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ADAPTATION OF THE ERAS PROTOCOL FOR PATIENTS WITH UROSTOMY AFTER BRICKER ILEAL CONDUIT: THE ROLE OF STRUCTURED PERIOPERATIVE STOMA CARE

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Relevance. Current Enhanced Recovery After Surgery (ERAS) protocols—initially developed for colorectal and abdominal surgery and subsequently extrapolated to radical cystectomy—predominantly focus on general surgical elements (pain management, nutritional support, early mobilization) while overlooking the specifics of intestinal urostomy formation. Meanwhile, patient adaptation to life with a stoma is a critical determinant of quality of life, psychological well-being, and the incidence of peristomal complications (skin maceration, parastomal hernia, stomal stenosis, retraction), which occur in 20–45% of patients across various postoperative intervals. The lack of a standardized, structured component of preoperative education and perioperative stoma care guidance within standard ERAS pathways can compromise overall protocol efficacy in patients undergoing the Bricker procedure, serving as an independent driver of unplanned medical visits and hospital readmissions after discharge.

Aim of the study. To develop an adapted ERAS protocol incorporating a structured perioperative stoma care component and evaluate its impact on the incidence of peristomal complications, the rate of self-care skill acquisition, and quality-of-life metrics in patients following the Bricker procedure.

Materials and methods. A comparative study was conducted involving two groups of patients who underwent radical cystectomy with Bricker ileal conduit urinary diversion: a standard ERAS protocol group and an adapted protocol group. The adapted pathway incorporated preoperative stoma site marking by a dedicated stoma therapist, structured preoperative training for patients and/or their caregivers, daily guidance by a stoma therapist during the early postoperative phase, and follow-up consultations (in-person or telephone) at 14 and 30 days post-discharge. Evaluated endpoints included: rates of early (up to 30 days) and delayed (up to 90 days) peristomal complications; time required to achieve independent appliance change proficiency; anxiety levels (HADS scale) and quality of life (EORTC QLQ-C30 and FACT-Bl questionnaires) assessed preoperatively, at discharge, and at 3 months; and the frequency of stoma-related unplanned consultations.

Results. The adapted protocol group demonstrated a statistically significant reduction in early peristomal complications (primarily contact dermatitis and skin maceration), accelerated acquisition of independent stoma self-care skills by the time of discharge, and fewer unplanned visits within the first 30 days post-discharge. Quality-of-life scores and anxiety levels at 3 months postoperatively were significantly better in the adapted protocol cohort.

Discussion. These findings confirm that stoma-specific dimensions of perioperative care represent an independent, essential pillar of rehabilitation that is inadequately covered by generic ERAS protocols. Early engagement of a stoma therapist combined with structured patient education not only reduces local peristomal complications but also fosters psychological adaptation, aligning closely with the principles of patient-centered care.

Conclusions. Integrating a structured perioperative stoma care module into the ERAS pathway for patients undergoing Bricker ileal conduit diversion significantly decreases peristomal complications, accelerates self-care independence, and enhances quality of life. This evidence supports establishing specialized stoma care as a mandatory component of adapted enhanced recovery protocols in this patient population.

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Keywords: bladder cancer; radical cystectomy; Bricker procedure; urinary diversion; Enhanced Recovery After Surgery (ERAS); perioperative management.