Patterns in current perioperative practice

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Evidence for optimal perioperative care in colorectal surgery is abundant. By avoiding fasting, intravenous fluid overload, and activation of the neuroendocrine stress response, postoperative catabolism is reduced and recovery enhanced. The specific measures that can be used routinely include no bowel preparation, epidural anaesthesia/analgesia continued for one to two days postoperatively; no nasogastric decompression tube postoperatively, intravenous fluid/saline restriction, and free oral intake from postoperative day one. This survey aimed to characterise perioperative practice in colorectal cancer surgery in five northern European countries: Scotland, the Netherlands, Denmark, Sweden, and Norway.

Participants, methods, and results

We mailed a questionnaire to the head surgeons of all digestive surgical centres in the five countries of the departments belonging to the Enhanced Recovery After Surgery (ERAS) Group in late spring 2003. We presented a hypothetical case of elective laparotomy with colonic resection for cancer in an otherwise healthy 70 year old man. We asked the respondents to answer according to the practice most widely used in their department at that time.

The table shows the results (fuller version on bmj.com). Response rate was 70% (200 centres). Oral bowel preparation was still the rule in all countries. The nasogastric decompression tube was widely used postoperatively only in the Netherlands. "Nil by mouth" was hardly used in Scandinavia but was common in the Netherlands and Scotland. By postoperative day one, patients ate at will in 85% of Danish units and in almost half of units in Norway, the Netherlands, and Sweden. In Scotland, only a quarter of units allowed free eating on day one. The use of epidural analgesia in general

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**Patterns in current perioperative practice: survey of colorectal surgeons in five northern European countries**

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<table>
<thead>
<tr>
<th>Responses (percentages) to questionnaire on perioperative care in colonic resections in five northern European countries</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responses</strong></td>
</tr>
<tr>
<td><strong>Responses</strong></td>
</tr>
<tr>
<td><em><em>For an elective left sided</em> hemicolectomy for cancer, would bowel preparation be administered?</em>*</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td><strong>When would patients be allowed to resume oral intake at will for solids (eat freely)?</strong></td>
</tr>
<tr>
<td>0 days</td>
</tr>
<tr>
<td>1-2 days</td>
</tr>
<tr>
<td>3-4 days</td>
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<tr>
<td><strong>If epidural analgesia used routinely postoperatively after transfer to general ward? (Not high dependency ward/intensive care unit)</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

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"Nil by mouth" was hardly used in Scandinavia but was common in the Netherlands and Scotland. By postoperative day one, patients ate at will in 85% of Danish units and in almost half of units in Norway, the Netherlands, and Sweden. In Scotland, only a quarter of units allowed free eating on day one. The use of epidural analgesia in general
A restricted fluid regimen aiming at unchanged body weight may reduce complications after elective colorectal surgery. Scotland had the only substantial group claiming such practice. However, the volume of fluids allowed (table) indicates an inadequate reduction as it is twice as high as in the unrestricted (standard) group in the study by Brandstrup et al (median 1500 ml/24 hours). In spite of a large evidence base for perioperative care aiming to alleviate postoperative catabolism and organ dysfunction, surgical patients remain exposed to unnecessary starvation, suboptimal stress reduction, and fluid overload.

We thank the Scottish Chapters, Associations of Coloproctology and Upper GI Surgeons, the Surgical Society of Sweden, the Dutch Society for Gastrointestinal Surgery, and the Norwegian Society for Digestive Surgery. Preliminary data from this study have been presented as an abstract to the XXXVI Nordic Meeting of Gastroenterology (Oslo, June 2004) and as a lecture to the 26th ESPEN congress (Lisbon, September 2004).

Contributors: KL participated in the planning of the survey, constructed the questionnaire, collected national data, did the analysis, wrote and reviewed the manuscript, and participated in the choice of journal. He is guarantor. All other authors participated in the planning of the survey, construction of the questionnaire, collection of national data, reviewing of the manuscript, and choice of journal.

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Competing interests: OL owns some stock in Royal Nuncio (the mother company for Nutricia) and has a research grant from them.


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Papers

Taking histories—theft by clinicians

Medical education now stresses the importance of partnership between health professionals and patients. The hierarchical model of the doctor-patient relationship is old fashioned and inappropriate.

So why do we still tell students to "take a history" from patients? Does this phrase undermine our efforts to teach about collaboration? Shouldn’t we instead "listen to people’s stories"?

This would emphasise the importance of meeting the patient in his or her world and context and ensure that the start of the medical consultation does not perpetuate an outmoded and ineffective world view.

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