MARCH 2017

Newsletter

Surgery
UNIVERSITY OF TORONTO

UPCOMING EVENTS & COURSES

SAVE THE DATE!

First year residents participating in the resident QI course led by Najib Safieddine will present their QI projects. The event will take place toward the end of the day and we hope you will be able to come and show your support!

BEST PRACTICE IN SURGERY RESIDENT QI PRESENTATIONS

MAY 23, 2017

LOCATION TBD

CHECK OUT OUR **WEBSITE:**

bestpracticeinsurgery.ca

For more on Best Practice in Surgery

Information

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WELCOME! *In this months newsletter we want to highlight the importance of timely catheter removal and address some current issues with post-discharge opiod use. As always, if you would like to be featured as a guest writer or contribute to our newsletter, please email us at bestpracticeinsurgery@utoronto.ca.*

QI @ UofT

Did you know that urinary tract infections are the most common infections in hospitalized patients? And, the vast majority of them are associated with the use of indwelling catheters. Using NSQIP data, Trickey and colleagues found that two thirds of patients who developed urinary tract infections post-operatively had had a catheter in place for more than 2 days.

Nowadays, with the adoption of Enhanced Recovery after Surgery (ERAS) pathways there is an emphasis on multimodal pain control with limited use of opioids, early ambulation and early feeding with the rationale that it will lead to improved recovery and early discharge from hospital. Early removal or elimination of catheters are also part of most ERAS pathways as this will also promote early ambulation as well as prevent UTIs.

In the ERAS implementation study which was led by the Best Practice in General Surgery group, early removal of urinary catheters-by 24 hours after colon surgery and 72 hours after rectal surgery-was one of our guideline recommendations.

How did we do? Well, not very well. In fact, only **53%** of patients had their catheters removed according to guideline recommendations. Furthermore, we saw no improvement in earlier removal of catheters over the 18 months of the project suggesting that catheter use is embedded in our post-operative care of patients.

Not surprisingly, those patients who were not compliant with the guideline recommendations were significantly more likely to develop a urinary tract infection: **4.1% vs. 0.8%** who had colonic operations and **9.6% vs. 3.5%** who had rectal operations. The compliant patients also had shorter lengths of stay (a decrease of 1 to 3 days).

Why are we so reluctant to not insert catheters or if we do use them, why do we leave them in so long? It is probably habit. However, now is the time to change our practice. Our anaesthesia colleagues tell us they don't need catheters for monitoring purposes in many cases. Post-operatively, we also don't need them for monitoring or need them in patients with epidurals in place and there are many benefits from earlier removal including earlier ambulation, decreased risk of infection and earlier discharge!

We will be providing recommendations for early removal of Foley catheters in our upcoming ERAS guideline.

CURRENT WORK

Post-Discharge Opiod Use Guideline

Our working group on post-discharge opioid use led by **Dr. Hance Clarke** has had their first meeting to start the developing the guideline. To date, the group has conducted a systematic review of the literature to determine current prescribing patterns for opioids post-discharge. The review, written by **Adina Fienberg** and colleagues, shows that on average, patients use a small proportion of the opioids that are prescribed to them when they are discharged. Furthermore, information on how to dispose of the unused opioids are often not provided which may lead to these drugs becoming available to unintended users. The next step is to survey current practices for prescribing opioids at discharge. We hope to send this to you in the next few months.

KUDOS!

Kudos to **Dr. Anand Govindarajan** who was successful in receiving a grant from the AFP to conduct a bi-institutional trial, to see if a multimodal prehab intervention comprising both physical and psychological conditioning can improve postoperative quality of life and other outcomes in patients undergoing major GI surgery. "Prehabilitation" involves preoperative conditioning to help improve postoperative outcomes.