ERAS - An evidence-based protocol and data-driven care with the patient in the team

Dr Chris Jones
Consultant Anaesthetist
Royal Surrey County Hospital & St Lukes Cancer Centre
SPACeR (Surrey Perioperative And Critical care Research) Group
Honorary Senior Lecturer UCL
ERAS - An update based on the Guildford experience

Dr Chris Jones
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SPACeR (Surrey Perioperative And Critical care Research) Group
Honorary Senior Lecturer UCL
• Nil
ERAS

- Fast track programmes
- Enhanced Recovery programmes
- Enhanced Recovery After Surgery
- ERAS
A Clinical Pathway to Accelerate Recovery After Colonic Resection

Linda Basse, MD, Dorthe Hjort Jakobsen, RN, Per Billesbølle, MD, Mads Werner, MD, PhD, and Henrik Kehlet, MD, PhD

From the Department of Surgical Gastroenterology and Anesthesiology, Hvidovre University Hospital, Denmark
ERAS Society
ERAS Society Guidelines

- 2005 – Colonic surgery
  - Fearon et al Clin Nutr 2005
- 2009 – Rectal Surgery
- 2012 – Updated Colonic surgery
  - Gustafsson et al Clin Nutr 2012
- 2012 – Updated Rectal & Pelvic surgery
  - Nygren et al Clin Nutr 2012
- 2012 – Pancreatic Resections
  - Lassen et al Clin Nutr 2012
- 2013 – Radical Cystectomy
  - Carentola et al Clin Nutr 2013
- 2014 – Gastrectomy
  - Mortensen et al BJS 2014
- 2016 – Gynae Oncology [1&2]
  - Nelsen et al Gynecol Onc 2016
- 2016 – Bariatric
Guidelines – coming soon

• Head & Neck
• Liver resection
• Hip Replacement
• Knee Replacement
• Thoracic
• Oesophageal Resection
Guidelines – coming soon

• Head & Neck
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Guidelines for Perioperative Care for Liver Surgery: Enhanced Recovery After Surgery (ERAS) Society Recommendations

Emmanuel Melloul1,2 · Martin Hübner1 · Michael Scott3 · Chris Snowden4,5 · James Prentis6 · Cornelis H. C. Dejong7 · O. James Garden8 · Olivier Farges9 · Norihiro Kokudo10 · Jean-Nicolas Vauthey11 · Pierre-Alain Clavien12 · Nicolas Demartines1
Guidelines can be a base for implementation but do not do the implementation for you.
Overall rapid uncomplicated recovery leads to:

• Improved Quality
• Improved Patient satisfaction
• Reduced Length of Stay
• Reduced Costs
• Reduction in short term and long term morbidity and mortality
Referral from Primary Care

Pre-Operative

- Optimised health / medical condition
- Informed decision making
- Pre operative health & risk assessment
- PT information and expectation managed
- DX planning (EDD)
- Pre-operative therapy instruction as appropriate

Admission

- Admission on day
- Optimised Fluid Hydration
- CHO Loading
- Reduced starvation
- No / reduced oral bowel preparation (bowel surgery)

Intra-Operative

- Minimally invasive surgery
- Use of transverse incisions (abdominal)
- No NG tube (bowel surgery)
- Use of regional / LA with sedation
- Epidural management (inc thoracic)
- Optimised fluid management
  - Individualised goal
  - Directed fluid therapy

Post-Operative

- DX when criteria met
- Therapy support (stoma, physio)
- 24hr telephone follow up

Follow Up

- Planned mobilisation
- Rapid hydration & nourishment
- Appropriate IV therapy
- No wound drains
- No NG (bowel surgery)
- Catheters removed early
- Regular oral analgesia
- Paracetamol and NSAIDS
- Avoidance of systemic opiate-based analgesia where possible or administered topically

- Optimising pre operative haemoglobin levels
- Managing pre existing co morbidities e.g. diabetes
- Informed decision making

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Guildford - Enhanced Recovery

International Centre of Excellence for Surgery and Perioperative Medicine

Colorectal ERAS Pathways 2003
ERP MSK / Gynae Onc 2007
ERP # Neck Of Femur 2009
ERP Liver / Pancreas 2009
ERP Emergency Laparotomy 2009
ERP Oesophagus 2010
ERP Cystectomy 2013
ERP Head & Neck 2014
UK - Mean LOS by Provider - Colectomy

Colectomy: Mean LOS by Provider Oct - Dec 2010

Provider Organisations
Mean length of stay (days)
Source: Hospital Episodes Statistics (Provisional)

Guildford: Consistently low length of stay
ORIGINAL CONTRIBUTION

23-Hour-Stay Laparoscopic Colectomy

B. F. Levy, M.R.C.S.¹ • M. J. P. Scott, F.R.C.A.² • W. J. Fawcett, F.R.C.A.²
T. A. Rockall, F.R.C.S¹

1 Department of Surgery, Minimal Access Therapy Training Unit, Post Graduate Medical School, University of Surrey, Manor Park, Guildford, Surrey, United Kingdom
2 Department of Anesthesia, Minimal Access Therapy Training Unit, Post Graduate Medical School, University of Surrey, Manor Park, Guildford, Surrey, United Kingdom

Diseases of the Colon & Rectum Volume 52: 7 (2009)
Impact of a multidisciplinary standardized clinical pathway on perioperative outcomes in patients with oesophageal cancer

S. R. Preston¹, S. R. Markar², C. R. Baker¹, Y. Soon¹, S. Singh¹ and D. E. Low²

¹Oesophago-Gastric Unit, Royal Surrey County Hospital, Guildford, UK and ²Department of Thoracic Surgery, Virginia Mason Medical Center, Seattle, Washington, USA

Correspondence to: Dr D. E. Low, Department of Thoracic Surgery, Virginia Mason Medical Center, 1100 Ninth Avenue, Seattle, Washington 98111, USA (e-mail: Donald.low@vmmc.org)

British Journal of Surgery 2013; 100: 105–112
Use of a pathway quality improvement care bundle to reduce mortality after emergency laparotomy

S. Huddart\textsuperscript{1}, C. J. Peden\textsuperscript{2}, M. Swart\textsuperscript{3}, B. McCormick\textsuperscript{4}, M. Dickinson\textsuperscript{1}, M. A. Mohammed\textsuperscript{5} and N. Quiney\textsuperscript{1}, on behalf of the ELPQuiC Collaborator Group

\textsuperscript{1}Department of Anaesthesia and Intensive Care, Royal Surrey County Hospital NHS Foundation Trust, Guildford, \textsuperscript{2}Department of Anaesthesia and Intensive Care, Royal United Hospital Bath NHS Trust, Bath, \textsuperscript{3}Department of Anaesthesia and Perioperative Medicine, South Devon Healthcare NHS Foundation Trust, Torbay Hospital, Torquay, \textsuperscript{4}Department of Anaesthesia and Intensive Care, Royal Devon and Exeter NHS Foundation Trust, Exeter, and \textsuperscript{5}School of Health Studies, University of Bradford, Bradford, UK

Correspondence to: Dr S. Huddart, Department of Anaesthesia, Royal Surrey County Hospital NHS Foundation Trust, Egerton Road, Guildford GU2 7XX, UK (e-mail: samhuddart@nhs.net)
Head and Neck

Enhanced Recovery Programme for Head & Neck Free Flap Surgery
Drug Prescribing and Recording Chart for Pancreatico-duodenectomy Enhanced Recovery

Chart of ____________________________

Ward ____________________________

Date of Admission ____________________________

Consultant ____________________________

Information relevant to prescribing

Renal Impairment ☐
Liver Impairment ☐
Pregnancy ☐
Breast Feeding ☐

Previous History of (Check on admission):
MRSA colonisation Yes / No
Previous history of Cdifficile Yes / No

Nil by mouth - Surgery
Give all regular prescribed medication with 30mL of water on the day of surgery except for:-
• Insulin and Oral hypoglycaemic drugs (see Diabetic Protocol)
If in any doubt check with patient’s anaesthetic team

VTE Risk Assessment
Please complete MANDATORY risk assessment on pages 2 and 3 for ALL patients.

Other Charts in Use ____________________________

Start | Sign | Finish | Sign
Randomized clinical trial on enhanced recovery versus standard care following open liver resection

C. Jones¹, L. Kelliher¹, M. Dickinson¹, A. Riga², T. Worthington², M. J. Scott¹,³, T. Vandrevala³, C. H. Fry³, N. Karanjia² and N. Quiney¹

Departments of ¹Anaesthesia and ²Hepatobiliary Surgery, Royal Surrey County Hospital NHS Foundation Trust, and ³Faculty of Health and Medical Sciences, University of Surrey, Guildford, UK

Correspondence to: Dr C. Jones, Department of Anaesthesia, Royal Surrey County Hospital NHS Foundation Trust, Egerton Road, Guildford GU2 7XX, UK (e-mail: drchrisnones@yahoo.co.uk)

British Journal of Surgery 2013; 100: 1015–1024
## Enhanced Recovery - Liver

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<td>Standard anaesthetic protocol</td>
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<td>PONV</td>
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<td><strong>Laparoscopy</strong></td>
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<td>Avoid NG Tube</td>
</tr>
<tr>
<td>Prevent intraoperative hypothermia</td>
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</tr>
<tr>
<td>Routine surgical drainage</td>
</tr>
<tr>
<td>Urinary drainage</td>
</tr>
<tr>
<td>Prevention of ileus</td>
</tr>
<tr>
<td>Postop analgesia - epidural (avoid opiates)</td>
</tr>
<tr>
<td>Perioperative nutritional care</td>
</tr>
<tr>
<td>Postop glucose control</td>
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<tr>
<td>Early mobilisation</td>
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Gustafsson World J Surg  Oct 2012
## Enhanced Recovery – Liver

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<tr>
<td>PONV</td>
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### Laparoscopy

- Avoid NG Tube
- Prevent intraoperative hypothermia
- **Perioperative fluid management**
- Routine surgical drainage

### Urinary drainage

- Prevention of ileus
- Postop analgesia - epidural (avoid opiates)

### Perioperative nutritional care

- Postop glucose control
- **Early mobilisation**

---

But 13/20 would be considered standard care
Enhanced Recovery in Liver Resection

- ERP Group
- Education
- CHO preOp + ONS
- Thoracic epidural
- Early mobilisation

- Standard Group
- Standard Surgical Technique
- Standard Anaesthetic
- Thoracic epidural

- Goal Directed Fluid Therapy for 6 hours post operatively with LiDCOrapid™
Results

• Both groups similar in age, sex, BMI, ASA
• Significantly more malignancies in ERP group [p=0.021]
• Significantly more neoadjuvant chemo in ERP group [p=0.021]
• Significantly higher P-POSSUM operative severity [p=0.012]
• Major resections 21 vs 12 [p=0.06]
## Results

<table>
<thead>
<tr>
<th></th>
<th>ERP Group</th>
<th>Standard Group</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time until medically fit for discharge - days [IQR]</strong></td>
<td>3.00 [3-4]</td>
<td>6.00 [6-7]</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>Hospital Length of Stay - days [IQR]</strong></td>
<td>4.00 [3-5]</td>
<td>7.00 [6-8]</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>
## Results – Liver complications

<table>
<thead>
<tr>
<th>Morbidity</th>
<th>ERP Group</th>
<th>Standard Group</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Collection/Infection</td>
<td>2</td>
<td>3</td>
<td>0.319</td>
</tr>
<tr>
<td>Bile Leak</td>
<td>3</td>
<td>3</td>
<td>0.322</td>
</tr>
<tr>
<td>Biliary Stricture</td>
<td>1</td>
<td>0</td>
<td>0.511</td>
</tr>
<tr>
<td>Transient hepatic insufficiency</td>
<td>3</td>
<td>1</td>
<td>0.266</td>
</tr>
<tr>
<td>Liver failure</td>
<td>1</td>
<td>1</td>
<td>0.505</td>
</tr>
<tr>
<td>Total complications</td>
<td>10</td>
<td>8</td>
<td>0.829</td>
</tr>
<tr>
<td>Total no of patients</td>
<td>7 (15.2%)</td>
<td>5 (11.1%)</td>
<td>0.612</td>
</tr>
</tbody>
</table>
### Results – Medical Complications

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<th>Standard Group</th>
<th>p-value</th>
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<tbody>
<tr>
<td>Arrhythmia</td>
<td>1</td>
<td>3</td>
<td>0.255</td>
</tr>
<tr>
<td>Chest Infection / Pneumonia</td>
<td>1</td>
<td>5</td>
<td>0.101</td>
</tr>
<tr>
<td>Delirium</td>
<td>1</td>
<td>0</td>
<td>0.511</td>
</tr>
<tr>
<td>GI Bleed</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Hypotension</td>
<td>0</td>
<td>2</td>
<td>0.253</td>
</tr>
<tr>
<td>Incarcerated port-site hernia</td>
<td>1</td>
<td>0</td>
<td>0.511</td>
</tr>
<tr>
<td>Perforated diverticulum</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Pleural Effusion</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Postoperative Ileus</td>
<td>0</td>
<td>3</td>
<td>0.129</td>
</tr>
<tr>
<td>Thromboembolic disease</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>0</td>
<td>1</td>
<td>0.5</td>
</tr>
<tr>
<td>Wound Dehiscence/infection</td>
<td>0</td>
<td>2</td>
<td>0.253</td>
</tr>
<tr>
<td><strong>Total Complications</strong></td>
<td><strong>4</strong></td>
<td><strong>20</strong></td>
<td><strong>0.009</strong></td>
</tr>
<tr>
<td><strong>No. of patients with complications</strong></td>
<td><strong>3 (6.5%)</strong></td>
<td><strong>12 (26.7%)</strong></td>
<td><strong>0.020</strong></td>
</tr>
</tbody>
</table>
VAS Pain Scores

Error Bars: 95% CI
Quality of Life
EQ-5D
Quality of Life
EQ-5D
p=0.002
Cost Analysis

• Based on anaesthetic, surgical, length of stay (per level of care), and community costs (POD-28)
• $\Delta$ Costs = £995.17 in favour of ERP

• LiDCOrapid™, ONS, preOp
• Physio
• Acute Pain Team
Sustainability

![Box plot showing sustainability data]

- Pre
- Std
- ERAS
- Post
Robotic Cystectomy

- New service started 2013
- Single surgeon (with mentor)
- Small consistent team
- ERP written with input from the entire team
Robotic Cystectomy

- Minimally invasive surgery
  - Initially open diversions now mostly intracorporeal
- Spinal analgesia (Diamorphine)
- Goal directed fluid therapy
- HDU post-op
- Early mobilisation
- Normal diet + chewing gum
- Early removal of pelvic drain (day 2)
LOS Trend 2000/01 – 2010/11 for Urology

Trend in national LOS, HES: Urology

Length of stay (days)

Median LOS Cystectomy

Median LOS Prostatectomy

Mean LOS Cystectomy

Mean LOS Prostatectomy
Robotic Cystectomy - Results

- 137 patients
- LoS 5 days – overall.
- For 50+ patients 2016 = 4 days
- Median blood loss 200mls
- Morbidity 30.9%
  - Ileus 7%
- Mortality – 1.45%
- 10.3% Readmissions
x2 Robotic Cystectomies – Ileal Conduits
OG - Visit to Virginia Mason, Seattle

Multidisciplinary Team

- Surgeon
- Intensivist
- Anaesthetist
- Nurse Specialist
- Physiotherapist
- Surgical Directorate Manager
- Dietician
- Intensive Care Sister
# Initial Results

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<td>Patients Mobilising on Day 1 Post-op (%)</td>
<td>93</td>
<td>8.3</td>
<td>42</td>
<td>100</td>
<td>&gt;0.99 [1 vs 4]</td>
</tr>
<tr>
<td>Complications (All cause %)</td>
<td>47.3</td>
<td>75</td>
<td>75</td>
<td>33.3</td>
<td>&lt;0.05 [2 vs 4]</td>
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<tr>
<td>ICU Stay (days)</td>
<td>1 (0-22)</td>
<td>4 (2-20)</td>
<td>3 (2-9)</td>
<td>3 (1-5)</td>
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<td>8 (6-54)</td>
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Mobilization

- Patient is head up
- Patient standing and mobilizing

- Pulmonary Function
- Also muscle activity reduces post operative insulin resistance
Aids to Mobilization

- Non slip socks
- Chest drains that can be inverted
- All drips on 1 stand
- Regular walks charted
Incidence of emergency laparotomy 1:1000 per annum
Mortality rate UK 15%
(Elective surgical outcomes 1-2%)

UK 9000 deaths per annum (2000 deaths per annum RTA)

Modest improvement in outcomes save many lives
In UK evidence of ‘substandard’ care
Emergency Laparotomy Pathway Quality Improvement Care Bundle

Small group developed ‘care bundle’
ELPQuiC

Five elements
Evidence based
Measurable
Emergency Laparotomy Quality Improvement Care Bundle

- All emergency admissions to surgical assessment area have an EWS completed. Outreach to review all patients with EWS of 4 or more.
- Broad spectrum antibiotics to be given to all patients with suspicion of peritoneal soiling or with septic shock.
- Once decision is made to carry out laparotomy patient takes next available slot on emergency list (or within 6 hours of decision made).
- Start resuscitation using goal directed techniques as soon as possible or within 6 hours of admission.
- Admit all patients after emergency laparotomy to ICU.
Emergency Laparotomy Pathway Quality Improvement Care Bundle

Four general hospitals in England
Baseline data for 299 patients
Eight month prospective data collection (427 patients)
Use of ‘statistical process control’ to identify changes
Meet every 4-6 weeks for results/learning
Results

Crude 30-day mortality

25% reduction
Results

30 day outcomes
- Pooled data risk adjusted mortality 15.6 to 9.6% (38% reduction)
- 6.0 additional lives saved per 100 patients treated
- NNT 16.4

In hospital outcomes
- Pooled data risk adjusted mortality 17.4 to 10.1% (42%)
- 8.1 additional lives saved per 100 patients treated
- NNT 12.4
Summary – ERAS Pathways

- Get all Stakeholders together and devise a patient centered pathway that everyone can agree to (not necessarily 100%)
- Some items may remain variable between surgeon – don’t make that a deal breaker?
- Surgeon & Anaesthetist must work together
- Get Management buy in (literally)
- Empower and teach staff
- Remember the patient is central to success
- Audit what you do and review as a team
SUMMARY

• ERAS Pathways are now established as a Standard of Care in Guildford
• ERAS Culture takes time to develop
• Team working and team building
• Need to empower staff to deliver the key elements of ERAS