APPLYING ENHANCED RECOVERY PRINCIPLES: EARLY TESTING IN UPPER GI CANCER

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ENHANCED RECOVERY
? POSSIBLE

- Major procedure
- Painful
- Anastomotic complications
- Nutritional problems

ENHANCED RECOVERY
? EVIDENCE

- US reports of “streamlined care pathways”
- 90 patients – Ivor Lewis oesophago-gastrectomy
- Median hospital stay 7 days – range 6 -74
- Long stay
  neoadjuvant therapy
  > 70 years

ENHANCED RECOVERY
? EVIDENCE

- Spanish report – “written clinical pathway”
- Two groups before and after pathway
- Median length of stay
  before: 13 (range 8-106)
  after: 9 (range 5-98)
- Delay if > 65 years

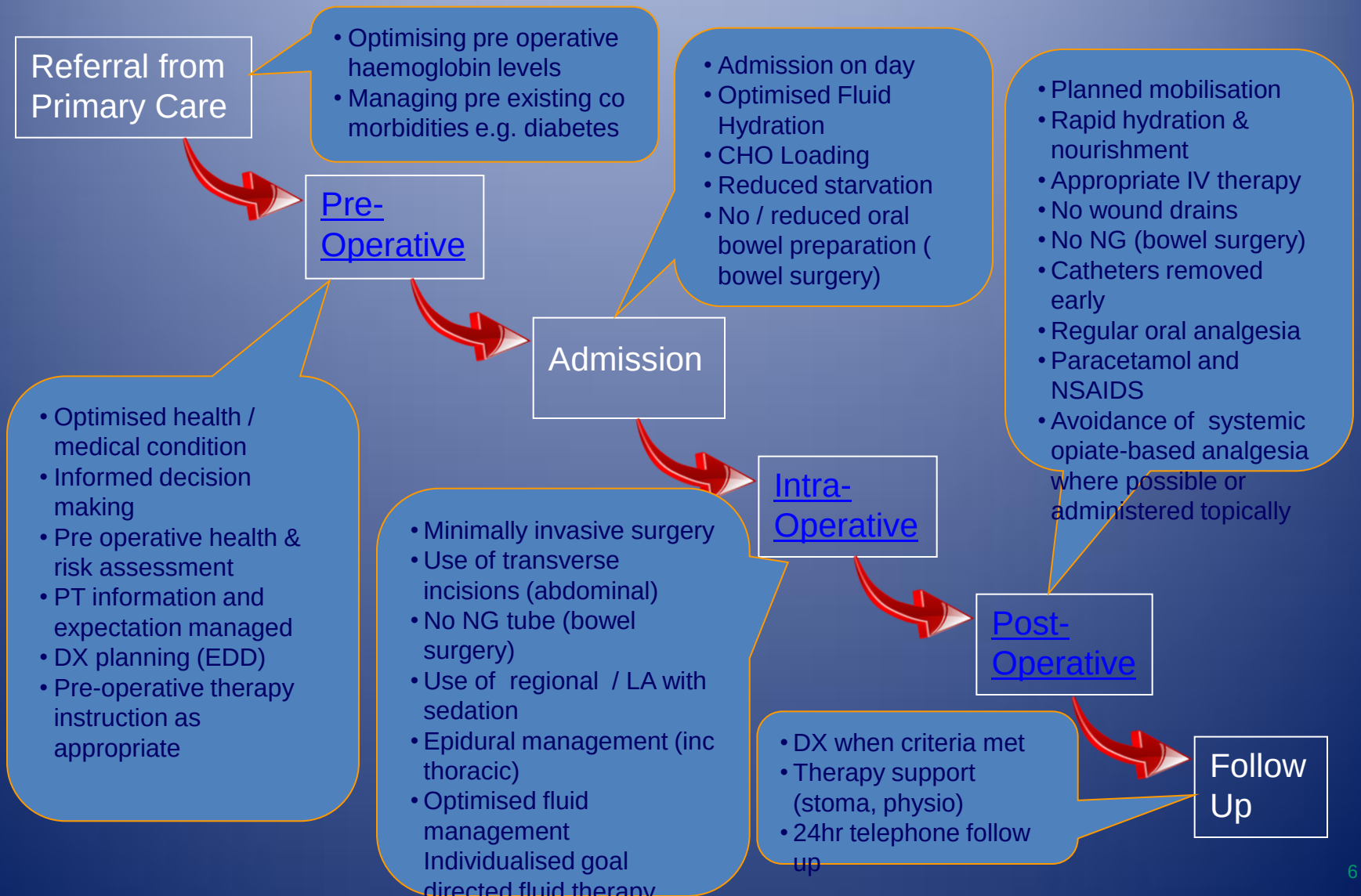
ENHANCED RECOVERY
? EVIDENCE

- Pancreas – fast-track programme
- Compared 2 groups before and after intervention

- Improved delayed gastric emptying
- Reduced length of stay

- Complications increased length of stay

Example of enhanced recovery elements



ENHANCED RECOVERY
ROYAL MARSDEN NHS FOUNDATION TRUST

- Cancer Centre – SW London Cancer Network
- Population 1.6M
- Referrals – 6 cancer units plus extra network
- 350 new referrals per year
- 75 resections annually

ENHANCED RECOVERY STEERING GROUP

- Trust Executive – Lead Nurse
- Medical
  - Surgeon
  - Intensivist
- Nursing
  - Ward
  - Critical Care
  - Rehabilitation
  - CNS
- AHP
  - Dietician
  - Physiotherapy

ENHANCED RECOVERY PATHWAY

- MDT
- Outpatients
- Perioperative
- Discharge planning
- Audit

ENHANCED RECOVERY OUTPATIENT CLINIC

- Medical / Health Questionnaire
- Comorbidity assessment
- Dietician
- Physio
  shuttle walk test
  spirometry
- CNS
  Written information

ENHANCED RECOVERY CLINIC ASSESSMENT

- very fit with no comorbidity
- fit enough to proceed with treatment plan but have comorbidity
- patients with comorbidity who are borderline for radical surgery
- unfit due to significant comorbidity or patient choice not to proceed with treatment plan.

ENHANCED RECOVERY MANAGEMENT PLAN

- (i) will proceed with treatment plan
- (ii) refer for CPX but will proceed with treatment plan in parallel with comorbidity assessment
- (iii) refer for CPX and anaesthetic review and be reviewed prior to proceeding with treatment plan. If for surgery to be managed as group (ii); if unfit to be managed as group (iv)
- (iv) will be referred for non-radical therapy or palliative care.

ENHANCED RECOVERY OUTPATIENTS

- Post preop chemo review
- Repeat process of assessment

ENHANCED RECOVERY
PRE-ADMISSION ASSESSMENT

- 2 weeks before surgery
- Intensivist
- Dietician
  nutrition suppliment
- Physiotherapy
  exercise
  incentive spirometer
- CNS

NUTRITIONAL SUPPORT

- Use of immunonutrition pre-operatively
  - 5 days of 750 ml or *Oral Impact* containing arginine (oral)
  - A reduction in length of stay in hospital
  - significantly fewer post operative infectious complications, such as wound infections, UTIs, pneumonia

ENHANCED RECOVERY PERIOPERATIVE

- Care pathway – daily plan
- Analgesia
- Mobilisation
- Nutrition

ENHANCED RECOVERY PERIOPERATIVE - ANALGESIA

Epidural

PCA

Regional blocks

ENHANCED RECOVERY PERIOPERATIVE - PHYSIOTHERAPY

- Mobilisation
- Incentive spirometer
- Pedometer

ENHANCED RECOVERY PERIOPERATIVE - NUTRITION

- Oral intake

- Jejunostomy feed

  standard enteral formula for normally nourished patients

  immunonutrition for malnourished patients

- Continued use of jejunostomy feeding until patient meets their nutritional requirement

ENHANCED RECOVERY
DISCHARGE PLANNING

- Verbal and written instruction
- Treatment Record Summaries
- Nutritional support
  dietary advice to optimise oral intake
  monitoring of nutritional status in outpatients

ENHANCED RECOVERY EXPERIENCE

- Group I – 10 days post oesophagectomy
- Group II – 8 -13 days post gastrectomy
- Group III – 20+ days post oesophagectomy

CONCLUSION

- Enhanced Recovery possible for Upper GI
- Team approach
- Culture change
- Impact on quality of care
- ? Suitable for all