

Commentary

Daycase Robotic Surgery- The Future for Cancer Care

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ABSTRACT

Prostate cancer is one of the most common cancers in men. Radical robotic assisted laparoscopic prostatectomy (RALP) is the standard technique to treat localised prostate cancer. Standard operating procedure dictates an overnight admission. Yet the technique is minimally invasive and patients operated on early in the list with no complications are fit for discharge by that evening.

We review the literature on Daycase prostatectomies. The majority of patients have no complications and complications that do occur are minor. Based on these results, a new follow-up protocol is developed for Daycase radical robotic laparoscopic prostatectomy.

Keywords: Prostate cancer; Radical robotic assisted laparoscopic prostatectomy; Day case surgery

Robotic radical prostatectomy has a far lower complication rate when compared to laparoscopic or retro pubic prostatectomies [1-3]. Current clinical practice dictates patients are kept in hospital overnight. This is despite being first/second on the theatre list and being clinically stable at the end of the post-operative day. Post-operative clinical practice is often outlined by potential complications that can occur post-surgery. Several studies examine the complication rate of RALPs [4-9]. These vary from 0.9% to 26.1%, depending on surgeon experience and number of cases. Complications range from minor UTIs/ retention to more major anastomotic leakage, bladder neck stenosis, when classified according to the Clavien system [10,11].

In line with current clinical practice, patients are currently kept in hospital overnight, before being discharged home. In the hands of an experienced surgeon, RALPS can be performed routinely with a short operative time, low risk of blood loss and complications.

The first objective of any RALP is oncological control; the second is to give patients a straightforward postoperative recovery with no complications. The complications in one study were Clavien [12]. Out of 100 patients, only 12 had complications, with 7 of those being detected 4 hours postop [12]. However, only five cases needed secondary care intervention, the others could have been managed by primary care [12]. These results demonstrate it is possible for this procedure to be conducted as a day case procedure.

The protocol involved would be as follows. Patients would undergo pre-assessment. If they are ASA 1 or 2 they are suitable candidates. If they require an anaesthetic assessment or are ASA 3 and above, they would not be considered for day case surgery. The clinical notes would be vetted by the senior surgeon and deemed as suitable for day case. Patients would be admitted as per usual to the day case unit. The procedure would be conducted. If intraoperative complications occurred, the patient would be admitted. If the

procedure was uneventful, patients would be transferred back to the day case unit for recovery. Hourly observations would be taken including drain output for four hours. A post-operative set of bloods would also be taken. A medical review would be conducted at four hours post op by the senior surgeon. Provided observations (HR<90 bpm BP>110/<140, apyrexial, RR 15-20) are within normal range and bloods are normal, patients can be discharged home with the drain, and attend the urology ward the next morning to have it removed. Should patients have any issues post discharge with complications, they will have a nominated keyworker to get in contact with re: assessment or admission if required. Patients with an ASA of 3 or greater would not be candidates for day case surgery.

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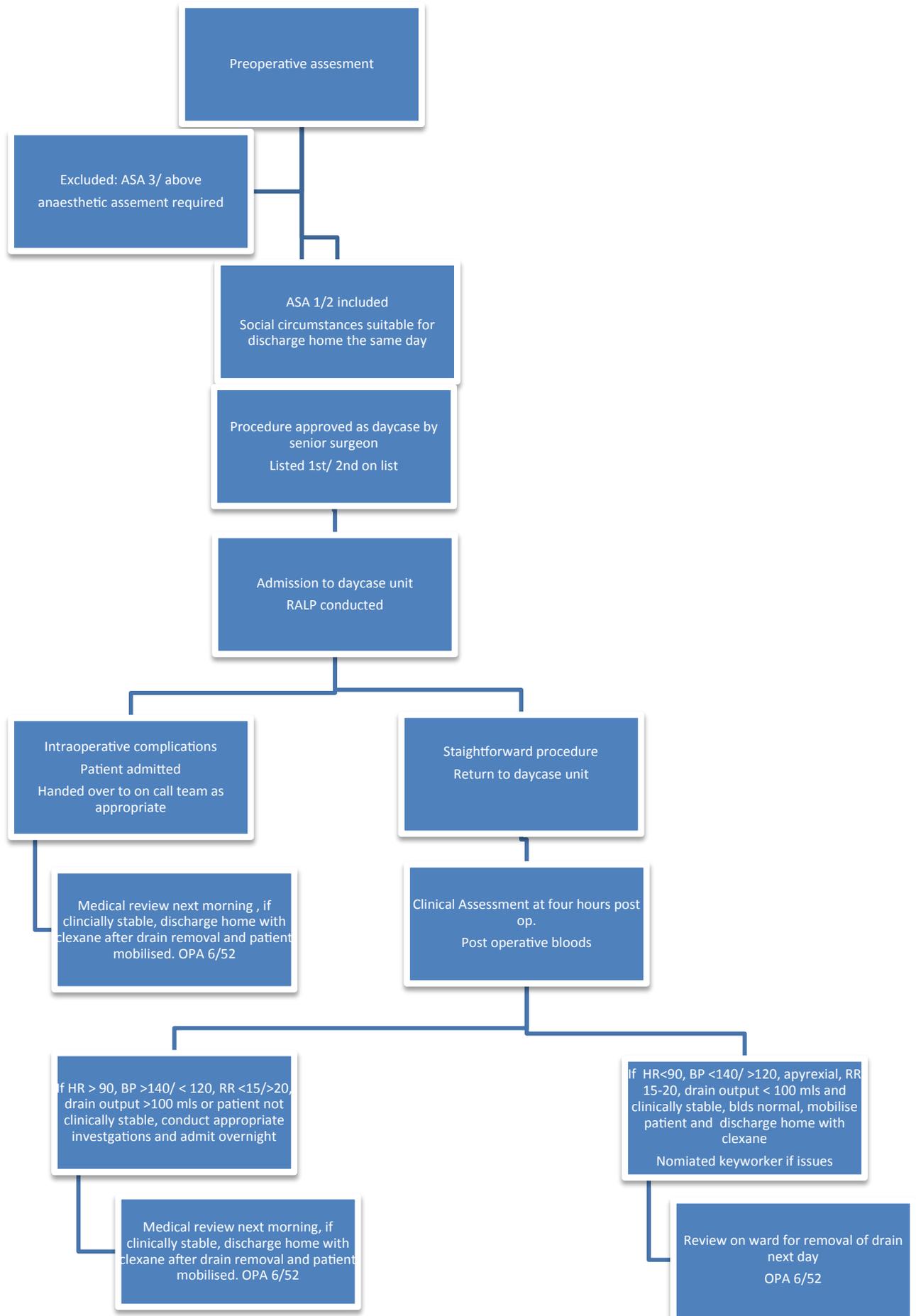


Figure 1: Protocol for day case RALPS.

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