



Carpe diem for same-day discharge following minimally invasive gynecologic oncology surgery

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Enhanced recovery after surgery (ERAS) has effectively evolved the best available evidence into protocols that safely accelerate post-operative recovery and push the limits of decreasing length of stay. Minimizing length of stay, without incurring increased readmissions and patient dissatisfaction, has the greatest potential to improve clinical, operational, and financial outcomes of surgical care. Same-day discharge is the ultimate realization of this in the practice of minimally invasive surgery. To date, surgeon and patient preferences have been the major drivers of low same-day discharge utilization. Same-day discharge after minimally invasive surgery for endometrial cancer, the most targetable patient population in our field, has historically been less than 10%. With the SARS-CoV-2 pandemic, a rapid paradigm shift resulted in an almost overnight transition from inpatient stay to same-day discharge across the surgical specialties: robotic prostatectomy and nephrectomy, transcatheter aortic valve replacement, hip and knee arthroplasty, and mastectomy with immediate prosthetic reconstruction, to name a few. Many have published their same-day discharge experience and outcomes and three important trends have emerged: more patients than ever before are willing to opt for, and in fact insist on, same-day discharge following minimally invasive surgery to decrease the risk of contracting nosocomial infections such as SARS-CoV-2; same-day discharge following minimally invasive surgery is feasible, efficient, and safe when a standardized, multidisciplinary care protocol is implemented; and same-day discharge decreases hospital resource utilization.¹⁻³

In their paper, Kim et al¹ outline a same-day discharge protocol implemented on a gynecologic oncology service for patients undergoing minimally invasive surgery at a tertiary cancer center during the first year of the pandemic. They saw a remarkable increase in same-day discharge from 30% to 75% with no impact on emergency room visits, 30-day readmission, re-operation, morbidity, or mortality rates. Critically, same-day discharge was associated with high patient satisfaction and acceptance.¹

The same-day discharge protocol the group implemented is rooted in the canonical ERAS principles of standardized patient education and expectation setting, opioid-sparing analgesia, maintenance of euolemia, and immediate post-operative ambulation and oral intake. Further, the same-day discharge protocol outlined an operations process to support successful outcomes including clear pre-operative eligibility criteria, scheduling same-day discharge at the start of the day, ensuring availability of an extended post-anesthesia care unit (PACU) stay or transfer to an observation unit with same-day discharge nursing care, objective discharge criteria, and a follow-up telephone call 24 to 72 hours after discharge. Each of these elements were critical contributors to the success of the program and are sufficiently detailed to enable other centers to implement comparable protocols.

Post-operative nausea and vomiting prophylaxis is an integral ERAS intervention that should be rigorously applied to same-day discharge protocols. Post-operative nausea and vomiting is one of the biggest deterrents to same-day discharge, as evidenced by the authors' finding that post-operative nausea and vomiting was the leading identifiable cause of unplanned admission in their cohort. Per the Society for Ambulatory Anesthesia, three of the top risk factors for post-operative nausea and vomiting apply to nearly all of our patients: female gender, gynecologic surgery, and laparoscopy. The AAGL white paper on ERAS for minimally invasive gynecologic surgery provides a useful summary of measures for post-operative nausea and vomiting prophylaxis based on the Apfel risk scoring system.²

Finally, the work of Kim et al is impactful because it validates existing benchmarks for same-day discharge. It sets the goal same-day discharge rate for gynecologic oncology minimally invasive surgery at 75%, with the alternative benchmark of a median length of stay of 8 hours. In prospective trials of same-day discharge, median readmission and re-evaluation rates are 1% and 7%, consistent with the authors' observations. Given these compelling data, surgeon support for same-day discharge



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should rise to achieve a 100% recommendation rate for all eligible patients. Indeed, most patients find same-day discharge acceptable if their surgeon recommends it.³ While same-day discharge implementation was accelerated during the SARS-CoV-2 pandemic due to immediate requirements for resource rationing, the quality and value of care benefits are timeless. It is time that same-day discharge for minimally invasive surgery patients be a requisite part of ERAS. Health systems and reimbursement strategies should support and incentivize it.

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