AB013. ERAS: what it is, what it isn't

Alan D. L. Sihoe[1,2,3]

[1]Department of Surgery, The University of Hong Kong, Hong Kong, China; [2]Department of Thoracic Surgery, The University of Hong Kong Shenzhen Hospital, Shenzhen 518053, China; [3]Department of Thoracic Surgery, Tongji University Shanghai Pulmonary Hospital, Shanghai 200433, China

Abstract: Physical and physiological trauma is a necessary consequence of any surgery. The aim of many—if not most—advances in surgery today is to minimize such trauma and therefore allow better recovery. Even in the early days of minimally invasive thoracic surgery, there was a recognition that the reduced surgical access trauma should permit 'fast tracking' of post-operative recuperation. Today, it is understood that the goal should not be simply a reduction in hospital stay, but an overall and holistic improvement of the post-operative experience. Hence, enhanced recovery after surgery (ERAS) is today the preferred term. A modern ERAS program should include: stated focus for specific disease and/or procedure; multi-disciplinary involvement (not just surgeon-dominated management); evidence-based design of a comprehensive clinical pathway; balanced consideration of pre-, intra- and post-operative management to improve outcomes; time-tabled, structured management ('defined events at defined times'); objective, standardized execution: variance is allowed but must be documented and analysed; regular audit of adherence and outcomes—with feedback and continuous improvement. In recent years, ERAS has rapidly become such a popular concept that many centers around the world are zealously rushing to adopt it. Regrettably, this is increasingly leading to all manner of practices that no longer relate to the original goals of ERAS. These include: covering all non-specific management of all patients in a unit with the blanket term 'ERAS'; design and execution only by surgeons (neglecting nursing and other specialties involvement); using the term 'ERAS' to embellish unrelated research, rather than using good research evidence to design ERAS; over-emphasis on only intra-operative technical and technological advances; describing vague management principles only, but omitting a structured plan of specific actions; allowing excessive subjective management and hence poor adherence to the clinical pathway; failing to conduct audit to ensure that ERAS is actually being provided effectively to patients. Such deviance from the core principles of ERAS weakens the ability of the surgical community to research the actual mechanisms of ERAS, to define its clinical role, and to effectively use it to improve patient care. Surgeons must take care not to try jumping on the ERAS bandwagon by simply wrapping the term around themselves. Instead, a conscientious respect for the core elements of modern ERAS is needed to enable the intended enhancement of patient outcomes.

Keywords: Enhanced recovery after surgery (ERAS); fast track; thoracic surgery; video assisted thoracoscopic surgery (VATS)

doi: 10.21037/shc.2018.AB013

Cite this abstract as: Sihoe AD. ERAS: what it is, what it isn't. Shanghai Chest 2018;2:AB013.