

Whipple ERAS Pain/Anesthesia Protocol

Exclusions - Patients on daily pre-op opiates for >2 months.
Abnormal LFTs
Abnormal coags
Abnormal Creatinine

Immediately Pre-op- 1000 mg Acetaminophen po (and then po or IV q6h till discharge).

Intra-op

Dr. Park's patients:

- Administer short/long acting opiates as needed for adequate pain control .
- Two TAP block catheters will be placed intraoperatively by the surgical team prior to abdominal wall closure
- Initial bolus of ropivacaine 0.2% 15 mL per catheter by surgical team; total dose not to exceed 2 mg/kg.
- Initiate TAP catheter infusions with ropivacaine 0.2% at 5 mL/hr per catheter

Dr. Pillarisetty's patients: NO epidural. Titrate opiates as usual

Fluid Goals: Induction – 500 ml of LR bolus over 30 min
Maintenance – 2 ml/kg/hr of LR (urine target >25ml/hr urine)

If hypotensive: Treat with fluid boluses and/or phenylephrine up to 0.8 micrograms/kg/min.
Avoid vasopressin

Start D5LR at 1 ml/kg/hr and Insulin if BG>140.

PACU/POD0

Dr. Pillarisetty's patients: Start IV PCA per surgeons (NO APS)

Dr. Park's patients: Continue TAP infusions of Ropivacaine and start IV PCA at 0.2 mg bolus, 6 min lockout, no continuous infusion or 4 hour limit

For breakthrough pain: Adjust PCA first as needed.
Limit 0.2% Ropivacaine infusions through TAP catheters to a maximum of 15 ml/hr.

POD 1

Continue TAP blocks and IV PCA. Transition to po acetaminophen after clear liquids started. Discuss ketorolac (15 mg q6h) or other NSAID with surgeons for pain if not contraindicated.

POD 3

- Discontinue TAP infusion at 0600 if tolerating Whipple diet
- Discontinue ketoralac/start ibuprofen 600 mg PO q6 h
- Transition from PCA to PO narcotic pain medications after lunch
- Surgical team to remove TAP catheters by mid-afternoon