Components of the ERAS® Care Pathway (Table 1)

Preoperatively, patients were educated about fasting guidelines. They were instructed to stop eating meals at least 8 hours prior to surgery, while they could drink clear fluids up to 3 hours before. Further, patients were instructed to drink a carbohydrate rich juice the evening prior to surgery and the morning of surgery as per the ERAS® carbohydrate loading protocol.[23] On the morning of surgery, patients received 1000 mg of acetaminophen, 400 mg of celecoxib, 80 mg of aprepitant orally, and 5000 units of dalteparin subcutaneously. Four milligrams of hydromorphone and 300 mg of gabapentin were given to patients in the holding area once seen by the anesthesiologist and the surgeon for markings.

Intraoperatively all patients had intravenous access, an arterial line, and a Foley bladder catheter. Hypothermia was prevented by using forced-air warming units and monitored by a temperature probe. Mechanical sequential compression devices were used intraoperatively for venous thromboembolism prophylaxis in addition to preoperative subcutaneous dalteparin. The intraoperative goal was to use total intravenous anesthesia and maintain euvolemia; however, the choice of anesthetics and the amount of intravenous fluids used was at the discretion of the anesthesiologist. Further, intraoperative choice of antiemetics and analgesics were left to the anesthesiologist. Prior to abdominal closure 20 cc of 0.25% bupivicaine were used by the surgeons for rectus sheath blocks. In addition, after closure of the lower abdominal incision and drain placement, 10 cc of 0.25% bupivicaine were infiltrated into the abdominal wound cavity through each of the two drains. The drains were clamped for 30 minutes and then placed to suction.

Postoperatively, all patients were transferred to the post-anesthetic care unit and then admitted to the plastic surgery ward with nurses experienced in monitoring flaps. Once on the ward, they received scheduled dosing of acetaminophen, celecoxib, and gabapentin (Table 1). Opioids were ordered on an as needed basis for breakthrough pain. A variety of common antiemetics were ordered and available for patients if needed (Table 1). Patients were started on clear fluids postoperatively and resumed a regular diet as tolerated on postoperative day 1 (POD1). They got up to a chair and were supported to ambulate on day one postoperatively. Lactated ringers infusion was started postoperatively based on total fluid intake (TFI)

requirements. The intravenous fluid administration was discontinued on POD1, if patients were drinking well. The Foley catheter was removed on POD1, if the patient was able to ambulate comfortably to the washroom. Vital signs were checked hourly for the first 24 hours postoperatively, every two hours for the next 24 hours, and then every eight hours until discharge. Flap checks were performed every hour for the first 24 hours, every two hours for the next 24 hours, and then every four hours until discharge. Drain teaching, dalteparin teaching, physiotherapy and activity restriction teaching were all provided prior to discharge.