ONCOLOGY TIMES

Independent News on
HEMATOLOGY / ONCOLOGY

Special Edition Supplement to April 25, 2015 issue

Meeting Reporter:

Miami Breast Cancer Conference

February 26 - March 1, 2015

Lymphedema: The Buzz about Surgery 2

The Coming 'Tsunami' of Older Breast Cancer Patients 9

'Medical Crossfire' Debate: Is Genetic Susceptibility Panel Testing for Breast Cancer Ready for Prime Time? 10

ERAS Protocol Now Shown Helpful in Breast Reconstructive Surgery 14

Innovations in Pain Management for Breast Cancer Patients 15

Team Approach Shown to Reduce Local Regional Relapse 16

Deciding When Neoadjuvant Endocrine Therapy is Appropriate for Patients with Operable Breast Cancer 18

Early-Stage Breast Cancer: Value of Monitoring for Recurrence Questioned 19

'Medical Crossfire' Debate: Will Metastatic Breast Cancer Ever Be Cured? 20

@OncologyTimes /OncologyTimesNews Wolters Kluwer

ERAS Protocol Now Shown Helpful in Breast Reconstructive Surgery

BY ROBERT H. CARLSON

MIAMI BEACH—Enhanced Recovery After Surgery (ERAS) pathways are achieving earlier recovery and decreased lengths of hospital stay in multiple surgical specialties, and now are showing benefits in reconstructive surgery as well.

Speaking here at the Miami Breast Cancer Conference, Valerie Lemaine, MD, MPH, FRCSC, FACS, Assistant Professor of Plastic Surgery and Vice Chair for Research at Mayo Clinic College of Medicine, described an ERAS pathway designed specifically at Mayo for women undergoing immediate or delayed microsurgical breast reconstruction.

"This first ERAS pathway in microvascular breast reconstruction achieved a 71 percent reduction in narcotic use, a 71 percent reduction in time to first walk, and a reduced hospital length of stay by 1.6 days—all with no change in the rate of major complications," she said.

ERAS, a multimodal, multiprofessional approach to perioperative care, was pioneered by D. Henrik Kehlet, MD, PhD, a Danish colorectal surgeon, in 1997, to enhance recovery after colorectal surgery. Kehlet determined that the key factors that keep patients hospitalized after surgery were the need for extra hydration, the need for parenteral analgesia, and decreased mobility.

"Kehlet challenged time-honored surgical dogma by stopping bowel prep before colorectal surgery, stopping the use of nasogastic tubes, and feeding patients immediately after surgery," Lemaine said.

First for Breast Cancer Surgery

ERAS protocols have been developed in orthopedic, gynecologic, and urologic surgery, she said, but the Mayo protocol is the first for breast cancer surgery.

Basically, ERAS focuses on minimizing metabolic stress after surgery while maintaining homeostasis during surgery, by reducing physiologic alterations caused by surgery and traditional postoperative care, she explained. For example, on the morning of surgery, patients are allowed to ingest clear fluids up to two hours prior to microsurgical breast reconstruction. Patients also receive antibiotic and thrombotic prophylaxis.

Patients were also given preoperative medication one hour prior to surgery, including celecoxib, gabapentin, and acetaminophen, she said.

Microsurgical Breast Reconstruction Extremely Taxing

Microsurgical breast reconstruction is extremely taxing on patients, Lemaine said. It involves multiple donor tissue sites, a long surgical procedure, specialized postoperative care, and a traditional length of stay of five to seven days.

Lemaine cited a study she coauthored of 100 patients undergoing 181 free-flap breast reconstructions performed by two surgeons (***J Plast Reconst Aesthet Surg 2015;68:395-402***). Among 51 patients treated with a traditional recovery after surgery protocol, postoperative opioids were required in 95.9 percent, versus 19.6 percent in the 49 patients in the ERAS group.

An anesthesiologist was on hand in the operating room for the intraoperative components of ERAS, including:

- Maintenance of euvolemia (no more fluid overload called for as had been the case);
- Normothermia;
- Antiemetic protocol; and
- Liposomal bupivacaine field block anesthesia for the transversus abdominis plane (TAP), rectus sheath incisions, and subcutaneous infiltration.

VALERIE LEMAINE, MD, MPH: "This first ERAS pathway in microvascular breast reconstruction achieved a 71% reduction in both narcotic use and time to first walk, and a reduced length of hospital stay by 1.6 days—all with no change in the rate of major complications."

Postoperative components included scheduled acetaminophen and celecoxib, and opioid analgesia only as needed.

When Lemaine was introduced by Conference Program Co-director J. Michael Dixon, MD, Professor of Surgery and Clinical Director of the Breakthrough Research Unit, Edinburgh Breast Unit, Edinburgh, U.K., he said the conference organizers had invited her as a plastic surgeon to speak because they felt they needed to hear from other specialists in terms of total care after surgery.