### Extended Mastectomy/ and or any Plastic Reconstruction of the breast or face

**Goals**
Reduce PACU length of stay and increase patient satisfaction by reducing post-op pain, PONV, and sedation by minimizing opioids and incorporating a multimodal analgesic regimen.

**To whom it applies**
- Axillary node dissections
- Simple mastectomies
- Any plastic surgery except free flaps.
- Includes IP, SDA and outpatients

**Meds ordered night before**
- Gabapentin 300-400 mg PO x 1 OR Pregabalin 75mg PO x 1.
- Acetaminophen 1000mg PO x 1
- Celecoxib 400mg PO (except for facial plastics)
- Scopolamine Patch for PONV

**Consider a HOLDING AREA HUDDLE: between surgeons, patient and anesthesia to discuss:**
- PO meds administered in holding area.
- Prescriptions that the patient will take home (so that PACU orders can be coordinated).

**Blocks**
- All cases that need a block will be booked as such. If not booked as a block, surgeon will infiltrate locally.
- Suggested guideline for blocks: All mastectomies if booked and combined cases if booked as such.

**Induction**
- Dexamethasone 8mg IV SLOW.
- Dexamethasone 4mg IV SLOW.
- MAC anesthesia if appropriate.

**Surgeon**
- If block not performed, surgeon to instill local anesthetic into wound as appropriate
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**Intraop**
- **NO Ketorolac**
- Ondansetron 4mg IV at end of case.
- Minimal opioids. Short acting (Fentanyl or Dilaudid in low doses)
- Consider Ketorolac if Celecoxib has NOT been given at end of case
- Ondansetron 4mg IV at end of case
Consider using:

- **Esmolol Infusion in place of opioids.** 10 mcg/kg/min, adjusted 5-15 mcg/kg/min based on HR. Start during induction, end with removal of airway device

**PACU**

- **PO Opioid as needed when able to tolerate PO.**
- **IV opioid (fentanyl or hydromorphone in low doses) for breakthrough pain, if unable to tolerate PO, or VAS>5.**

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