

Evaluation of the catheter related symptoms between suprapubic and standard catheter in Retzius-Sparing RARP

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INTRODUCTION AND AIM

A day case protocol RARP aiming to minimise the hospital stay and the NHS cost has been introduced by our department with success over the last 18 months. For patients fulfilling the day case criteria, a combination of general anaesthesia with spinal versus general anaesthesia solely, has been utilised.

We aim to evaluate the effect of the anaesthesia type delivered concerning the ability of the patient to proceed with a safe discharge as per the day case protocol.

METHODS AND MATERIAL

Data was prospectively collected for patients deemed suitable for a day-case RARP between July 2023 and January 2024. The decision for non-spinal versus spinal regime was at the anaesthetist's discretion.

The patient's pain, consciousness and ability to mobilise independently were assessed post-operatively.

RESULTS

48 patients were enrolled in the study group. 27 (56%) had general anaesthesia versus 21 (44%) who were delivered a combined spinal and general anaesthetic.

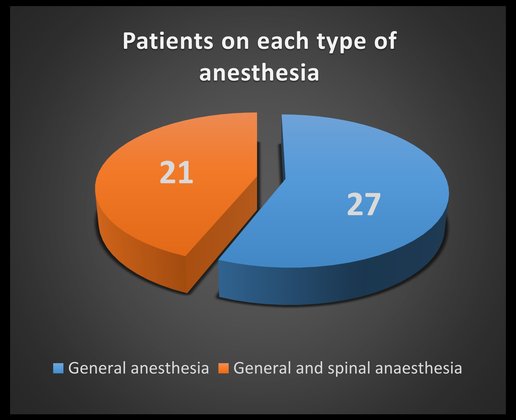
26 (97%) from the non-spinal arm were able to be discharged as per the protocol as opposed to 20 (96%) from the second arm.

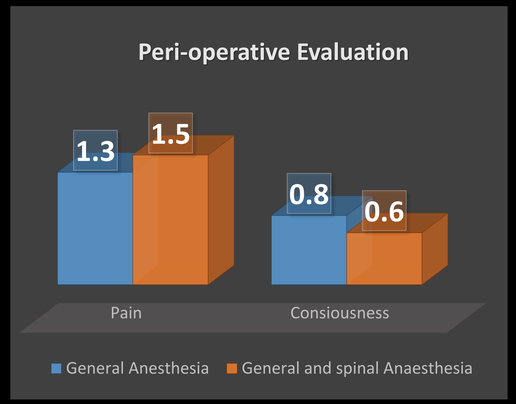
The pain and mobility/consciousness levels were recorded three hours post operatively with a mean of 1.3 and 0.8 for the first arm and 1.5 and 0.6 for the second arm, in an objective scale from 0 to 5 and 3 respectively.

On mobilization three hours post operatively, 2 patients in the first arm and 1 in the second felt dizzy limiting their ability walk but this did not affect their eligibility for discharge later the same day. The analysis did no demonstrate any statistically significant difference amongst the two arms (p value > 0.05).

Table 2. Anesthetic protocol

General Anesthetic	Spinal and General Anesthetic
1. Propofol TCI with Remifentanil + Rocuronium 0.6mg/kg 2. Antibiotics - 1.5g Cefuroxime/120mg Gentamicin on induction 3. Antiemetics - Dexamethasone 6.6mg post-induction, Ondansetron 4mg 30 minutes prior to emergence 4. Diclofenac 100mg PR prior to first incision unless contra-indicated 5. IV Paracetamol 1g post induction 6. IV s-Ketamine 125mcg/kg bolus on induction 7. IV Magnesium 50 mg/kg over 15 minutes post-induction 8. IV Tranexamic Acid 1g post induction 9. IV Morphine 0.1-0.2 mg/kg post anastomosis 10. Restrictive fluid regime (<10ml/kg) 11. 40 mls 0.25% L-Bupivicaine into the bladder after leak test, spigot for 20 minutes 12. Local Anaesthetic infiltration by surgeon 20 mls 0.25% L-Bupivacaine (Max 2mg/kg total dose)	1. Awake Single Shot Spinal 3-4ml (7.5-10mg) of 0.25% L-bupivicaine + 300mcg diamorphine 2. Propofol TCI with Remifentanil + Rocuronium 0.6mg/kg 3. Phenylephrine infusion as required 4. Antibiotics - 1.5g Cefuroxime/120mg Gentamicin on induction 5. Antiemetics - Dexamethasone 6.6mg post-induction, Ondansetron 4mg 30 minutes prior to emergence 6. Diclofenac 100mg PR prior to first incision unless contra-indicated 7. IV Paracetamol 1g post induction 8. IV Magnesium 50 mg/kg over 15 minutes post-induction 9. IV Tranexamic Acid 1g post induction 10. Restrictive fluid regime (<10ml/kg) 11. 40 mls 0.25% L-Bupivicaine into the bladder after leak test, spigot for 20 minutes 12. Local Anaesthetic infiltration by surgeon 20 mls 0.25% L-Bupivacaine (Max 2mg/kg total dose)





Pain and Consciousness assessment scale:
Pain scale: 0. No pain, 1. Dull ache, 2. Mild pain, 3. Painful, 4. Very painful, 5. Unbearable pain
Dizziness scale: 0. No dizziness – able to mobilise independently, 1. Mild dizziness – no support required in mobilisation – dizziness settled spontaneously, 2. Moderate dizziness – able to mobilise but had to sit a few minutes later, 3. Severe dizziness – not able to stand or mobilise

Table 1. Post-operative assessment

	General Anesthetic	Spinal and General Anesthetic	P-value	Total
	n=27 (56%)	n=21 (44%)	-	48
Consciousness	0.8/3	0.6/3	0.41	-
Pain	1.3/5	1.5/5	0.58	-
Discharged as per day-case protocol	26 (97%)	20 (96%)	1	46

CONCLUSIONS

The use of spinal anaesthetic does not seem to affect the patient's fitness for discharge as per the day-case protocol. It seems to have minimised the pain levels and did not affect the patient's consciousness or restrict their mobility. Both spinal and non-spinal approaches can be considered safe for day-case RARPs.

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