgical outcomes is limited. A Cochrane review of 20 randomized trials with 5, participants undergoing elective colorectal surgery demonstrated no difference in wound infections or anastomotic leakage rates between groups of participants who received or did not receive mechanical bowel preparation Although some studies showed that the combination of oral antibiotics with a mechanical bowel preparation regimen reduces rates of infection and anastomotic leakage 37â€”39 , other data have not demonstrated a significant difference Mechanical bowel preparation also has been proposed as a method of enhancing visualization of the surgical field during laparoscopic surgery. Additionally, mechanical bowel preparation is time-consuming, expensive, and unpleasant for patients. Institutions may individualize their approach; data support that in cases of well-defined location and size of the lesion, shared decision-making between the obstetricianâ€”gynecologist and the patient is the recommended approach Perioperative Enhanced Recovery After Surgery Components Minimizing Infection Risk Minimally invasive approaches should be undertaken whenever possible and incisions kept as small as possible Patients undergoing hysterectomy, which is classified as a clean contaminated surgery, should receive broad-spectrum antibiotics to cover skin, vaginal, and enteric bacteria 23, For laparoscopic surgeries that do not involve genitourinary or digestive contamination, no antibiotic prophylaxis is necessary Intravenous antibiotics should be administered within 60 minutes before skin incision. Amoxicillinâ€”clavulanic acid and cefazolin provide appropriate antibiotic coverage against the microbes frequently involved in postoperative infections, although amoxicillinâ€”clavulanic acid is more effective against anaerobes Health care providers should consult their institutional antibiograms to confirm local susceptibility rates to the chosen coverage regimen. For lengthy procedures, additional intraoperative doses of the chosen antibiotic, given at intervals of two times the half-life of the drug measured from the initiation of the preoperative dose, not from the onset of surgery , are recommended to maintain adequate levels throughout the operation Prophylactic antibiotic dosage should be increased in obese patients BMI [calculated as weight in kilograms divided by height in meters squared] greater than or equal to 30 and, in surgical cases with excessive blood loss, a second dose of the prophylactic antibiotic may be appropriate Perform preoperative surgical site skin preparation with an alcohol-based agent unless contraindicated

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Chlorhexidine-alcohol is an appropriate choice. Scrub time gentle, repeated back-and-forth strokes for chlorhexidine-alcohol preparations should last for 2 minutes for moist sites inguinal fold and vulva and 30 seconds for dry sites abdomen , and allowed to dry for 3 minutes However, if using povidone-iodine scrubs for abdominal preparation, recommended scrub time can be as long as 5 minutes The solution should then be removed with a towel and the surgical site painted with a topical povidone-iodine solution, which should be allowed to dry for 2 minutes before draping Although currently only povidone-iodine preparations are U. If hair removal is needed, electric clipping is preferred to shaving Any necessary hair removal should be done immediately before the operation Although there are situations in which the judicious use of opioids is appropriate to achieve postoperative pain control, the epidemic of opioid use disorder and drug diversion has focused increased attention on development of alternative, stepwise and multimodal, and nonopiate pain management strategies. As an alternative to the administration of opioids, ketorolac is effective in controlling postoperative pain and does not increase postoperative bleeding Preemptive medication strategies eg, medications given to the patient before surgery , including paracetamol and acetaminophen, gabapentin, nonsteroidal antiinflammatory drugs, and COX-2 inhibitors, have been shown to decrease total narcotic requirements and improve postoperative pain and satisfaction scores in women undergoing total abdominal hysterectomy Intraoperatively, epidural and spinal anesthesia strategies, when compared with general anesthesia, decrease overall mortality and postoperative complications, including VTE, blood loss, pneumonia and respiratory depression, myocardial infection, and renal failure 50 , although such strategies limit mobilization. However, epidural and spinal anesthesia strategies are not feasible or appropriate for all surgical procedures. The transversus abdominis plane block commonly referred to as a TAP block , which involves injection of local anesthetic into the transversus abdominis fascial plane, also has been shown to be effective in some studies for reduction of postoperative opioid use in patients undergoing laparoscopic surgery, as well as women undergoing total abdominal hysterectomy 51 , However, other trials have yielded less promising results.

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Interdisciplinary Team Approach: Issues and Procedures 3 Karlind T. Moller Chapter 2 Social Work: Assessing Family Issues and Burdens of Care.

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