**Supplementary table**

Items included in our ERAS protocol according to the ERAS society recommendations.

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| **ERAS single item** | **Specifics for cystectomy patients** |
| **Preoperative** |
| Preoperative counseling and education | Surgical details, hospital stay and discharge criteria in oral and written form; stoma education; patient’s expectations. |
| Preoperative medical optimization | Correction of anemia and co-morbidities Nutritional support.Smoking cessation and reduction of alcohol intake 4 weeks prior to surgery; encouraging physical exercise. |
| Oral mechanical bowel preparation | Preoperative bowel preparation can be safely omitted. |
| Preoperative carbohydrates loading | Preoperative oral carbohydrate loading should be administrated to all non-diabetic patients. |
| Preoperative fasting | Intake of clear fluid up until 2 h before induction of general anesthesia is recommended. Solids are allowed up until 6 h before anesthesia. |
| Preanesthesia medication | Avoidance of long-acting sedatives. |
| **Peroperative** |
| Minimally invasive approach | At most feasible; in trial settingLong term oncological results awaited. |
| Resection site drainage | Perianastomotic and/or pelvic drain can be safely omitted. |
| Preventing intraoperative hypothermia | Normal body temperature should be maintained per- and postoperatively. |
| Perioperative fluid management | Fluid balance should be optimized by targeting cardiac output using the esophageal Doppler system or other systems for this purpose and avoiding overhydraion. Judicious use of vasopressors is recommended with arterial hypotension.  |
| Epidural analgesia | Thoracic epidural analgesia is superior to systemic opioids in relieving pain. It should be continued for 72h. |
| Standard anesthetic protocol | To attenuate the surgical stress response, intraoperative maintenance of adequate hemodynamic control, central and peripheral oxygenation, muscle relaxation, depth of anesthesia, and appropriate analgesia is recommended. Fast acting agents? |
| Prevention of PONV | A multimodal PONV prophylaxis should be adopted in all patients with ≥2 risk factors. |
| Antimicrobial prophylaxis and skin preparation | Patient should receive a single dose antimicrobial prophylaxis 1 h before skin incision. Skin preparation with chlorhexidine-alcohol prevents/decreases surgical site infection. |
| Thrombosis prophylaxis | Patient should wear well-fitting compression stockings and receive pharmacological prophylaxis with LMWH. Extended prophylaxis for 4 weeks should be carried out in patients at risk. 12 h interval between injections and epidural manipulation.  |
| **Postoperative** |
| Nasogastric intubation | Postoperative nasogastric intubation should not be used routinely.  |
| Prevention of postoperative ileus  | A multimodal approach to optimize gut function should involve gum chewing and oral magnesium. |
| Early oral diet | Early oral nutrition should be started 4 h after surgery. |
| Urinary drainage | Ureteral stents and transurethral neo-bladder catheter should be used. The optimal duration of ureteral stenting and transurethral catheterization is unknown.  |
| Postoperative analgesia | A multimodal postoperative analgesia should include thoracic epidural analgesia |
| Early mobilization | Early mobilisation should be encourage. |
| Audit | All patients should be audited for protocol complicance and outcomes |