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Editorial

Perioperative multimodal rehabilitation in colorectal surgery: Its use is more than justified

Rehabilitación multimodal perioperatoria en cirugía colorrectal. Su utilización está más que justificada

While health professionals can clearly adapt quickly to certain changes and improvements in the management of different processes, at the same time, there are intangible barriers that render the implementation of changes and improvements difficult, even when supported by scientific evidence. An example is the so-called Multimodal Rehabilitation, or *Fast-track*, the most notorious paradigm[1] of which is colorectal surgery.[1]

For years, we learned that surgery was an aggression, but we were not taught how to control it. Certainly, the idea of a minimally invasive approach arguably led the way in reducing postoperative trauma; however, we also came to faulty conclusions due to the bias of some studies. Thus, for example, we assumed that laparoscopic surgery allowed for early oral tolerance, while it required dietary restriction until the restart of transit in open surgery. We also believed in the need for mechanical preparation to prevent intraoperative contamination, the passage of faeces through a suture line or the systematic use of tubes and drains.

Our teachers taught us these and other beliefs and, in turn, we passed them down to our disciples, preserving a tradition which we did not question. However, little by little, studies have dispelled these and other "truths" with the highest level of scientific evidence. Moreover, a solid doctrine concerning perioperative care has been created. The key architect of its integration was Henrik Kehlet.[2] The integration of these principles aims to reduce postoperative morbidity and mortality and to promote a more rapid recovery through a multimodal approach, thus minimising the impact of the factors that lead to surgical stress. The reduction of hospital stay is a secondary effect brought on by this integration. Kehlet's results, and those of other authors, have shown the benefits of this package of measures, including the knowledge that antegrade mechanical cleaning may even be harmful; complete preoperative fasting is unnecessary and not beneficial; the use of tubes and drains should be selective; perioperative pain management is essential in recovery; fluidotherapy should be optimised and adjusted; surgery should be as minimally invasive as possible; early mobilisation is effective; and early feeding is safe and essential.[2-5] Any perioperative incentive programme should be based on the completion of specific procedures such as those described above or others.[6]

We therefore know of the integration's advantages. This is a first step. However, the movement from evidence to practice is not an easy task. Why is it blocked when it reaches the patient? Why do evidence-based protocols not automatically change daily practice? Should we fund the research to get scientific evidence, only to ignore it afterwards? As previously mentioned, it would be better to spend public money on determining why we do not apply what we know.[7]

On the other hand, pioneers, perhaps with a certain degree of audacity, go even further and even speak of the feasibility of a greater number of colorectal outpatient surgeries.[8] In any case, it is essential to ensure the optimisation of all points of the clinical pathways and the cooperation of team members, whether surgeons, anaesthesiologists or nursing staff. Are we even remotely near ensuring this optimisation? Obviously not. The 2003 Spanish national study on the management of colorectal cancer processes showed a mean hospital stay of 11.9 days,[9] while unpublished data from an updated reissue suggest no improvement in this regard. In addition, an international study found less use of some perioperative measures based on the Spanish evidence.[10] But what is the Spanish reality? A recent survey sponsored by the Spanish Association of Surgeons and the Spanish Association of Coloproctology, showed that although we have improved, there is still a quarter of surgeons who routinely use a nasogastric tube.[11] It also showed that doctors still use antegrade mechanical preparation in 59% of the surgeries performed in the left colon and in 80% of those performed in the right colon,[12] while 55% of the doctors wait until the start of the intestinal transit to begin oral intake. Moreover, only 8% of the doctors use a *fast-track* model and, what is worse, fewer than half of the respondents believe that using *the fast-track* model may reduce complications.[13] These underused

tools that improve results are associated with less experience and specific accreditation. Conversely, those with more experience on coloproctology than overall surgery, those who perform more major colorectal resections or those certified by a European Board, perform a job that is more in line with scientific evidence.[13,14]

Certainly, putting this into practice is not a simple task. Drafting a protocol is not enough. We need to reach a consensus and coordinate the entire working group. For example, there is little point in ordering a mobilisation or eating a few hours after surgery if the doctor does not have the cooperation of the operating room staff or the ward staff, or if the staff are reticent and are not convinced of the usefulness of such methods.[15,16] As shown in this issue of Cirugía Española by Salvans et al.,[17] an analysis of three successive cohorts of patients, on whom a perioperative incentive protocol is applied with greater and better results, should show gradual improvement. It is not necessary, nor even desirable, to start from a high level of demand, because it would be impossible to comply with it, since we are already going up against traditions, dogmas and phobias. Continuous progressive improvement in the protocol is, as shown by the authors, more operative, and the results themselves should encourage the continuation of the change, which shall be obtained through practice and shall convince the sceptics.

In Spain, there are also initiatives such as the "Spanish research group on fast-track", which invites anyone who wants to work on common prospective protocols and provides a base of information and a relevant discussion forum, with access to the www.ftsurgery.com network. Another initiative is the cross-sectional study funded by the Spanish Association of Surgeons, which, similar to the above-mentioned initiative, aims to raise awareness to achieve what was previously considered unattainable.

If our key desideratum is to treat our patients properly and to pursue excellence by having the lowest morbidity possible and the greatest satisfaction and comfort; if evidence is on the table; and if we have simple and inexpensive tools to work in this sense, why do we not take the necessary steps to do so? We should not wait any longer.

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