APPENDIX 1. UCSF RALP SDD Pathway*

Patient exclusion criteria

- On anticoagulation with plan to continue anticoagulation through surgery
- No responsible adult caretaker at home overnight POD0
- Lives >75 miles away from UCSF
- Patient discomfort with SDD
- Higher-grade disease or other complex patient factors (i.e., significant comorbidity, surgical history, etc.) as discussed below
- Surgeon discretion
    - Ultimately the surgeon is the ultimate decision-maker with regard to whether to offer SDD to patients. While the following are not strict exclusion criteria, we encourage surgeons to consider carefully before offering SDD to patients with a history of severe systemic comorbidities, extensive abdominal/pelvic surgery or radiation, BMI >35, or untreated obstructive sleep apnea. Of note, while there is less evidence on the topic, pelvic lymph node dissection (PLND) typically is not considered a barrier to SDD. Studies in which all patients undergo PLND have demonstrated no difference in outcomes amongst patients undergoing RALP-PLND SDD and inpatient RALP-PLND.[6,12] Further, Liem et al. demonstrated that patients undergoing RALP SDD alone were actually marginally more likely to experience sepsis/infectious complications within 30 days than those undergoing RALP-PLND SDD; otherwise, there was no significant difference in 30-day postoperative complications nor readmissions between the two groups.[13]

Patients who are deemed eligible for SDD with regard to the above criteria will then have the choice to elect SDD or inpatient RALP, with the understanding that successful SDD is dependent on their intra/postoperative course.

Preoperative preparation

- At the preoperative visit:
    - Patients eligible for SDD will receive preoperative counseling on the SDD pathway, and postoperative care/expectations. This counseling will be integrated into the existing RALP preoperative counseling video (https://ucsf.app.box.com/s/yivvq5l8578ny6n32eu9ajvh9beeiusu), provided in written form, and discussed during their preoperative visit with their surgeon. Counseling will cover preparing for surgery, what to expect on the day of surgery including with regard to SDD, pain management, catheter management, drain management, incentive spirometry during recovery, return to exercise/activity, postoperative urinary incontinence, and postoperative erectile dysfunction.
    - Patients will receive the standard prescriptions for postoperative medications, so that patients will have these medications available when they return home on the day of surgery.
- On the day of surgery:
    - Patients will receive 1 gm acetaminophen and 5 mg of oxybutynin preoperatively.

Intraoperative considerations

- Short-acting anesthetics with use of reversal agents
- Opioid free anesthesia
- Toradol 15-30 mg IV during closure if appropriate from bleeding and renal function perspectives
- Local anesthesia administered at incision sites
- Antiemetics (dexamethasone, ondansetron)
- Limited intraoperative fluids

Postoperative management

- PACU HCT
    - If postoperative value <24 or >6 points lower than preoperative value, repeat at postop + 4 hours
    - Repeat HCT must be stable relative to immediate postop value (no more than 2 points lower) to be eligible for discharge

*Proposed; subject to refining prior to implementation

- PACU Cr
    - If postoperative value >0.3 points above baseline, repeat at postop + 4 hours
    - Repeat Cr must be within 0.3 points of baseline to be eligible for discharge
- Clear liquids at postop + 2 hours, then advance diet as tolerated at postop +4 hours
- Ambulate with RN within 3 hours postop
- Acetaminophen 6 hours after preop dose
- Ibuprofen 6 hours after intraoperative toradol if appropriate from bleeding and renal function perspectives
- Oxybutynin 5 mg 8 hours after preop dose
- Short-acting opioids as needed for breakthrough pain

Discharge criteria (after minimum 4 hours postoperative monitoring)

- Afebrile
- Heart rate ≤100 bpm
- Systolic blood pressure ≥100 mmHg
- SpO2 ≥92% on room air
- Urine output ≥ 0.5 cc/kg/hr
- Pain and nausea controlled
- Tolerating liquid diet
- Ambulating independently
- Labs reviewed:
- PACU HCT
    - If postoperative value <24 or >6 points lower than preoperative value, repeat at postop + 4 hours
    - Repeat HCT must be stable relative to immediate postop value (no more than 2 points lower) to be eligible for discharge
- PACU Cr
    - If postoperative value >0.5 points above baseline, repeat at postop + 4 hours
    - Repeat Cr must be within 0.5 points of baseline to be eligible for discharge
- Responsible adult caregiver at home POD0 confirmed
- Surgeon approves discharge
- Patient desires to go home

Postoperative contact

- 24h access to urology consultation (contact clinic during daytime hours, urology resident on-call after hours as per current protocol)
- Contacted by surgeon's RN on POD1 (or on-call resident if POD1 is a weekend/holiday)