

Preparation of the patient

Preparation of the patient

Although the patient may be in hospital for a shorter period, - careful preoperative management is essential to minimise morbidity . Recognition of patient- or procedure-related factors that may in turn complicate a minimal access approach is vital to optimise outcomes. History Patients must be fit for general anaesthesia and open operation if necessary . Potential coagulation disorders are particularly dangerous in minimal access surgery where options for haemostasis may be more limited. A prior history of surgical intervention in the same area is vitally important and should be carefully documented, so as to best predict factors such as adhesions that may preclude a minimal access approach. Previous oncological treatment can also create a more hostile surgical environment and an appropriate threshold for conversion to open access should be set prior to the procedure and communicated clearly with the patient. Preparation for minimal access surgery

Examination Routine preoperative physical examination is required as for any major operation. Although, in general, minimal access surgery allows quicker recovery , it may involve longer operating times and carbon dioxide insufflation in both the chest and abdomen may provoke cardiac arrhythmias. Severe chronic obstructive airways disease and ischaemic heart disease may be contraindications to a minimal access approach. Moderate obesity does not increase operative difficulty significantly , but morbid obesity may require specialist instrumentation and trocars. Patients with a particularly low body mass index and small body habitus may present separate challenges in terms of port placement, particularly when adopting a robotic approach. Severe spinal deformity including kyphosis and scoliosis may present problems in terms of positioning as well as impact on overall recovery if there are associated problems with sputum clearance and mobility . Prophylaxis against thromboembolism Venous stasis induced by the reverse Trendelenburg position during laparoscopic surgery coupled with prolonged duration of operation are risk factors for deep vein thrombosis. Subcutaneous low-molecular-weight heparin and antithrombotic stockings should be used routinely in addition to pneumatic calf compression during the operation. Patients already taking anticoagulation should have this stopped temporarily or appropriate, be converted to intravenous or subcutaneous heparin, depending on the underlying condition and local thromboprophylaxis protocols. In most cases patients can continue on aspirin when the benefits outweigh the slight increase in bleeding potential. Urinary catheters and nasogastric tubes In the early days of minimal access surgery , routine bladder catheterisation and nasogastric intubation were advised. Most surgeons now omit these in favour of enhanced recovery , which has demonstrated benefits in terms of both length of stay and morbidity outcomes. It remains essential to check that Friedrich Trendelenburg , 1844-1924, Professor of Surgery successively at Rostock (1875-1882), Bonn (1882-1895), Leipzig (1895-1911), Germany . The Trendelenburg position was first described in 1885. particularly before creating pneumoperitoneum for minimal access surgery approaches to the abdomen. Informed consent It is essential that the patient understands the nature of the procedure, the risks involved and, when appropriate, the alternatives that are available. A locally prepared explanatory booklet concerning the minimal access procedure to be

under-taken is extremely useful (Chapter 14). The patient should understand that the procedure may be converted to an open operation. Common complications should be mentioned, such as shoulder tip pain and minor surgical emphysema, as well as rare but serious complications, such as inadvertent visceral injury from trocar insertion or diathermy . Patients may also have specific questions or requests in terms of the application of minimal access surgery . It is important to be considerate and address these. Some patients remain concerned about the application of technology , particularly robotics, to their care and it is important to ensure they understand and agree with the proposed surgical approach. -

Overall fitness: cardiac arrhythmia, lung function, medications, allergies Previous surgery or oncological intervention: scars, adhesions Body habitus: obesity, skeletal deformity Normal coagulation Thromboprophylaxis Informed consent Operative difficulty is predicted when possible with appropriate risk model Appropriate theatre time and facilities are available (especially important for robotic cases)

Preparation of the patient

Although the patient may be in hospital for a shorter period, - careful preoperative management is essential to minimise morbidity . Recognition of patient- or procedure-related factors that may in turn complicate a minimal access approach is vital to optimise outcomes. History Patients must be fit for general anaesthesia and open operation if necessary . Potential coagulation disorders are particularly dangerous in minimal access surgery where options for haemostasis may be more limited. A prior history of surgical intervention in the same area is vitally important and should be carefully documented, so as to best predict factors such as adhesions that may preclude a minimal access approach. Previous oncological treatment can also create a more hostile surgical environment and an appropriate threshold for conversion to open access should be set prior to the procedure and communicated clearly with the patient. Preparation for minimal access surgery /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Examination Routine preoperative physical examination is required as for any major operation. Although, in general, minimal access surgery allows quicker recovery , it may involve longer operating times and carbon dioxide insufflation in both the chest and abdomen may provoke cardiac arrhythmias. Severe chronic obstructive airways disease and ischaemic heart disease may be contraindications to a minimal access approach. Moderate obesity does not increase operative difficulty significantly , but morbid obesity may require specialist instrumentation and trocars. Patients with a particularly low body mass index and small body habitus may present separate challenges in terms of port placement, particularly when adopting a robotic approach. Severe spinal deformity including kyphosis and scoliosis may present problems in terms of positioning as well as impact on overall recovery if there are associated problems with sputum clearance and mobility . Prophylaxis against thromboembolism Venous stasis induced by the reverse Trendelenburg position during laparoscopic surgery coupled with prolonged duration of operation are risk factors for deep vein thrombosis. Subcutaneous low-molecular-weight heparin and antithrombotic stockings should be used routinely in addition to pneumatic calf compression during the operation. Patients already taking anticoagulation should have this stopped temporarily or appropriate, be converted to intravenous or subcutaneous heparin, depending on the underlying condition and local thromboprophylaxis protocols. In most cases patients can continue on aspirin when the benefits outweigh the slight increase in bleeding potential. Urinary catheters and nasogastric tubes In the

early days of minimal access surgery , routine bladder catheterisation and nasogastric intubation were advised. Most surgeons now omit these in favour of enhanced recovery , which has demonstrated benefits in terms of both length of stay and morbidity outcomes. It remains essential to check that Friedrich Trendelenburg , 1844–1924, Professor of Surgery successively at Rostock (1875–1882), Bonn (1882–1895), Leipzig (1895–1911), Germany . The Trendelenburg position was first described in 1885. particularly before creating pneumoperitoneum for minimal access surgery approaches to the abdomen. Informed consent It is essential that the patient understands the nature of the procedure, the risks involved and, when appropriate, the alternatives that are available. A locally prepared explanatory booklet concerning the minimal access procedure to be undertaken is extremely useful (Chapter 14). The patient should understand that the procedure may be converted to an open operation. Common complications should be mentioned, such as shoulder tip pain and minor surgical emphysema, as well as rare but serious complications, such as inadvertent visceral injury from trocar insertion or diathermy . Patients may also have specific questions or requests in terms of the application of minimal access surgery . It is important to be considerate and address these. Some patients remain concerned about the application of technology , particularly robotics, to their care and it is important to ensure they understand and agree with the proposed surgical approach. -

Overall fitness: cardiac arrhythmia, lung function, medications, allergies Previous surgery or oncological intervention: scars, adhesions Body habitus: obesity, skeletal deformity Normal coagulation Thromboprophylaxis Informed consent Operative difficulty is predicted when possible with appropriate risk model Appropriate theatre time and facilities are available (especially important for robotic cases)

Preparation of the patient

Although the patient may be in hospital for a shorter period, - careful preoperative management is essential to minimise morbidity . Recognition of patient- or procedure-related factors that may in turn complicate a minimal access approach is vital to optimise outcomes. History Patients must be fit for general anaesthesia and open operation if necessary . Potential coagulation disorders are particularly dangerous in minimal access surgery where options for haemostasis may be more limited. A prior history of surgical intervention in the same area is vitally important and should be carefully documented, so as to best predict factors such as adhesions that may preclude a minimal access approach. Previous oncological treatment can also create a more hostile surgical environment and an appropriate threshold for conversion to open access should be set prior to the procedure and communicated clearly with the patient. Preparation for minimal access surgery /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF /uni25CF Examination Routine preoperative physical examination is required as for any major operation. Although, in general, minimal access surgery allows quicker recovery , it may involve longer operating times and carbon dioxide insufflation in both the chest and abdomen may provoke cardiac arrhythmias. Severe chronic obstructive airways disease and ischaemic heart disease may be contraindications to a minimal access approach. Moderate obesity does not increase operative difficulty significantly , but morbid obesity may require specialist instrumentation and trocars. Patients with a particularly low body mass index and small body habitus may present separate challenges in terms of port placement, particularly when adopting a robotic approach. Severe spinal deformity including kyphosis and scoliosis may present problems in terms of positioning as well as impact on overall

recovery if there are associated problems with sputum clearance and mobility . Prophylaxis against thromboembolism V enous stasis induced by the reverse Trendelenburg position during laparoscopic surgery coupled with prolonged duration of operation are risk factors for deep vein thrombosis. Subcutaneous low-molecular-weight heparin and antithromboembolic stockings should be used routinely in addition to pneumatic calf compression during the operation. Patients already taking anticoagulation should have this stopped temporarily or appropriate, be converted to intravenous or subcutaneous heparin, depending on the underlying condition and local thromboprophylaxis protocols. In most cases patients can continue on aspirin when the benefits outweigh the slight increase in bleeding potential. Urinary catheters and nasogastric tubes In the early days of minimal access surgery , routine bladder catheterisation and nasogastric intubation were advised. Most surgeons now omit these in favour of enhanced recovery , which has demonstrated benefits in terms of both length of stay and morbidity outcomes. It remains essential to check that Friedrich Trendelenburg , 1844–1924, Professor of Surgery successively at Rostock (1875–1882), Bonn (1882–1895), Leipzig (1895–1911), Germany . The Trendelenburg position was first described in 1885. particularly before creating pneumoperitoneum for minimal access surgery approaches to the abdomen. Informed consent It is essential that the patient understands the nature of the procedure, the risks involved and, when appropriate, the alternatives that are available. A locally prepared explanatory booklet concerning the minimal access procedure to be undertaken is extremely useful (Chapter 14). The patient should understand that the procedure may be converted to an open operation. Common complications should be mentioned, such as shoulder tip pain and minor surgical emphysema, as well as rare but serious complications, such as inadvertent visceral injury from trocar insertion or diathermy . Patients may also have specific questions or requests in terms of the application of minimal access surgery . It is important to be considerate and address these. Some patients remain concerned about the application of technology , particularly robotics, to their care and it is important to ensure they understand and agree with the proposed surgical approach. -

Overall fitness: cardiac arrhythmia, lung function, medications, allergies Previous surgery or oncological intervention: scars, adhesions Body habitus: obesity, skeletal deformity Normal coagulation Thromboprophylaxis Informed consent Operative difficulty is predicted when possible with appropriate risk model Appropriate theatre time and facilities are available (especially important for robotic cases)

Revision #1

Created 2025-12-31 15:08:04 UTC by Omar Ayman

Updated 2025-12-31 15:08:04 UTC by Omar Ayman