Surgical Oncology Resident Expectations
WVU

What can you expect from us?
The faculty are committed to your education and graduated autonomy. This means taking the time to review imaging, patient plans, literature, surgical plans, and graduated autonomy in the OR with appropriate supervision. We will also give you timely verbal and written feedback. Finally, we will be fair and non-partial. Any concerns should be brought up with Dr. Kledzik and/or Dr. Dudas (program director).

What do we expect from you?

- We ask that you take ownership of our patients and their health. This may mean staying late to take care of patient issues/complications (within hours guidelines of course), being available for the on call team if they have questions/concerns, and following up on orders and concerns after rounding on the weekends. You are expected to round with the attending you are working with that day and communicating plans with the team. The more active and enthusiastic you are to care for our patients, the more we enjoy teaching and giving you autonomy.
- We also expect you to have reviewed the cases for the week and discussed any complex cases with the assigned attending before the operation. This means reviewing imaging, going over port placement/operative approach prior to being in the operating room.
- Finally, we expect updates on our patients before 8 AM, including consults. We are all comfortable with updates from all levels of the team.
- **IF, however, there is a sick/concerning patient, we expect that the chief on service will CALL the appropriate faculty.**
- Friday afternoons the chief on services should email out a summary of surgeries, complications, and plans to the team. The faculty will provide any updates/clarifications, but the expectations is that the chief knowns the patients well enough that this should not be necessary.

Resident Roles
In general the chief should be with HPB, including clinic, and the midlevel should be with General Surgical Oncology. This may need to be altered some days (HIPECs for instance), but in general, the rotation should be more apprenticeship model. Interns are expected to be in clinic any and all days unless floor work/OR is not complete.

Consults
We appreciate your thorough history and physical exams.
Things we expect in your consult:

- Does the patient need surgery- urgently or non-urgently?
- Oncologic history including stage, surgeries, radiation, chemotherapy (including type and last dose)
- Pertinent medical hx, especially things like blood thinners, which may not be on the current MAR, but they took at home yesterday…

Who to consult?
If the patient is known to an attending and it is during working hours, please call that attending.
During working hours, please staff consults with the most appropriate faculty (e.g. new pancreas masses should go to Schmidt/Boone/Thomay; new axillary masses, sarcomas, gastric cancer, etc should go to Thomay/Kledzik). The attending on call can also help direct this.

Clinic
This is where you will learn outpatient management, which is extremely important in surgical oncology. Additionally, you will have the opportunity to meet patients that you will be operating on and review their imaging with the attending. Every week the chief resident will assign ALL residents to an OR or clinic with a minimum of 1 full day of clinic/week. You are expected to be there unless a patient needs to be seen in the hospital and there is no APP available to see them. You are NOT there just as a scribe so please be interactive about reviewing images and labs and developing a plan.

Tumor boards/conferences
These are a part of your education as well and you may be asked to present. You are expected to come if you are not in the OR, with an attending in clinic, or seeing an urgent issue on the floor/ICU.
Breast- Monday at noon (Cancer center conf room)
Cutaneous- 1 & 3rd Monday at 4 pm (Cancer center conf room)
Sarcoma- 1& 3rd Wednesday at 7:30 AM (Cancer center conf room). We do not expect you to leave M&M, but FYI.
HPB- Wednesday at noon (next to POC clinic)
GI- Thursday at noon (Cancer center conf room)

Journal Club
These will be the second Wednesday of every month at 4 pm. The chief resident on service is expected to meet with the faculty advisor for that month and find 2-3 articles. These should be sent out by the Friday morning prior to journal club. A resident should be assigned to each of them. Please see the JAMA User's Guide (https://jamanetwork.com/collections/44069/users-guide-to-the-medical-literature) to help you interpret the article. This is available through the WVU online library.

POST OP Enhanced Recovery After Surgery (ERAS) Orders

All patients unless otherwise noted

Foley- out POD1; if retention- start Flomax and do I&O x1. If still retaining, replace foley.

Pain meds- 975 mg Tylenol Q8H scheduled, Toradol 30 mg (15 mg if > 60 yo) Q8H scheduled (alternating with tylenol)- omit if CKD, Robaxin 500 mg Q6H scheduled, narcotics PRN

Meds- all statins should be started back post op. Betablockers back POD 1 if stagble; Hold diuretics until POD2 unless otherwise directed.

Labs- WBC, CMP, Mag, Phos POD1 and trend until normalizing WBC/LFTs; Keep mag>2, K>4 for bowel fn.

GI- docusate POD1, PPI POD1 – do not use laxative such as senna, miralax unless directed

Lovenox ppx 40 mg daily (heparin if CKD) – POD1 and should remain on during stay (unless bleeding issues). Discuss with attending possible d/c with Lovenox x 1 month for any abdominal resections.

Fluids- D5 1/2NS + 20 K; 75cc/hr POD0, 30 cc/hr when taking clears (POD1), SLIV when taking diet (generally POD2)

Activity- OOB day 0, walking day 1. If not walking on their own POD 1- get PT/OT involved.

Drains- do not pull without speaking to attending.

Liver

Pain meds- if large liver resection- hold Tylenol; if heavy bleeding- hold Toradol

Fluids- D5 1/2NS; 125cc/hr POD0

Labs- Watch phosphorous closely. Should need regular aggressive replacement as liver heals

Diet- Clears POD0, If tolerating advance POD1 afternoon or POD2

Whipple

Drains- amylase on Day 1 &3; if bright blood- call attending ASAP

Diet- NPO POD0, clears POD1, advance diet as tolerated with bowel fn.

Pain meds- hold toradol

Labs- closely monitor blood glucose. May need endocrine involvement

Meds- consider pancreatic enzymes if diarrhea

Discharge on PPI

Distal pancreatectomy/splenectomy

Drains- amylase on Day 1 &3

Diet- Clears POD0, If tolerating advance POD1 afternoon or POD2

Spleen- confirm that they got their splenic vaccines pre-op

Labs- closely monitor blood glucose. May need endocrine involvement

Meds- consider pancreatic enzymes if diarrhea

Gastric

Distal: Diet- NPO POD0, clears POD1, advance diet as tolerated with bowel fn.

Discharge on PPI

Total: Trickle TF in Jtube POD1, Do NOT replace NGT wo an attending present, No PPI needed

HIPEC

Fluids – LR POD0 @ 125cc/hr. Can drop to 75 cc if good UOP overnight. Goal UOP 0.5-1cc/kg/hr

Diet- high risk of ileus. NGT postop. Discuss diet advancement based on extent of resection.

Discuss with attending an other orders based on hysterectomy, LAR, gastrectomy, splenectomy, liver resection, etc