OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Enhanced Recovery After Surgery (ERAS):

Major Laparoscopic Surgery Pathway for Gynaecologic Oncology Patients including those Eligible for Same Day Discharge

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH

This document should be read in conjunction with this Disclaimer

Contents

Purpose

This document describes the Enhanced Recovery After Surgery (ERAS) care pathway aimed to standardise the perioperative care of patient's undergoing major laparoscopic surgery, including those eligible for same day discharge (SDD). This includes patients having laparoscopic surgery including but not limited to hysterectomy, salpingo-oophorectomy, lymph node biopsy/dissection, omentectomy, appendicectomy, peritonectomy, and adhesiolysis.

By standardising care, this pathway reduces care variabilities and provides a evidence-based approach that supports improved patient outcomes, enhances recovery, and increases patient engagement and satisfaction.

Scope

This procedure applies to all parties involved in the care of Gynaecologic Oncology major laparoscopy patients, including Anaesthetists, Anaesthetic technicians, Surgeons, Physicians, Nursing, Pharmacy, Physiotherapy, Dietiticans, Hospital Administration, the patient and patients' support systems.

Procedure for ERAS

ERAS: Major laparoscopic surgery

ERAS is a multimodal perioperative care pathway designed to achieve early recovery for patients undergoing major surgery.

This document will focus on elements of the care pathway for the preadmission, pre-operative, intra-operative, and post-operative periods.

Pre-admission components

Patient selection

- All major laparoscopic patients will be placed on the ERAS pathway regardless of whether SDD eligible
- There is no set criteria for same day discharge eligibility; patients will be assessed on a case by case basis by the surgical and anaesthetic team both pre-operatively in clinic and prior to discharge
- Factors that may lead to admission include frailty/mFI ≥3 (calculated using the modified frailty index), age >80, DASI (MET <4), BMI ≥40, operative time >3 hours, and comorbidities requiring in hospital postoperative follow-up
- Patients must have a responsible adult to stay with them for the first 24 hours following discharge

Patient information, education and counselling

- The ERAS Clinical Nurse provides patient and/or caregiver education ideally 2-4 weeks pre-operatively and again on the day/s prior to surgery, delivered via phone or video conference call.
- Education includes the principles of ERAS, surgical optimisation (e.g. smoking cessation/NRT, alcohol cessation, nutrition and exercise), and expectation-setting regarding surgery, length of stay, and recovery
- Mixed-format educational material will be provided including verbal, written, and visual information
- The ERAS nurse and physiotherapist will provide advice on:
    - aCOUGH
        - **a**ctive **C**ycle of Breathing Technique (aCBT)
        - **O**ral hygiene
        - **U**nderstanding the concepts
        - **G**etting out of bed
        - **H**ead Elevation
    - Inspiratory muscles training (IMT) device use and education (if applicable)
    - Lymphodema education (if applicable)
    - Safe movement after surgery
- Patients will be contacted by pharmacy via phone and/or seen in pre-admission clinic (PAC) particularly for those taking ≥5 medications, or those on diabetic, antiplatelet and anticogulant medications.
- Enoxaparin education and injection technique (if applicable) will be provided with the ERAS nurse and available online via ‘Surgery School’. Patient information leaflets on preventing and treating blood clots will also be provided.
- The following patient Information booklets will be provided to Gynaecologic Oncology patients
    - Gynaecologic Oncology Same Day Discharge ERAS
    - ERAS Gynaecologic Oncology
    - Major Gynaecologic Oncology Surgery: ERAS
    - Physiotherapy post-operative advice
- Online ‘Surgery School’ access will be provided to all patients,available in English, Greek, Mandarin, Vietnamese, Cantonese, and Arabic. Patients will receive QR codes and URL for access.

Theatre timing

- Timing of surgery is critical to successful same day discharge

- Same day discharge is most successful when cases are scheduled first on the list, and/or completed by early afternoon
- Gynaecologic Oncology theatre lists will be arranged to facilitate this scheduling
- Senior surgeon involvement should be optimised to minimise operative time

Preoperative optimisation: alcohol, smoking, anaemia, diabetes, Obstructive Sleep Apnoea, nutrition

- **Alcohol**
  - Patients will be screened for alcohol use and offered alcohol cessation interventions and counselling at least 4 weeks pre-operatively
- **Smoking and vaping**
  - Patients will receive counselling on the importance of smoking and vaping cessation
  - A 4 week quit pack/NRT will be provided at least 4 weeks pre-operatively
- **Anaemia**
  - Patients will undergo anaemia screening and optimisation (iron studies +/- Vit B12, folate)
  - Referral for iron infusion if Hb <120 g/L and criteria are met for absolute (ferritin <30 µg/L, TSAT <20%) or functional iron deficiency (ferritin <150 µg/L, TSAT <20%).
- **Diabetes screening and management**
  - Patients with diabetes risk factors will have HbA1C screening. Risk factors include:
    - Age >40 years
    - Age >18 years if Aboriginal or Torres Strait Islander
    - BMI >35
    - Random BGL >5.6 mmol/L
    - AUSDRISK score >6
  - Referral to physicians if HbA1C ≥6.5% (diagnostic of new diabetes)
  - Patients with known diabetes should have HbA1C measured within the last 3 months, but preferably 4-6 weeks prior to surgery
  - Referral to gynaecology physician for optimisation and/or consideration of surgical delay is required if
    - HbA1C ≥8.5%
    - Glycaemic control is highly variable with frequent hypo- or hyperglycaemia requiring intervention or hospitalisation
    - there is suspected hypoglycaemic unawareness, indicated by a history of asymptomatic hypoglycaemia (blood glucose level

<4.0 mmol/L) without typical symptoms such as tremor, sweating, or cognitive changes

- Complex diabetes with significant comorbidities (e.g. heart disease, renal disease, stroke, morbid obesity, peripheral neuropathy)

- **Obstructive Sleep Apnoea**
  - Screening using STOP-BANG tool
  - Encourage nightly CPAP use for at least 4 weeks pre- and post-operatively if prescribed. Educate patients to avoid lying flat, especially when apnoea risk is greatest and to avoid opioids post-operatively where feasible.
- **Nutrition**
  - Nutritional screening using the Modified Malnutrition Screening Tool (MMST) in clinic +/- Subjective Global Assessment (SGA)
  - Referral to a dietitian if indicated for:
    - Nutritional and protein supplementation in cases of severe malnutrition
    - Oral immunonutrition (e.g. Arginaid)
    - Weight loss interventions (e.g. Optifast)
  - Three(3) Online Surgery School Videos (external website) are available on ‘General Nutrition’, ‘Cancer Nutrition’ and ‘Nutrition and Surgical Optimisation for Patients with Obesity’

Pre-operative components

Skin Preparation

- Patients will be provided with chlorhexidine pre-op body wash 4% and instructed to shower with this both the night prior to surgery and the morning of surgery.

Fasting Instructions

- Patients can have solid food up to six (6) hours prior to surgery
- Patients can have clear fluids until two (2) hours prior to surgery, then ‘Sip til send’ 50 mL/hr of approved clear fluids is allowed in the day surgery unit or on the ward, and should be documented on the Fluid balance chart (MR729)
- Patients taking GLP1 agonists/co-agonists will be given written patient information from ANZCA in the PAC titled ‘Preparing for your medical procedure when taking some diabetes and/or weight loss medications’. They will be instructed to have clear fluids only on the day before surgery (24 hours pre-operatively), followed by standard 6-hour fasting.

Carbohydrate Loading

- Carbohydrate (CHO) drink Nutricia preOp 25 g x 6 will be provided to patients
    - On the day prior to surgery, patients will be instructed to drink 2 bottles (400 mL total) at 4pm and 8pm
    - On the day of surgery, patients will be instructed to drink 2 bottles (400 mL total) between 5-6am

Contraindications and Cautions:

- Patients should avoid CHO drinks if they have diabetes (type 1 and 2 regardless of BSL control/HbA1C), are on dialysis, or have renal impairment (CKD>3, eGFR<60)
- Patients on GLP-1 agonists without diabetes and patients who have had bariatric surgery within the last 2-3 years can take Nutricia at 4 pm and 8 pm on the day prior to surgery, but must omit on the day of surgery

Pre-operative analgesia

- Preoperative medications to be charted by the surgical team in clinic
- On arrival to DSU, patients to be given:
    - Oral paracetamol 1 g (regardless of weight) and
    - 200 mg Celecoxib (or 100 mg celecoxib if >65 years old, renal impairment (eGFR 40-60 – CKD class 3), weight <50kg, patients on frusemide <40 mg daily)
- Do not use celecoxib if renal impairment (eGFR <40, single kidney), hypertension controlled with two or more agents, hypersensitivity or active peptic ulcer disease
- Patients to avoid anxiolytics (e.g., lorazepam) unless severe pre-operative anxiety is present

Thromboprophylaxis

- Ensure well-fitting TEDS in DSU

Normothermia maintenance

- Use of active warming, via warmed linen blanket or space blanket in DSU prior to theatre even if the patient is normothermic on arrival

Observations

- Standard DSU assessment on arrival – temperature, blood pressure (BP), heart rate (HR), respiratory rate (RR), oxygen satuaration, weight, blood glucose level (BSL) if indicated
- Hypoglycaemia (BSL <4mmol/L) or hyperglycaemia (BSL >12mmol/L) warrants medical review/treatment (see MR 265.03)

Intra-operative components

- **Thromboprophylaxis**
  - Chemoprophylaxis with Heparin 5000 units subcutaneous injection immediately after induction. If <50kg, consider 2500 units.
  - Mechanical prophylaxis with both TEDS and Flotrons/sequential compression devices in theatre
- **Normothermia maintenance**
  - Prevent heat loss after induction and at the end of procedure by avoiding unnecessary patient exposure (e.g., during surgical scrubbing) and considering the use of heated blankets
  - Maintain theatre temperature at least 21 degrees
  - Use active warming to maintain patient temperature >36 degrees throughout the procedure
    - Hourly temperature monitoring and documentation on anaesthetic chart
    - Use forced-air warming devices, such as fullbody Bair Hugger surgical access warming blanket
    - Consider heated underbody mat e.g. Hot Dog
    - Consider warmed IVFs
    - Consider warmed fluids for intraoperative wash
- **Surgical Site Infection reduction**
  - Antibiotics prophylaxis
    - Cefazolin: 2 g IV or 3g if ≥120 kg with GFR more than 40 mL/min (if GFR ≤40mL/min, give 2g), within the 60 minutes before skin incision to achieve the peak drug serum levels at incision. Prioritise administration shortly after IVC insertion to faciliate this.
    - Redose cefazolin 4 hours from intraoperative dose administration (not from surgery start time) or if blood loss >1500 mL

      PLUS
    - Metronidazole: 500 mg IV for hysterectomy and/or appendicectomy (redosing not required)
    - ß-lactam alternatives: Use only to those with history of IgE-mediated penicillin hypersensitivity reaction, including urticaria (not

just rash), angioedema and anaphylaxis. NB: SSI risk is higher with ß-lactam alternatives.

- **Penicillin allergy**
  - Clindamycin: 600 mg IV within the 120 minutes before surgical incision. Redose at 6 hours if required.

    PLUS
  - Gentamicin 3mg/kg IV (maximum 280mg) over 3-5 minutes within 60 minutes before surgical incision if CrCL ≥20mL/min. Redosing or higher doses unlikely required as anticipate most laparoscopies will be < 4 hour duration.
- **MRSA colonisation or infection**
  - Glycopeptides (e.g vancomycin) should be added to the prophylactic regimen (ie. In addition to cefazolin and metronidazole)
  - Vancomycin:15 mg/kg IV (maximum 2 g), requires slow infusion at a rate not exceeding 10 mg/minute, but it should not be less than 60 minutes for a 1 g dose, 90 minutes for a 1.5 g dose or 120 minutes for a 2g dose. Start infusion within 120 minutes before skin incision. It is the consensus view of the Therapeutic Guidelines Antibiotic Expert Group that the infusion should be started at least 15 minutes before incision to ensure adequate blood and tissue concentrations at the time of incision and allow potential infusion-related toxicity to be recognised before induction of anaesthesia. The infusion can be completed after surgical incision.
- **MRSA with pencillin allergy**
  - Vancomycin 15mg/kg IV (maximum 2g) 120 minutes prior to skin incison

    AND
  - Gentamicin 3mg/kg IV (maximum 280mg) over 3-5 minutes within 60 minutes before surgical incision if CrCL ≥20mL/min.
  - **Gentamicin – contraindications**
  - Contraindicated in patients with pre-existing vestibular or auditory impairment, severe aminoglycoside hypersensitivity, or chronically impaired renal function (eGFR <40) or rapidly deteriorating renal function.
  - A single dose can be used with caution in the frail or elderly (e.g >80 years).

- **Fluid management**
  - Aim to maintain euvolemia provided there are no major fluid shifts or blood losses

- Consider the use of <5mL/kg/hour crystalloid solution (1-2L total)
- Discontiune IVFs at the end of procedure or upon transfer from recovery
- Maintain IV access until the patient is tolerating oral fluids and free from postoperative nausea and vomiting (PONV)

- **Initiation of multimodal analgesia**
  - Total intravenous anaesthesia (TIVA) is recommended
  - Consider the following:
    - NSAIDs if not given pre-operatively
      - Exercise caution when prescribing NSAIDs in elderly patients, patients on multiple antihypertensive medications, and patients with renal impairment
    - IV ketamine
      - 0.25 mg/kg bolus then 0.1-0.2 mg/kg/hour
    - IV magnesium
      - Option of bolus only (50 mg/kg) or bolus and infusion (30-50 mg/kg followed by 10-15 mg/kg/hr till the end of surgery) dose mg/kg/hour
    - IV opioid
      - Preference for short-acting agents and limitation of dose, if administered
    - IV lidocaine
      - 1.5 mg/kg then 1-1.5 mg/kg/hr
    - Avoidance of benzodiazepines
    - TAP blocks (surgeon placed or ultrasound guided) if mini laparotomy is performed for specimen retrieval

- **Postoperative nausea and vomiting prophylaxis and treatment**
  - Calculate Apfel score to assess the risk of PONV
  - Most patients will have an Apfel score of 2-3, giving a 39-61% of PONV in first 24 hours of surgery
  - Administer at least two prophylactic IV antiemetics with different mechanisms of action for patients
    - Examples:
      - Glucocorticoid

        Dexamethasone 8 mg IV or 4 mg IV if age >80 years or weight <50 kg before skin incision

        Do not give to type 1 diabetics
      - 5HT antagonist

        Ondansetron 4 mg IV or granisetron 1 mg IV before skin closure

- Consider adding another antiemetic for patients with additonal risk factors (e.g. history of motion sickness or PONV) such as a D2 receptor antagonist (e.g., metoclopramide 10 mg IV)
- TIVA can be considered a form of antiemetic prophlylaxis

- **Lung protective ventilation strategies**
  - Aim for low tidal volumes 6-8mL/kg of ideal body weight
  - Optimise PEEP to minimise driving pressure
  - Perform alveolar recruitment manoeuvres prior to PEEP and at the end of the procedure
- **Anaesthetic depth optimisation– aim for BIS/entropy 40-55**
- **Neuromuscular block reversal – ensure documented reversal to a train-of-four ratio of 90% prior to extubation**

  - **Skin preparation**
    - Use chlorhexidine-alcohol for abdominal skin preparation
    - Use povidone-iodine or cetrimide for vaginal preparation
    - Allow skin preparation solution to dry completely before draping
  - **BSL management**
    - Measure BSL hourly in patients with diabetes via finger or ear prick
    - Maintain blood glucose within 5-10mmol/L in patients with diabetes
    - Follow ADS-ANZCA peri-operative diabetes and hyperglycaemia guidelines
    - Consider treating hyperglycaemia when BSL >10mmol with correction dose of insulin delivered subcutaneously or recheck in 1 hour
    - For T2DM and other types of diabetes:
      - Administer Subcutaneous rapid-acting insulin for BSL >12mmol/L with dosing based on body weight:
        - >100 kg: 6 units every 3 hours until BSL <10mmol/L
        - 55-100 kg: 4 units every 3 hours until BSL <10mmol/L
        - <55 kg: 2 units every 4 hours until BSL <10mmol/L
      - Use variable rate insulin infusion if BSL>15mmol/L or rising rapidly. Perform blood gas and fingerstick ketones to check for ketoacidosis.
  - Prevent hypothermia (as above)

- **Urinary catheter**
  - Insert IDC at start of procedure
  - Remove IDC at end of procedure if no concerns

- Consider emptying bladder with cystoscope if cystoscopy is performed, to avoid repeat instrumentation

Surgical techniques

- Use Orogastric Tube for Palmer's point entry to reduce risk of gastric perforation; remove at extubation
- Consider local anaesthetic at port sites
- Select port size (5mm vs 10mm) and pneumoperitoneum pressures (usually 12-15mmHg) at surgeon's discretion. Recommend lower pressures but without compromising surgical field visualisation
- Consider positive pressure ventilations (Valsalva) prior to fascial closure to reduce residual pneumoperitoneum,decrease post-op pain, and recruit collapsed alveoli from pneumoperitoneum and Trendelenburg positioning.
- Avoid surgical drains

Post-operative components

Recovery / Post Anaesthetic Care Unit (PACU)

- Provide warming with blanket or space blanket
- Aim for temperture ≥36 degrees
- Encourage aCOUGH
- Pain protocol
  - Fentanyl IV as per PACU protocol
  - Tramadol 50 mg IV 2 hourly (maximum of 400 mg in 24 hours)
  - Buprenorphine 200 microg sublingual 2 hourly (maximum of 1600 microg in 24 hours)
  - Tapentadol IR 50 mg every 4 to 6 hourly if Tramadol is contraindicated or not tolerated due to sensitivity.Refer to Formulary One (external website) and follow direction of Pain Service or Anaesthetist only
- Antiemetics (as per PONV chart) MR810.02
  - 1st line - Ondansetron 4 mg 6 hourly PO/IV prn (maximum of 20 mg in 24 hours)
  - 2nd line - Metoclopramide 10 mg 8 hourly IV/IM (maximum of 30 mg in 24 hours)
  - 3rd line - Droperidol 500 microgram IV
  - 4th line- Cyclizine 25-50 mg IV
- Cease IVFs
- Transfer patient to ward when ready

Recovery on ward

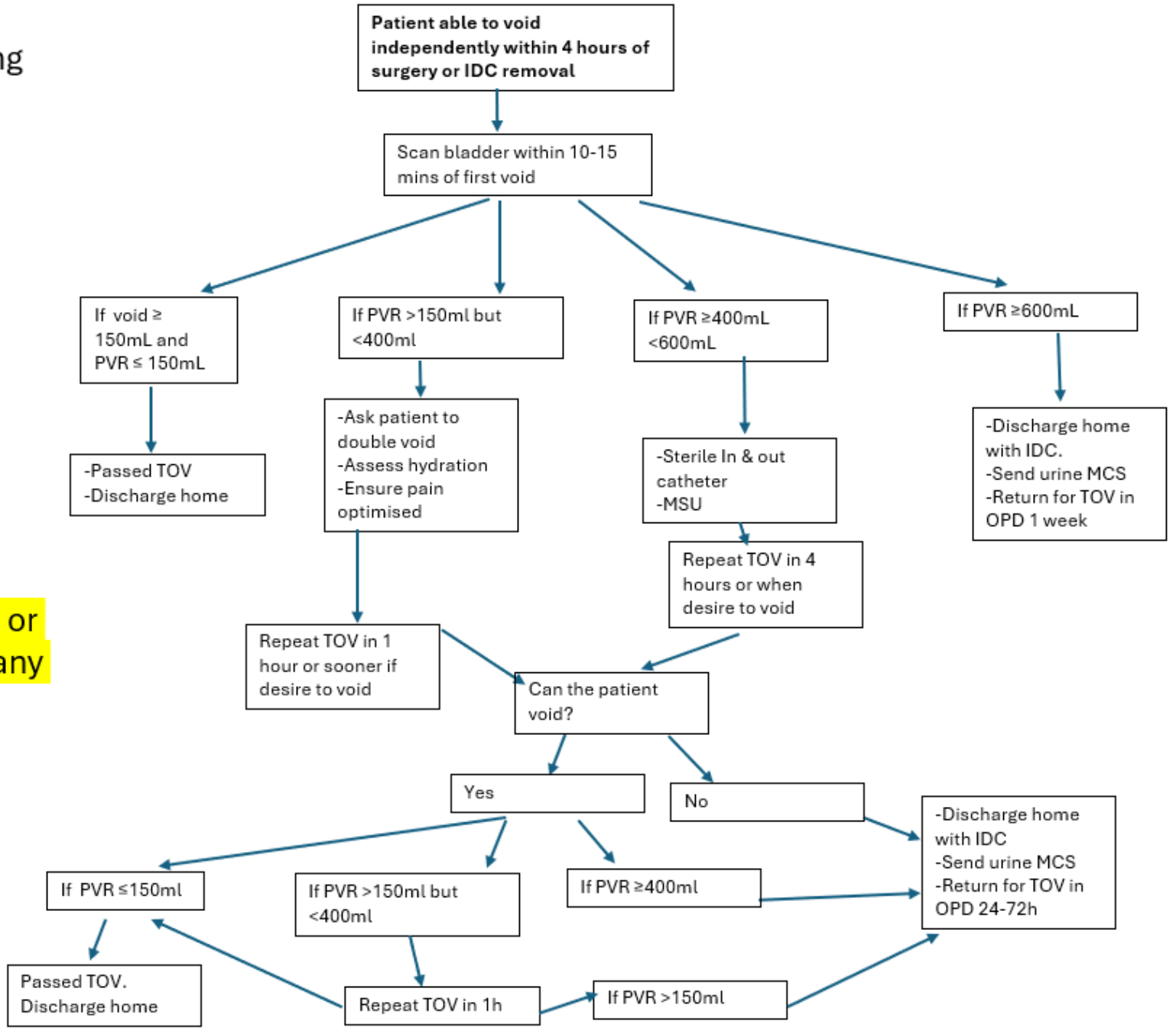
- Offer normal diet and oral fluids within 1 hour

- Remove IVC once tolerating diet
- Encourage aCOUGH
- Adminiter oral analgesia for pain
    - Tramadol 50-100 mg every 4 hours (maximum of 400 mg in 24 hours),
    - Buprenorphine 200-400 microg every 4 hours (maximum of 1600 microg in 24 hours),
    - Alternative is Oxycodone 5-10 mg every 4 hours (maximum of 30 mg in 24 hours)
- Administer antiemetics medication if required by following PONV chart
- Check for minimal vaginal bleeding
- Mobilise patient within 2 hours of surgery or on arrival to ward, initially with assistance, progressing to minimal to no assistance
- Follow evidence-based, gynaeoncologic patient specific bladder management using Bladder Algorithm 1: Above to void and Bladder algorithm 2: Unable to void as outlined below
- Monitor observations as per Adult Observation and Response Chart (MR258.02) – Temperature ≤37.9C, HR<100, systolic blood pressure (SBP) <160 or >110, respiratory rate ≥10 and <21, oxygen saturation ≥94% in room air (RA)

- Trigger the surgical team to consider initiating basal bolus insulin in diabetic patients if daytime or pre-dinner BSLs are >10mmol/L on 2 occasions OR if IV insulin is required intra-operatively
    - Surgical team to contact gynaecology physician on call (ideally prior to dinner) to facilitate post-dinner administration of long-acting insulin, providing the following information:
        - Patient history
        - BMI and eGFR
        - Pre-admission diabetic medications
        - Assessment of post-operative complications such as PONV, ileus and ketones

Bladder algorithm 1: Able to void

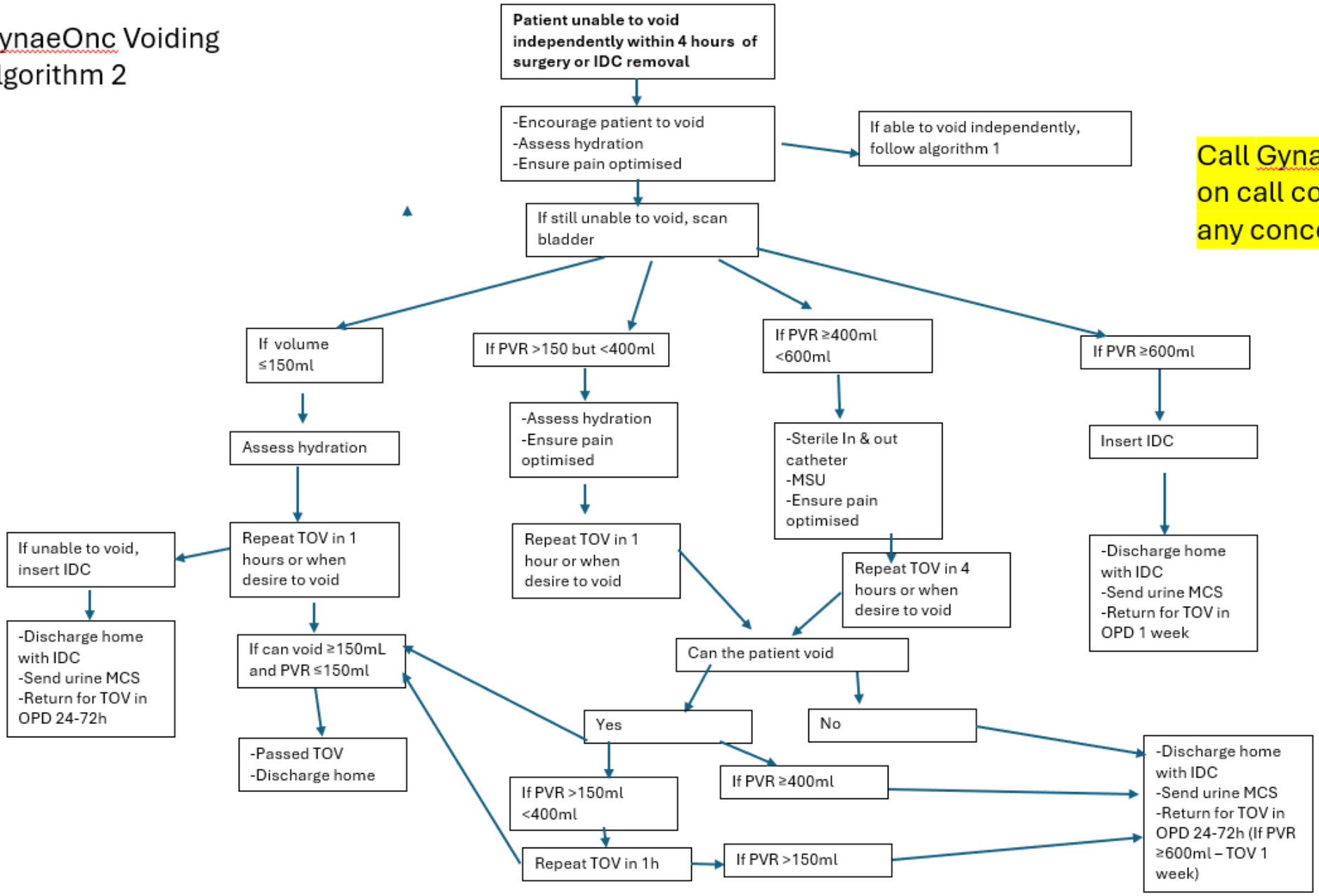
GynaeOnc Voiding Algorithm 1



Call GynaeOnc team or on call consultant if any concerns re: TOV

Bladder algorithm 2: Unable to void

GynaeOnc Voiding Algorithm 2



Call GynaeOnc team or on call consultant if any concerns re: TOV

Discharge

Criteria led discharge

Patient may be discharged if the following criteria is met:

- Observed in hospital for a minimum of 4 hours
- Pain controlled
- Eating and drinking
- Able to void (1 void of >150mL with <150mL PVR)
- Mobilise independently
- Observations within range as per Adult Observation and Response Chart (MR258.02):
- Has a responsible adult to pick up and stay with them overnight

Patients who experience complications during surgery or anaesthesia, or do not meet the above discharge criteriamay be admitted overnight until it is safe to be discharged.

Discharge orders

- Recommended analgesic medication on hospital prescription upon discharge
    - Paracetamol 1 g PO every 6 hours (maximum dose 4 g in 24 hours) for 7 days [50 tablets]
    - Non-steroidal anti-inflammatory for 5 days:
        - Ibuprofen 400 mg PO every 8 hours [12 tablets] OR
        - Celecoxib 100 – 200 mg PO every 12 hours [10 capsules]
    - Stronger pain relief when required (PRN)
        - Tramadol 50-100 mg every 6 hours PRN (maximum dose 400 mg in 24 hours) [10 capsules] OR
        - Buprenorphine sublingual tablet 200 microg every 4 hours (maximum dose 1200 microg in 24 hours) [10 sublingual tablet] *Schedule 8 - prescribe on a separate prescription

          OR
        - Tapentadol IR 50 mg every 4 to 6 hours (if tramadol contraindicated or unable to take due to sensitivity under the direction of a Pain Service or Anaesthetist only (Formulary One, external website)) [10 tablets] *Schedule 8 prescribe on a separate prescription
    - WNHS 'Your Pain Relief at Home' leaflet
- Constipation management
    - Macrogol 1 sachet bd for 7 days [10 sachets] AND
    - Docusate 120 mg bd for 7 days [20 tablets]

    - WNHS 'Medicines to Manage Constipation' leaflet
- Antiemetic - Ondansetron 4 mg every 6 hours PRN [4 wafers]
- Thromboprophylaxis management:
    - TEDS until mobilising to normal levels
    - For active cancer patients, prescribe enoxaparin 40 mg subcutaneously daily for 28 days, commencing 8 hours after the intra-operative dose
    - For benign or borderline cases, omit enoxaparin or use a shorter duration based on the Caprini VTE score
    - Adjust dosing in renal impairment and at extremes of body weight (e.g. consider 20 mg if <50 kg; 60 mg if >120 kg)
    - Provide consumer leaflet "Preventing and Treating Blood Clots"
    - NMHS: KEMH Gynae Oncology- English: Online Surgery School Video (external website) on enoxaparin administration and safe needle disposal (see 'Clexane Pre-Filled Syringe with Safety Lock' and other relevant videos)
    - See also WNHS VTE guideline
- Discharge summary by RMO
- Provide Major Gynaecologic Oncology Surgery ERAS booklet (if not already given prior). See KEMH website Patient Fact Sheets
- Provide post-operative discharge guide Wound Care Leaflet

Follow-up

- Telehealth appointment with ERAS nurse 24-72 hours post-operatively
- OPD appointment with the urogynaecology team for bladder management if required via e-referral
- Australian Hospital Patient Experience Question Set to be completed after discharge (via email)
- Myles QoR-15 Patient Surbey to be completed within the first 24 hours post - operatively (via email)
- ERAS nurse mobile provided for any concerns between 7am–3pm Monday to Wednesday and Friday and 8am-4pm on Thursday.
- Advised to attend local Emergency Department or KEMH Emergency Centre for any after hours concerns/emergencies.
- Patients can expect a phone call from Tumour Conference Clinical Nurse Consultant with pathology results and follow-up plan 2 weeks post-operatively
- Telehealth ERAS nurse appointment 30 days post-operatively
- PROMIS 30 days post-op questionnaire (via email)
- GP appointment for post-operative wound check at 6 weeks

Clinical documentation

Clinical documentation will be recorded in the patient's Digital Medical Record (DMR) and must be accurate, timely, and reflect the entirety of patient care provided. The Redcap ERAS database will be used for the purpose of compliance and audit, covering the four components of the ERAS pathway (preadmission, pre-operative, intra-operative and post-operative), as well as auditing the patient experience and outcomes.

References and resources

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Related WNHS policies, guidelines and procedures

WNHS VTE guideline

Useful resources and related forms

Patient Information brochures/booklets- see titles within guideline

Forms

- Formulary One (external website)

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Version history

Version number	Date	Summary
1	Aug 2025	First version
1.1	May 2026	• The guideline has undergone significant formatting changes to improve overall readability. • An additional point has been added to the “Diabetes Screening and Management” section (page 4). • A dot point has been removed from the “Carbohydrate Loading” section (page 6). • The “Antibiotic Prophylaxis” section has been expanded (page 7). • An additional point related to diabetic management has been added to the “Recovery on Ward” section. • The Enoxaparin sub-point in “Thromboprophylaxis Management” has been expanded (page 16). • Contact hours have been expanded in the “Follow-Up” section (page 16). • OPD appointment with the urogynaecology team has been added in the “Follow-Up” section (page 16).

This document can be made available in alternative formats on request for a person with a disability.

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