

PERIOPERATIVE ANESTHESIA CARE FOR ROBOTIC ASSISTED PROSTATECTOMY

OR set up:

- OR table is quite far down the room (marked on floor) but you can have it closer to machine for induction
- Long circuit
- Green underpad for arms on OR table
- Head extension at feet and pt at correct place on table **so patient does not have to be moved once asleep**
- Must have 2 IV poles
- 100mL bag of 0.2% ropivacaine for port sites

Our equipment:

- Extension tubing on IV – no access to arms during case
- Additional IV (post induction) with extension to IV bag or syringe
- Art line at your discretion – long procedure time rather than blood loss is the surgical indication, patient indications at your discretion. (It is helpful for determining ET/arterial CO₂ gradient) – If using NIBP only, consider placing on both arms in order to alternate and give each arm a break
- PNS on face
- Don't plug the Bair Hugger in to the blue outlets on our pole as the other equipment for the robot is plugged in to this and will blow everything out

Induction:

- Can give Tylenol and Celecoxib as premed at your discretion
- Avoid long acting opioids or even fentanyl on induction (remi on induction works) – significant down time with no stimulation during positioning and set up
- +/- midazolam
- Need full paralysis
- Consider ropivacaine total dose if you use lidocaine infusion
- Tape ETT carefully as may go endobronchial with positioning/insufflation
- Heparin sc right after induction

Positioning:

- Before trendelenberg ensure that OR table is as low as it goes and slide to head **part way** (robot won't fit over legs for tall people) –confirm with surgeon re: degree of sliding as can't change after taping pt to table and robot may not reach if slid too far to head
- Hook up microbore extension tubing to IV close to pt (for phenyl infusion or any other infusion) before tucking arms – no access later
- Ensure IVs, (art line) and sat probe are functional after tucking arms

- Use a level to check bed is 24-25 degrees trendelenberg
- Arterial line transducer at your discretion – I have leveled at xiphoid? Head sees higher pressure, legs lower pressure - I have considered that a compromise – have also charted NIBP q 30 mins
- Our machine gets pulled back closer to our wall to allow enough room for first assist

Maintenance:

- Long acting opioids at your discretion. Usually need additional remi at incision if no other opioids given
- 1500-2000mL crystalloid for entire case if blood loss is <200mL as expected, assuming stable hemodynamics and not starting particularly volume depleted
- Must be paralyzed – can monitor on face
- Face gets quite ruddy, ensure no obstruction to venous drainage
- Watch that they aren't slipping down table

Emergence:

- Have not needed sugammadex (yet) but do use full reversal with neostigmine
- Have had enough time to lighten (and wake) patient at end as undocking robot and closing port sites takes time
- Surgeon will use 100mL of ropiv in port sites
- Ketorolac at end or in PACU if OK with surgeon
- Opioid requirement is variable. Overall, much less than open prostatectomy

PACU:

- Minimal iv opioids only if needed – foley catheter has been causing the most discomfort
- PO opioids and Tylenol (Urology manages)
- Plan to go home within 24 hrs