



Guidelines for perioperative care in elective colonic surgery: Enhanced Recovery After Surgery (ERAS[®]) Society recommendations[☆]

U.O. Gustafsson^{a,b,*,q}, M.J. Scott^{c,d,q}, W. Schwenk^{e,q}, N. Demartines^{f,q}, D. Roulin^{f,q}, N. Francis^{g,q}, C.E. McNaught^{h,q}, J. MacFie^{h,q}, A.S. Liberman^{i,q}, M. Soop^{j,q}, A. Hill^{k,q}, R.H. Kennedy^{l,q}, D.N. Lobo^{m,q}, K. Fearon^{n,q}, O. Ljungqvist^{o,p,q}

^a Department of Surgery, Ersta Hospital, Stockholm, Sweden

^b Department of Clinical Sciences, Danderyd Hospital, Karolinska Institutet, Stockholm, Sweden

^c Department of Anaesthesia and Intensive Care Medicine, Royal Surrey County Hospital, Foundation Trust, Guildford, UK

^d Faculty of Health and Medical Sciences, University of Surrey, UK

^e Department for General and Visceral Surgery, Center for Minimal invasive and Oncological Surgery, Asklepios Klinik Altona, Hamburg, Germany

^f Department of Visceral Surgery, University Hospital CHUV, Lausanne, Switzerland

^g South West Laparoscopic Colorectal Training, Yeovil District Hospital Foundation Trust, Yeovil, Somerset, UK

^h Department of Surgery, Scarborough Hospital, Scarborough, North Yorkshire, UK

ⁱ Department of Surgery, McGill University, Montreal, Quebec, Canada

^j Department of Surgery, The University of Auckland, Auckland, New Zealand

^k South Auckland Clinical School, University of Auckland, Department of Surgery, Middlemore Hospital, Auckland, New Zealand

^l St Mark's Hospital, North West London Hospital NHS Trust, UK

^m Division of Gastrointestinal Surgery, Nottingham Digestive Diseases Centre National Institute for Health Research Biomedical Research Unit, Nottingham University Hospitals, Queen's Medical Centre, Nottingham, UK

ⁿ University of Edinburgh, UK

^o Department of Surgery, Örebro University and University Hospital, Örebro, Sweden

^p Institute of Molecular Medicine and Surgery, Karolinska Institutet, Stockholm, Sweden

ARTICLE INFO

Article history:

Received 10 August 2012

Accepted 19 August 2012

Keywords:

Perioperative care in colonic surgery
ERAS

SUMMARY

Background: This review aims to present a consensus for optimal perioperative care in colonic surgery and to provide graded recommendations for items for an evidenced-based enhanced perioperative protocol.

Methods: Studies were selected with particular attention paid to meta-analyses, randomised controlled trials and large prospective cohorts. For each item of the perioperative treatment pathway, available English-language literature was examined, reviewed and graded. A consensus recommendation was reached after critical appraisal of the literature by the group.

Results: For most of the protocol items, recommendations are based on good-quality trials or meta-analyses of good-quality trials (quality of evidence and recommendations according to the GRADE system).

Conclusions: Based on the evidence available for each item of the multimodal perioperative-care pathway, the Enhanced Recovery After Surgery (ERAS) Society, International Association for Surgical Metabolism and Nutrition (IASMEN) and European Society for Clinical Nutrition and Metabolism (ESPEN) present a comprehensive evidence-based consensus review of perioperative care for colonic surgery.

© 2012 Elsevier Ltd and European Society for Clinical Nutrition and Metabolism. All rights reserved.

[☆] The guidelines are published as a joint effort between the Enhanced Recovery After Surgery (ERAS) Society, for Perioperative Care, The European Society for Clinical Nutrition and Metabolism (ESPEN) and The International Association for Surgical Metabolism and Nutrition (IASMEN) and copyrights for this publication is shared between the three societies. The guidelines are published jointly in World Journal of Surgery (IASMEN) and Clinical Nutrition (ESPEN), and will also be available on the ESPEN (<http://www.espen.org>) and ERAS Society websites (<http://www.erassociety.org>).

* Corresponding author. Department of Surgery, Ersta Hospital, Stockholm, Sweden. Tel.: +46 87146582; fax: +46 856634607.

E-mail address: ulf.gustafsson@erstadiakoni.se (U.O. Gustafsson).

^q On behalf of the ERAS[®] Society, the European Society for Clinical Nutrition and Metabolism and the International Association for Surgical Nutrition and Metabolism.

1. Introduction

The delay until full recovery after major abdominal surgery has been greatly improved by the introduction of a series of evidence-based treatments covering the entire perioperative period and formulated into a standardised protocol. Compared with traditional management, Enhanced Recovery After Surgery (ERAS[®]) represents a fundamental shift in perioperative care.^{1–4} The ERAS-care pathways reduce surgical stress, maintain postoperative physiological function, and enhance mobilisation after surgery. This has resulted in reduced rates of morbidity, faster recovery and shorter length of stay in hospital (LOSH) in case series from dedicated centres^{1–4} and in randomised trials.^{5,6}

Several versions of Enhanced-Recovery Programmes have been published over the years.^{7–9}

This article represents the joint efforts of the ERAS Society (www.erassociety.org), International Association for Surgical Metabolism and Nutrition (IASMEN; www.iasmen.org) and The European Society for Clinical Nutrition and Metabolism (ESPEN) to present an updated and expanded consensus review of perioperative care for colonic surgery based on current evidence.

2. Methods

2.1. Literature search

The authors met in April 2011 and the topics for inclusion were agreed and allocated. The principal literature search utilised MEDLINE, Embase and Cochrane databases to identify relevant contributions published between January 1966 and January 2012. Medical Subject Headings terms were used, as were accompanying entry terms for the patient group, interventions and outcomes. Key words included “colon”, “enhanced recovery” and “fast track”. Reference lists of all eligible articles were checked for other relevant studies. Conference proceedings were not searched. Expert contributions came from within the ERAS Society Working Party on Systematic Reviews.

2.2. Study selection

Titles and abstracts were screened by individual reviewers to identify potentially relevant articles. Discrepancies in judgement were resolved by the senior author and during committee meetings of the ERAS Society Working Party on Systematic Reviews. Reviews, case series, non-randomised studies, randomised control studies, meta-analyses and systematic reviews were considered for each individual topic.

2.3. Quality assessment and data analyses

The methodological quality of the included studies was assessed using the Cochrane checklist.¹⁰ The strength of evidence and conclusions were assessed and agreed by all authors in May 2012. Quality of evidence and recommendations were evaluated according to the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system.^{11–13} Quoting from the GRADE guidelines,¹³ the recommendations are given as follows: “Strong recommendations indicate that the panel is confident that the desirable effects of adherence to a recommendation outweigh the undesirable effects”. “Weak recommendations indicate that the desirable effects of adherence to a recommendation probably outweigh the undesirable effects, but the panel is less confident”. Recommendations are based not only on quality of evidence (“high”, “moderate”, “low” and “very low”) but also on the balance between desirable and undesirable effects; and on values and preferences.¹³

The latter implies that, in some cases, strong recommendations may be reached from low-quality data and *vice versa*.

3. Evidence base and recommendations–ERAS items

3.1. Preadmission information, education and counselling

Detailed information given to patients before the procedure about surgical and anaesthetic procedures may diminish fear and anxiety and enhance postoperative recovery and quicken hospital discharge.^{14,15} A preoperative psychological intervention, aimed at decreasing patient anxiety, may also improve wound healing and recovery after laparoscopic surgery.^{16,17} Personal counselling, leaflets or multimedia information containing explanations of the procedure along with tasks that the patient should be encouraged to fulfil may improve perioperative feeding, early postoperative mobilisation, pain control, and respiratory physiotherapy; and hence reduce the prevalence of complications.^{18–20} Ideally, the patient and a relative/care provider should meet with surgeon, anaesthetist and nurse.

Summary and recommendation: Patients should routinely receive dedicated preoperative counselling (can only be beneficial and not harmful).

Evidence level: Low (study quality, uncertain endpoints)

Recommendation grade: Strong

3.2. Preoperative optimisation

Eight randomised controlled trials (RCTs) have been undertaken in various settings investigating the role of preoperative physical conditioning (Prehab) on surgical outcomes.^{21–27} The surgical settings were general abdominal surgery, cardiothoracic surgery and orthopaedic surgery. Although there were varying degrees of improvement in physiological function and surgical recovery, only 1 study found improvement in physiological function that correlated with improved surgical recovery.²⁵ These results may have been influenced by: a lack of appropriate physiological endpoints; studies being conducted within elderly cohorts; excessively intensive exercise regimens; and lack of adherence to the designated programmes. Further research is needed by investigating Prehab in younger patient populations. There is also a need for further research into methods that can improve adherence to Prehab.

It is generally accepted that preoperative medical optimisation is necessary before surgery. Alcohol abusers have a two-to-threefold increase in postoperative morbidity, the most frequent complications being bleeding, wound and cardiopulmonary complications. One month of preoperative abstinence reduces postoperative morbidity by improving organ function.^{28,29} Smoking is another patient factor that has a negative influence on recovery. Current smokers have an increased risk for postoperative pulmonary and wound complications.³⁰ One month of abstinence from smoking is required to reduce the incidence of complications.^{30–33}

Summary and recommendation: Increasing exercise preoperatively may be of benefit. Smoking should be stopped 4 weeks before surgery and alcohol abusers should stop all alcohol consumption 4 weeks before surgery (can only be beneficial and not harmful).

Evidence level: Prehab: Very low (inconsistency)

Alcohol: Low (only one high-quality RCT)

Smoking: High

Recommendation grade: Prehab: No

Alcohol: Strong

Smoking: Strong

3.3. Preoperative bowel preparation

Mechanical bowel preparation (MBP) has adverse physiologic effects attributed to dehydration,³⁴ is distressing for the patient, and is associated with prolonged ileus after colonic surgery.³⁵ Moreover, it has been shown that patients receiving MBP have a tendency towards a higher incidence of spillage of bowel contents, which might increase the rate of postoperative complications.³⁶ Thus, the “dogma” of MBP before elective abdominal surgery has been strongly challenged. The last Cochrane review of 2011 (which included 18 RCTs with 5805 patients undergoing elective colorectal surgery) could not find statistically significant differences between patients with MBP versus no MBP, or with MBP versus rectal enema alone, in terms of anastomotic leakage, mortality rates, need for re-operation and wound infections.³⁷

Most of the RCTs on MBP have included patients undergoing open colorectal surgery, and the extrapolation to laparoscopic surgery might be questionable. Some surgeons argue that MBP makes laparoscopic surgery technically easier. It has been shown that laparoscopic colectomy might be undertaken safely without preoperative MBP.³⁸ Nonetheless, precisely localising small tumours is more difficult by laparoscopy due to loss of palpation, thus requiring intraoperative colonoscopy with preoperative MBP. However, preoperative tattoo would obviate such a need.

Summary and recommendation: MBP should not be used routinely in colonic surgery.

Evidence level: High

Recommendation grade: Strong

3.4. Preoperative fasting and carbohydrate treatment

Fasting from midnight has been standard practice in the belief that this secures an empty stomach and thereby reduces the risk of pulmonary aspiration in elective surgery. There has never been any scientific evidence behind this dogma. A meta-analysis including a Cochrane review of 22 RCTs showed that fasting from midnight neither reduce gastric content nor raises the pH of gastric fluid compared with patients allowed free intake of clear fluids until 2 h before anaesthesia for surgery.^{39,40} Equally, intake of clear fluids ≥ 2 h before surgery does not increase the prevalence of complications. National and European Anaesthesia Societies now recommend intake of clear fluids until 2 h before the induction of anaesthesia as well as a 6-h fast for solid food.^{41–44} Obese (and even morbidly obese) patients have been reported to have the same gastric-emptying characteristics as lean patients.^{45,46} Diabetic patients with neuropathy may have delayed gastric emptying for solids, thereby possibly increasing the risk of regurgitation and aspiration.⁴⁷ There are no conclusive data showing delayed emptying for fluids. Patients with uncomplicated type-2 diabetes mellitus have been reported to have normal gastric emptying.⁴⁸ When given along with normal diabetic medication, gastric emptying of a carbohydrate drink was shown to be normal.⁴⁹ The clinical effectiveness of preoperative carbohydrate treatment has yet to be established in diabetic subjects. By providing a clear fluid containing a relatively high concentration of complex carbohydrates 2–3 h before anaesthesia, patients can undergo surgery in a metabolically fed state. Four-hundred millilitres of a 12.5% drink of mainly maltodextrins has been shown to reduce preoperative thirst, hunger, and anxiety^{40,50} as well as postoperative insulin resistance.⁵¹ Carbohydrate treatment results in less postoperative losses of nitrogen and protein^{52,53} as well as better-maintained lean body mass⁵⁴ and muscle strength.^{55,56} Data from RCTs indicate accelerated recovery, and preliminary data from a meta-analysis show a one day-shorter stay in hospital

for patients receiving preoperative carbohydrate loading in major abdominal surgery.^{57,58}

Summary and recommendation: Clear fluids should be allowed up to 2 h and solids up to 6 h prior to induction of anaesthesia. In those patients where gastric emptying may be delayed (duodenal obstruction etc) specific safety measures should be taken at the induction of anaesthesia. Preoperative oral carbohydrate treatment should be used routinely. In diabetic patients carbohydrate treatment can be given along with the diabetic medication.

Evidence level: Solids and fluids (overall): Moderate (study quality)

Diabetic patients: Low (inconsistency)

Carbohydrate loading (overall): Low (inconsistency, study quality)

Diabetic patients: Very low (few studies, low quality)

Recommendation grade: Fasting guidelines: Strong

Preoperative carbohydrate drinks: Strong

Preoperative carbohydrate drinks, diabetic patients: Weak

3.5. Preanaesthetic medication

Preoperative education can reduce patient anxiety to an acceptable level without the need for anxiolytic medication. Avoiding prolonged starvation times and adhering to the ERAS guidance on carbohydrate loading is also beneficial.⁵⁰ Long-acting sedative premedication should be avoided within 12 h of surgery because it affects immediate postoperative recovery by impairing mobility and oral intake. In 2009, a Cochrane review on premedication for anxiolysis for adult day surgery concluded that patients receiving oral anxiolytics were discharged from hospital successfully but that some of the studies showed an impairment in psychomotor function 4 h postoperatively, which reduces the patient's ability to mobilise, eat and drink.⁵⁹ Administration of sedatives for anxiolysis (particularly by the oral route) can be unpredictable, and is difficult to facilitate effectively for patients being admitted on the day of surgery, so is best avoided. If necessary, short-acting anaesthetic drugs (e.g., fentanyl combined with small incremental doses of midazolam or propofol) can be administered under monitoring to facilitate regional anaesthetic procedures such as spinal anaesthesia or thoracic epidural placement before the induction of anaesthesia with minimal residual effect at the end of surgery.

Summary and recommendation: Patients should not routinely receive long- or short-acting sedative medication before surgery because it delays immediate postoperative recovery. If necessary, short-acting intravenous drugs can be titrated carefully by the anaesthetist to facilitate the safe administration of epidural or spinal analgesia because these do not significantly affect recovery.

Evidence level: Sedative medication: High

Recommendation grade: Strong

3.6. Prophylaxis against thromboembolism

The incidence of asymptomatic deep vein thrombosis (DVT) in colorectal surgical patients without thromboprophylaxis is $\approx 30\%$, with fatal pulmonary embolus (PE) occurring in 1% of subjects. Patients with malignant disease, previous pelvic surgery, taking corticosteroids preoperatively, extensive comorbidity and hypercoagulable states are at increased risk.⁶⁰ All colorectal patients should receive mechanical thromboprophylaxis with well-fitted compression stockings because these have been shown to significantly reduce the prevalence of DVT in-hospitalised patients.⁶¹ The

addition of intermittent pneumatic compression should also be considered, particularly in patients with malignant disease or who have undergone pelvic surgery.⁶² There is extensive evidence supporting the use of pharmacological thromboprophylaxis with low-molecular-weight-heparin (LMWH) or unfractionated heparin. A recent study of 4195 colorectal patients demonstrated that pharmacological prophylaxis reduced the prevalence of symptomatic venous thromboembolism (VTE) from 1.8% to 1.1% and also reduced overall colorectal cancer mortality.⁶³ Once-daily LMWH is as effective as twice-daily administration.⁶⁴ The risks of postoperative haemorrhage, heparin-induced thrombocytopenia and epidural haematoma with permanent injury are rare (best/worst case scenario, 1 in 54,000/1 in 24,000).⁶⁵ It is recommended that epidural catheters are not placed or removed within 12 h of heparin administration.^{66–68}

The use of VTE-prophylaxis for surgical in patients is well-established, but the benefit of extended prophylaxis for 28 days after discharge is controversial. A recent Cochrane meta-analysis of four RCTs demonstrated a significant reduction in the prevalence of symptomatic DVT in patients with extended prophylaxis from 1.7% to 0.2% (confidence interval (CI) 0.06–0.80; $P = 0.02$; number needed to treat = 66).⁶⁹ In an American audit of 52,555 patients entered into the National Surgical Quality Improvement Database from 2005 to 2008, the prevalence of early post-discharge symptomatic VTE was lower at 0.67%. This would suggest that >200 patients would have to receive thromboprophylaxis to prevent one symptomatic VTE event.⁶⁰ A cost analysis of prolonged prophylaxis undertaken by the UK National Institute of Health and Clinical Excellence demonstrated that it was cost-effective for cancer surgery patients, but this evidence was based only on 3 RCTs.⁶² A universal policy of protracted thromboprophylaxis may not be appropriate in all colorectal patients, particularly in patients having minimally invasive or laparoscopic surgery, where the VTE risk may be even lower.⁷⁰ Current international guidelines, however, advocate its use in patients who have had major cancer surgery in the abdomen or pelvis.^{62,71}

Summary and recommendation: Patients should wear well-fitting compression stockings, have intermittent pneumatic compression, and receive pharmacological prophylaxis with LMWH. Extended prophylaxis for 28 days should be given to patients with colorectal cancer.

Evidence level: Stockings, compression, LMWH, extended prophylaxis: High

Recommendation grade: Strong

3.7. Antimicrobial prophylaxis and skin preparation

In a Cochrane review on antimicrobial prophylaxis in colorectal surgery,⁷² the authors concluded that the use of antibiotic prophylaxis for patients undergoing colorectal surgery is imperative to reduce the risk of surgical-site infections. For intravenous antibiotics, it is accepted that the best time for administration is 30–60 min before the incision is made.⁷³ Repeated doses during prolonged procedures may be beneficial.⁷⁴ The timing of oral administration of antibiotics is much less certain, especially in the light of current recommendations against mechanical colon cleansing before surgery,⁷⁵ because oral antibiotics have not been studied in the uncleaned colon. Antibiotics to be given should include cover against aerobic and anaerobic bacteria.

A study comparing different types of skin cleansing showed that the overall prevalence of surgical-site infection was 40% lower in a concentration chlorhexidine-alcohol group than in a povidone-iodine group.⁷⁶ However, there is a risk of fire-based injuries and burn injuries if diathermy is used in the presence of alcohol-based

skin solutions.⁷⁷ Hair clipping is associated with fewer surgical-site infections than shaving with razors if hair removal is necessary before surgery, although the timing of hair removal does not seem to affect the outcome.⁷⁸

Summary and recommendation: Routine prophylaxis with intravenous antibiotics should be given 30–60 min before initiating colorectal surgery. Additional doses should be given during prolonged procedures according to the half-life of the drug used.

Evidence level: Antibiotic prophylaxis, chlorhexidine-alcohol preparation: High

Recommendation grade: Strong

3.8. Standard anaesthetic protocol

There are no RCTs comparing general anaesthetic techniques for colorectal surgery. It makes good sense to use short-acting induction agents such as propofol combined with a short-acting opioid like fentanyl, alfentanil or a remifentanyl infusion. Short-acting muscle relaxants can be titrated using neuromuscular monitoring. Maintaining a deep neuromuscular block during surgery helps to facilitate vision and surgical access. Anaesthesia can be maintained using short-acting inhalational anaesthetics such as sevoflurane or desflurane in oxygen-enriched air. Alternatively, total intravenous anaesthesia (TIVA) using target-controlled infusion pumps can be utilised, and may be beneficial in patients with susceptibility to postoperative nausea and vomiting (PONV).

In the elderly population, there is increasing evidence that too deep an anaesthetic can be harmful and can increase the risk of postoperative confusion. Using a bispectral index (BIS) monitor may help to titrate the depth of anaesthesia to a minimum in this group of patients.⁷⁹

The anaesthetist is responsible for three key elements in affecting outcome after surgery: stress reactions to the surgery, fluid therapy, and analgesia. Recognition of the importance of these ERAS components has led to the description of a “trimodal approach” for optimising outcomes in laparoscopic surgery for anaesthetists.⁸⁰ A regional anaesthetic block used in addition to general anaesthesia during surgery can minimise the need for postoperative intravenous opiates, thereby allowing rapid awakening from anaesthesia which can facilitate early enteral intake and mobilisation on the day of surgery. In open surgery, the use of epidural analgesia has proven to be superior to opioid-based alternatives for several important outcomes,⁸¹ including pain,⁸² PONV⁸³ and complications.⁸⁴ In laparoscopic surgery, emerging data indicate that alternative methods such as spinal anaesthesia, intravenous lidocaine and patient-controlled anaesthesia (PCA) may be equally effective.⁸⁰ A regional block can also reduce the stress response.⁸⁵ This includes reducing insulin resistance (the main mechanism behind hyperglycaemia). Glucose monitoring is important⁸⁶ because hyperglycaemia can lead to an increased prevalence of postoperative complications,⁸⁷ although the use of an intensive insulin regimen must be balanced against the risk of hypoglycaemia.⁸⁸ During surgery, fluid delivery should be targeted against physiological measures⁸⁹ and mean arterial pressure maintained using vaso-pressors once normovolaemia has been established so that overload of salt and water is avoided.⁹⁰ This is particularly important if using epidural anaesthesia to maintain blood flow to the gut.⁹¹ Minimal invasive monitoring of cardiac output is being increasingly used to target fluid therapy. Rockall et al. have shown consistently low LOSH using oesophageal Doppler monitoring to direct fluid on an individual basis in patients receiving morphine (2.8 days), epidural (3.7 days) and spinal (2.7 days) anaesthesia.⁹² Ultra-short LOSH

(<23 h) was achieved by the same research team by combining spinal analgesia and goal-directed fluids.⁹³

Attention to airway management and ventilation is important to reduce the risk of postoperative chest infection and lung injury (a major cause of morbidity after major surgery). Micro-aspiration during anaesthesia may be a risk factor and can be reduced by using correctly sized endotracheal tubes with cuff-pressure control. Levy et al. showed that pulmonary function after laparoscopic surgery was not significantly affected by the analgesic regimen (thoracic epidural analgesia, spinal or morphine). Early mobilisation has an important part to play in pulmonary function.⁸⁰

Summary and recommendation: A standard anaesthetic protocol allowing rapid awakening should be given. The anaesthetist should control fluid therapy, analgesia and haemodynamic changes to reduce the metabolic stress response. Mid-thoracic epidural blocks using local anaesthetics and low-dose opioids should be considered for open surgery. In laparoscopic surgery, spinal analgesia or morphine PCA is an alternative to epidural anaesthesia. If intravenous opioids are to be used the dose should be titrated to minimise the risk of unwanted effects.

Evidence level: Rapid awakening: Low (lack of data),

Reduce stress response: Moderate (extrapolated data)

Open surgery: High

Laparoscopic surgery: Moderate (study quality)

Recommendation grade: Strong

3.9. PONV

PONV affects 25–35% of all surgical patients and is a leading cause of patient dissatisfaction and delayed discharge from hospital. The aetiology of PONV is multifactorial and can be classified into three factors: patient, anaesthetic and surgical. Female patients, non-smokers and those with a history of motion sickness are at particular risk. The use of volatile anaesthetic agents, nitrous oxide and parenteral opiates increase the risk significantly. Major abdominal surgery for colorectal disease is associated with a high prevalence of PONV, reaching 70% in some trials.⁹⁴ There are numerous national and international guidelines relating to the use of prophylactic antiemetics, which can reduce PONV by <40%.⁹⁵ Many of these guidelines advocate the use of PONV scoring systems (e.g., Apfel score), which stratify patients into low-to-high-risk groups and dictates antiemetic prophylaxis based on the perceived preoperative risk.⁹⁶ These scoring systems have been proven to reduce PONV significantly in RCTs but have not been widely implemented into routine clinical practice. An alternative strategy not yet studied may be to administer antiemetic prophylaxis to all patients who are having inhalational anaesthesia, opiates or major abdominal surgery. This approach is gaining popularity among the anaesthetists given that the cost- and side-effect profile of commonly used antiemetic drugs is small.⁹⁷

In recent years, the concept of a multimodal approach to PONV has gained momentum. This combines non-pharmacological and pharmacological antiemetic techniques in addition to ERAS programmes.⁹⁸ Non-pharmacological techniques include the avoidance of emetogenic stimuli such as inhalational anaesthetics, and the increased use of propofol for the induction and maintenance of anaesthesia. Minimal preoperative fasting, carbohydrate loading and adequate hydration of patients can also have a beneficial effect. The use of high inspired oxygen concentrations during anaesthesia has been implicated in a reduced prevalence of PONV, although a recent meta-analysis has cast some doubt on its efficiency.^{99,100} Regional anaesthetic techniques such as epidurals and transversus abdominal plane (TAP) blocks, have been proven to

reduce postoperative opiate use, which may in turn influence the prevalence of PONV.¹⁰¹ The use of non-steroidal anti-inflammatory drugs (NSAIDs) as an alternative to opiate analgesia is well-established.

Antiemetics can be classified into four main pharmacological subtypes depending on the receptor system they act upon: cholinergic, dopaminergic (D2), serotonergic (5-hydroxytryptamine type 3 (5-HT₃)) and histaminergic (H1). Each of the classes is superior to placebo in reducing the risk of PONV.¹⁰² There is also extensive evidence for the use of dexamethasone, which is postulated to act via central and peripheral mechanisms.¹⁰³ The potency of the antiemetic effect is enhanced if ≥2 antiemetics are used in combination: the serotonin analogues ondansetron or droperidol.¹⁰⁴ Dexamethasone has also been shown to have positive effects on reducing the prevalence of PONV, but its immunosuppressive effects on long-term oncological outcomes are unknown. Newer antiemetic drugs such as neurokinin-1 (NK₁) receptor antagonists have been developed, and initial trial results have been encouraging.¹⁰⁵

If, despite prophylaxis, PONV is present postoperatively, the additional agents not used for prophylaxis can be added to maximise the potency of the multimodal approach.

Summary and recommendation: A multimodal approach to PONV prophylaxis should be adopted in all patients with ≥2 risk factors undergoing major colorectal surgery. If PONV is present, treatment should be given using a multimodal approach.

Evidence level: Low (multiple interventions)

Recommendation grade: Strong

3.10. Laparoscopy and modifications of surgical access

Laparoscopy in colonic resection improves recovery if judged by the prevalence of postoperative complications, pain and hospital stay.^{106–111} It may also reduce the prevalence of postoperative immunosuppression¹¹¹ while providing equivalence in cancer outcomes.^{112–116} The debate during the last 5 years has centred around whether open surgery undertaken within an ERAS programme can match laparoscopic resection which is similarly optimised. Two small blinded randomised studies reported conflicting results, with one showing no difference in hospital stay between laparoscopic and open surgery¹¹⁷ whereas the other non-blinded study reported a 2.5-day in hospital stay reduction after laparoscopic surgery.¹¹⁸ Readmission rates of >20% were high in both arms of the first trial and in the open group of the second trial, but acceptable at 5% in the laparoscopic arm of the latter trial.

Recently, the Laparoscopy and/or Fast-track Multimodal Management Versus Standard Care (LAFA) study reported the results from its multicentre RCT which randomised between laparoscopic and open segmental colectomy within 9 Dutch centres.¹¹¹ The median primary and total stay in hospital was 2-days shorter after laparoscopic resection. Regression analysis showed that laparoscopic surgery was the only predictive factor to reduce hospital stay and morbidity. A detailed analysis has suggested that laparoscopy has the potential to be used in >90% of patients undergoing elective surgery for colorectal cancer, and that a conversion rate of <10% is achievable.¹¹⁹

Other methods that one might consider to add value in colonic resection would include the use of robotic-assisted surgery, single incision laparoscopic surgery (SILS) and hand-assisted laparoscopic surgery (HALS). The advantages of robotic surgery include seven degrees of movement, three-dimensional (3D) views, tremor filtration, motion scaling, and improved ergonomics. Whether this will translate into substantial improvement in clinical outcomes

remains to be seen, and research is in progress in rectal surgery.¹²⁰ The use of SILS has increased recently but as yet there are no robust data to justify its advantage over conventional laparoscopy.¹²¹ HALS is more widespread in certain parts of the world, but no clear evidence exists demonstrating clinical improvements in recovery when compared with conventional multiport laparoscopic surgery.¹²² There are data demonstrating that recovery is influenced by wound length¹²³ and that rates of incisional hernia are proportional to it.¹²⁴ Also, there is debate regarding whether transverse incisions have an advantage over longitudinal ones⁸ but robust data are not available.

Summary and recommendation: Laparoscopic surgery for colonic resections is recommended if the expertise is available.

Evidence level: Oncology: High.

Morbidity: Low (inconsistency).

Recovery/LOSH: Moderate (inconsistency)

Recommendation grade: Strong

3.11. Nasogastric intubation

A meta-analysis in 1995 showed that routine nasogastric decompression should be avoided after colorectal surgery because fever, atelectasis, and pneumonia are reduced in patients without a nasogastric tube.¹²⁵ A meta-analysis of 28 RCTs on the use of nasogastric decompression after abdominal surgery included 4195 patients.¹²⁶ Surgery included colorectal resection (7 RCTs), gastroduodenal surgery (7 RCTs), biliary and gynaecological surgery (2 RCTs each), vascular and trauma surgery (1 RCTs each) and mixed surgical populations (7 RCTs). Eight RCTs with 862 patients showed a reduction of the time interval from surgery to the first passage of flatus by half a day if nasogastric intubation was avoided. Pulmonary complications tended to be less common and, in a subgroup analysis of only patients undergoing colorectal surgery, the incidence of pulmonary complications wound infection, ventral hernia or anastomotic leak was no different. LOSH and gastric discomfort showed data in favour of no nasogastric decompression in most of the RCTs. Similar results were confirmed in a published meta-analysis in 2011.¹²⁷ There is no rationale for routine insertion of a nasogastric tube during elective colorectal surgery except to evacuate air that may have entered the stomach during ventilation by using a facial mask before endotracheal intubation.

Summary and recommendation: Postoperative nasogastric tubes should not be used routinely. Nasogastric tubes inserted during surgery should be removed before reversal of anaesthesia.

Evidence level: High

Recommendation grade: Strong

3.12. Preventing intraoperative hypothermia

Maintaining normothermia is important to maintain normal body homeostasis. Patients becoming hypothermic (definition: $<36^{\circ}\text{C}$) have been shown to have higher rates of wound infection,^{128,129} and earlier studies reported morbid cardiac events¹³⁰ and bleeding.¹³¹ In recovery, there is a higher risk of shivering in patients who are hypothermic, which increases oxygen consumption at a critical time.¹³² Pain scores are also better in patients who are not hypothermic. It is imperative to maintain the patient's temperature, rather than allowing it to drop and then trying to restore it. Pre-warming patients with a warm air blanket before coming to the operating theatre has been shown to improve core temperature before surgery.^{133,134} This may be more important for patients who are exposed while having prolonged

anaesthetic procedures (e.g., monitoring catheters and epidural insertion).

Maintaining temperature during the procedure can be achieved by using forced-air warming blankets, heating mattresses under the patient, or circulating-water garment systems.¹³⁵ All have been shown to be effective at maintaining normothermia during surgery. Active warming should be continued into the postoperative period until the patient's temperature is $\geq 36^{\circ}\text{C}$.¹³⁶ In addition, intravenous fluids should be warmed from the start of administration.¹³² The patient's temperature should be monitored to enable warming to be adjusted and to avoid hyperpyrexia which otherwise may occur in prolonged procedures if patients develop a systemic inflammatory response syndrome (SIRS).

A Cochrane review in January 2011 reached the conclusion that heating or humidifying the carbon dioxide gas used for insufflation does not improve the patient's temperature or pain scores after surgery.¹³⁷

Summary and recommendation: Intraoperative maintenance of normothermia with a suitable warming device (such as forced-air heating blankets, a warming mattress or circulating-water garment systems) and warmed intravenous fluids should be used routinely to keep body temperature $>36^{\circ}\text{C}$. Temperature monitoring is essential to titrate warming devices and to avoid hyperpyrexia.

Evidence level: Maintenance of normothermia: High.

Temperature monitoring: Moderate (extrapolated data).

Recommendation grade: Strong

3.13. Perioperative fluid management

Fluid therapy plays a vital part in achieving optimal outcomes after surgery but continues to be one of the most controversial aspects of perioperative care. Intravascular volume is one of the key determinants of cardiac output and therefore oxygen delivery to the tissues. Intravascular hypovolaemia at a particular time can lead to hypoperfusion of vital organs and the bowel, which can lead to complications. However, administering too much fluid can lead to bowel oedema and increased interstitial lung water, which can also lead to complications.¹³⁸ If the patient is normovolaemic, blood pressure should be maintained using vasopressors to avoid fluid overload.

It is apparent that fluid requirements in patients undergoing surgery by a laparotomy are different to laparoscopic surgery due to increased fluid shifts, bowel handling and an increased SIRS. The patient is also more likely to have thoracic epidural analgesia (TEA), which also changes vascular tone and venous capacitance, and further complicates fluid therapy. Laparoscopic surgery, therefore, would appear to offer the potential to simplify the way fluid is administered and reduce fluid requirements, but there is evidence that cardiac output is reduced by the physiological consequences of the head-down position and pneumoperitoneum. Therefore, it is important to target fluid and oxygen delivery appropriately in this group of patients.¹³⁹

Fluid shifts should be minimised if possible. That is, avoiding bowel preparation, maintaining hydration by giving oral preload up to 2 h before surgery, as well as minimising bowel handling and exteriorisation of the bowel outside the abdominal cavity and avoiding blood loss.

Studies have tried to determine whether a restrictive fluid regimen is more beneficial than a liberal regimen. However, the exact definitions of what is "liberal" and "restrictive" have varied between studies, as have patient groups and endpoints, meaning comparison between the studies is difficult. A review by Bundgaard-Nielsen

concluded that fluid excess was detrimental.¹⁴⁰ Varadhan and Lobo examined the evidence in these earlier studies and concluded that it is more important to reclassify patients as being in a state of “fluid balance” or “fluid imbalance”: the former fared better.¹³⁸

Minimally invasive cardiac output monitors such as the oesophageal Doppler (OD) device target fluid on an individualised basis by challenging the patient with a fluid bolus (e.g., 200 ml colloid) and seeing if there is an increase in stroke volume of $\geq 10\%$. This fluid challenge is repeated every 10–15 min until there is no further increase in stroke volume. At this point, the stroke volume is “optimized”. A meta-analysis of the use of OD to target fluid therapy in major surgery has demonstrated LOSH, fewer complications, faster return of bowel function, reduced infection rates, less nausea and vomiting, a lower incidence of acute kidney injury, and the possible improvement of survival after surgery.^{89,141} There have been few studies using OD within an ERAS protocol for colorectal surgery, particularly in laparoscopic surgery. In 2009, Senagore et al.¹⁴² showed minimal benefit of outcome when comparing goal-directed administration of balanced salt solution or hetastarch using OD within an ERAS protocol. They did conclude, however, that less crystalloid was given when using OD.

Other minimally invasive cardiac output monitors that use arterial waveform analysis or thoracic bioimpedance/bioreactance are available but no RCTs in elective colorectal surgery using these devices have been carried out. Dynamic variables using arterial waveform analysis such as stroke volume variation (SVV) or pulse pressure variation (PPV) have been shown in ventilated patients to help predict fluid responsiveness.¹⁴³ The advantage of arterial waveform analysis is that it can be used postoperatively to target stroke volume and cardiac output.

Central venous catheters are not routinely used for monitoring of central venous pressure as this is a poor predictor of fluid responsiveness. Hence, they are inserted only if there is a genuine need for central venous access for drug infusions. The use of central venous saturation to represent oxygen extraction in the early postoperative period to guide fluid therapy has been validated by some studies, and may be useful in high-risk patients.^{144,145}

Postoperative intravenous fluids should be minimised to maintain normovolaemia and avoid fluid excess. The enteral route should be used in preference and the drip taken down at the earliest opportunity (preferably no later than the morning after surgery). Traditionally, there has been a reluctance to take the drip down in patients with TEA. Hypotensive normovolemic patients with TEA should be treated with vasopressors and not an excess of fluid.¹⁴⁶ Balanced crystalloids have been shown to be superior to 0.9% saline for the maintenance of electrolyte balance.¹⁴⁷

Summary and recommendation: Balanced crystalloids should be preferred to 0.9% saline. In open surgery, patients should receive intraoperative fluids (colloids and crystalloids) guided by flow measurements to optimise cardiac output. Flow measurement should also be considered if: the patient is at high risk with comorbidities; if blood loss is >7 ml/kg; or in prolonged procedures. Vasopressors should be considered for intra- and post-operative management of epidural-induced hypotension provided the patient is normovolaemic.

The enteral route for fluid postoperatively should be used as early as possible, and intravenous fluids should be discontinued as soon as is practicable.

Evidence level: Balanced crystalloids: High

Flow measurement in open surgery: High

Flow measurement in other patients: Moderate (extrapolated data). Vasopressors: High

Early enteral route: High

Recommendation grade: Strong

3.14. Drainage of the peritoneal cavity after colonic anastomosis

Peritoneal drainage has traditionally been used to prevent accumulation of fluid in the bed of dissection, infection, and anastomotic breakdown. At least 8 RCTS of ≈ 1390 participants have tested the efficacy of drainage in colorectal surgery; most trials evaluated closed-suction drainage for 3–7 days in elective colonic surgery. Meta-analyses did not demonstrate effects on clinical or radiological anastomotic dehiscence, wound infection, re-operation, extra-abdominal complications or mortality.^{148,149} Subgroup analyses of trials in elective colon resection replicated these findings.¹⁴⁹

Peri-anastomotic drainage has also been thought to allow early detection and/or control of anastomotic dehiscence. However, pooled data show that enteric content or pus is observed in only 1 in 20 drains in patients with clinical leaks.¹⁵⁰

Thus, peritoneal drainage is not associated with any advantage or disadvantage in the available literature. Empirical observation suggests that many drainage systems significantly impair independent mobilisation.

Summary and recommendation: Routine drainage is discouraged because it is an unsupported intervention that probably impairs mobilisation.

Evidence level: High

Recommendation grade: Strong

3.15. Urinary drainage

Bladder drainage is used during and after major surgery to monitor urine output and prevent urinary retention. Only low-grade evidence is available regarding the clinical value of perioperative monitoring of urine output; in observational studies in non-cardiac surgery, intraoperative urine output was not a predictor of subsequent renal function¹⁵¹ or acute kidney injury.¹⁵²

A brief duration of transurethral drainage is desirable because increasing duration is associated with increasing risk of urinary tract infection (UTI). In a recent randomised trial of early (day 1, $n = 105$) versus standard (approximately day 4, $n = 110$) removal of the transurethral catheter in patients having major abdominal and thoracic surgery, the prevalence of UTI significantly reduced with early removal (2% versus 14%).¹⁵³

It has been proposed that urinary drainage is necessary for the duration of epidural analgesia. However, all patients in the quoted trial had TEA for ≥ 3 days, and the rate of urinary retention was not significantly different between the 1-day and the 4-day group (8% versus 2% single in-out catheterisation; 3% versus 0% 24-h catheterisation).¹⁵³ This confirms findings from an uncontrolled prospective study of 100 patients treated with 48-h TEA after open colonic resection who had their transurethral catheter removed in the morning after surgery. Some 9% had urinary retention and 4% had a UTI.¹⁵⁴

A meta-analysis has shown that suprapubic bladder catheterisation in abdominal surgery is associated with lower rates of bacteriuria and lower patient discomfort than transurethral drainage.¹⁵⁵ However, these data are relevant for urinary drainage of 4–7 days' duration; benefit from suprapubic catheterisation in short-term transurethral drainage is uncertain.

Summary and recommendation: Routine transurethral bladder drainage for 1–2 days is recommended. The bladder catheter can be removed regardless of the usage or duration of TEA.

Evidence level: Low (few studies, extrapolated data)

Recommendation grade: Routine bladder drainage: Strong

Early removal if epidural used: Weak

3.16. Prevention of postoperative ileus (including use of postoperative laxatives)

Prevention of postoperative ileus is a major cause of delayed discharge after abdominal surgery as well as a key objective of enhanced-recovery protocols. No prokinetic agent has been shown to be effective in attenuating or treating postoperative ileus, but several other types of interventions have been successful. Mid-thoracic epidural analgesia¹⁵⁶ as compared with intravenous opioid analgesia is highly effective at preventing postoperative ileus.^{83,157} Fluid overloading during¹⁵⁸ and after¹⁵⁹ surgery impairs gastrointestinal function and should be avoided. Avoidance of nasogastric decompression may reduce the duration of postoperative ileus.¹²⁶ Laparoscopic-assisted colonic resection also leads to faster return of bowel function, as well as resumption of an oral diet, compared with open surgery.¹⁰⁹ This effect of laparoscopy in comparison to open surgery has been demonstrated in a recent RCT under traditional perioperative care as well as ERAS.¹¹¹ Oral magnesium oxide was demonstrated to promote postoperative bowel function in a double-blinded RCT in abdominal hysterectomy¹⁶⁰ and in reports from a well-established enhanced-recovery program in colonic resection.¹¹⁶¹ Another randomised trial in liver resection showed that oral magnesium enhanced the return of bowel function¹⁶² in an ERAS setting, whereas a small RCT (49 patients) failed to show any significant effect of oral magnesium on time to first flatus or bowel movement (18.0 versus 14.0 and 42 versus 50 h; each $p > 0.15$) nor on early intake of fluids, protein drinks, solid food, nausea and vomiting, mobilisation or LOSH¹⁶³ within a well-established ERAS protocol. Bisacodyl (10 mg, p.o.) administered twice a day from the day before surgery to the third postoperative day improved postoperative intestinal function in a RCT with 189 patients undergoing colorectal surgery.¹⁶⁴ There was no effect of bisacodyl on tolerance to solid food or LOSH. Alvimopan (a μ -opioid receptor antagonist approved for clinical use in postoperative ileus) given via the oral route accelerates gastrointestinal recovery and reduces the LOSH in patients undergoing open colonic resection having postoperative opioid analgesia.¹⁶⁵ Perioperative use of chewing gum has a positive effect on postoperative duration of ileus.¹⁶⁶

Summary and recommendation: Mid-thoracic epidural analgesia and laparoscopic surgery should be utilised in colonic surgery if possible. Fluid overload and nasogastric decompression should be avoided. Chewing gum can be recommended, whereas oral administration of magnesium and alvimopan (when using opioid-based analgesia) can be included.

Evidence level: Thoracic epidural, laparoscopy: High

Chewing gum: Moderate

Oral magnesium, alvimopan (when using opioids): Low (extrapolated data)

Recommendation grade: Thoracic epidural, fluid overload, nasogastric decompression, chewing gum, alvimopan (when using opioids): Strong

Oral magnesium: Weak

3.17. Postoperative analgesia

The optimal analgesic regimen for major surgery should give: good pain relief; allow early mobilisation, early return of gut function and feeding; and not cause complications.¹⁶⁷ There has been increasing recognition that different types of analgesic regimens are more suited to particular types of surgery and incision. The cornerstone of analgesia remains multimodal analgesia combining regional analgesia or local anaesthetic techniques and trying to avoid parenteral opioids and their side effects.

3.17.1. Postoperative analgesia in open surgery

For open midline laparotomy, TEA is the optimal established analgesic technique. It offers superior analgesia in the first 72 h after surgery⁸² and earlier return of gut function provided the patient is not fluid-overloaded. A national audit by Cook et al. on behalf of the UK Royal College of Anaesthetists has quantified the risks and highlighted its safety provided good practice is adhered to.⁶⁵

Using low-dose concentrations of local anaesthetic combined with a short-acting opiate appears to offer the best combination of analgesia while minimising the risk of motor block and hypotension due to sympathetic blockade. Several meta-analyses have shown improved outcomes with TEA compared with opioid-based analgesia, including pain, complications, PONV and insulin resistance.^{81–85} Hypotension induced by sympathetic block should be treated with vasopressors provided the patient is not hypovolaemic. The aim should be to remove the epidural ≈ 48 –72 h postoperatively by the time the patient has had a bowel movement.

3.17.2. Postoperative analgesia in Laparoscopic surgery

Recent publications have shown that the duration of pain after laparoscopic surgery requiring major analgesics is much shorter than for open surgery, thereby allowing discharge from hospital as soon as 23 h after surgery.⁹³ Provided early feeding is tolerated in the laparoscopic group, analgesic requirements at 24 h postoperatively are often addressed with oral multimodal analgesia without the need of regional blocks or strong opiates. However, even in laparoscopic surgery there is the need for a small, low transverse abdominal incision to deliver the specimen. There is increasing interest in looking at alternatives to TEA or morphine using spinal analgesia or TAP blocks. A RCT by Levy et al. comparing spinal analgesia, morphine and low TEA in fluid-optimised patients provided interesting results because patients with TEA had a longer LOSH.⁹² However, 3 RCTs reported contradictory effects on gastrointestinal function depending on the level of block: low-thoracic epidurals were not associated with benefits,^{92,168} whereas a trial using a mid-thoracic epidural demonstrated significantly earlier return of flatus, stools and tolerance of oral diet as compared with parenteral opioid analgesia.¹⁶⁹ Other work has confirmed that, although analgesia is superior in the early postoperative period using TEA, LOSH is not reduced.¹⁷⁰ Work by Virlos et al. confirmed that spinal analgesia allows earlier mobilisation and hospital discharge compared with TEA.¹⁷¹

TAP blocks have been used in laparoscopic surgery to cover the lower abdominal incisional and combined with intravenous paracetamol to reduce opioid administration.¹⁷² They are, however, short-acting and no significant RCT has compared TAP with spinal or epidural analgesia.¹⁰¹

3.17.3. Postoperative multimodal analgesia

During the postoperative phase, a multimodal analgesic regimen has been employed aiming to avoid the use of opioids. Paracetamol is a vital part of multimodal analgesia. It is available in an intravenous preparation and can be given as 1 g four times daily.

3.17.3.1. NSAIDs. NSAIDs are also an important part of multimodal analgesia. There have been clinical case series linking voltadol (150 mg, p.o. once a day) and celecoxib (cyclo-oxygenase (COX)-2 inhibitor) to an increased incidence of anastomotic dehiscence.^{173–176} However, until more thorough studies addressing this question have been carried out, there is not sufficient evidence to stop using NSAIDs as a component of multimodal analgesia in the postoperative period. Tramadol is an alternative to NSAIDs (although there are no recent studies relevant to colorectal surgery).

3.17.3.2. *To reduce postoperative opiate use.* There are several ongoing studies on alternative drugs to avoid the use of opioids, but no medication can be recommended for routine use.

Summary and recommendation: TEA using low-dose local anaesthetic and opioids should be used in open surgery. For breakthrough pain, titration to minimise the dose of opioids may be used. In laparoscopic surgery, an alternative to TEA is a carefully administered spinal analgesia with a low-dose, long-acting opioid. In connection with TEA withdrawal, NSAIDs and Paracetamol should be used.

Evidence level: TEA, open surgery: High

Local anaesthetic and opioid: Moderate (inconsistency).

TEA not essential in laparoscopic surgery: Moderate (inconsistency).

NSAID/Paracetamol: Moderate (inconsistency/ few studies).

Recommendation grade: Strong

3.18. Perioperative nutritional care

Most patients undergoing elective colonic resection can eat normally before surgery, and many have a seemingly normal nutritional status. In an ERAS setting, if the stress of surgery is minimised, a low body mass index (BMI) does not appear to be an independent risk factor for complications or prolonged LOSH, suggesting that, in this setting, baseline nutritional status may not be as critical as in more traditional perioperative-care situations.¹⁷⁷ The epidemic of obesity in Western society means that the average BMI of patients is often in the overweight or obese range, and this may hide underlying muscle wasting. A recent study has demonstrated that the presence of low muscle mass is predictive of complications and LOSH after colorectal surgery (Liefers et al.²³²). Whether such muscle wasting relates to pre-existing comorbidity or is related to cancer-associated myopenia is not known.

Regardless of the BMI, consumption of energy and protein is often low in the preoperative phase in patients about to undergo colonic surgery. Therefore, careful history-taking directed towards recent unplanned weight loss and reduced nutritional intake should be carried out. Normal food is the basis for nutrition before and after surgery for most patients treated according to ERAS. In the context of traditional perioperative care, addition of oral supplements can improve overall intake to reach nutritional goals.¹⁷⁸ In enhanced-recovery programmes, oral nutritional supplements (ONS) have been used on the day before surgery and for at least the first 4 postoperative days to achieve target intakes of energy and protein during the very early postoperative phase.^{179,180} One study combining preoperative oral treatment of carbohydrates, epidural analgesia, and early enteral nutrition showed that these three components of ERAS allowed nitrogen equilibrium while keeping glucose levels normal without the need for exogenous insulin by minimising insulin resistance.¹⁸¹ If significant unplanned weight loss is present, oral supplements should be prescribed in the perioperative period, and consideration should be given to continuing the prescription once the patient returns home.^{178,182} For significantly malnourished patients, nutritional supplementation (oral and/or parenteral) has the greatest effect if started 7–10 days preoperatively, and is associated with a reduction in the prevalence of infectious complications and anastomotic leaks.¹⁸³ Special nutritional considerations should be taken for elderly patients as well as those with chronic diseases and alcohol problems who may also have micronutrient deficiencies or ingest vitamins and minerals below recommended doses and who may need supplementation before and after surgery.^{184–187}

In the postoperative phase, patients undergoing ERAS can drink immediately after recovery from anaesthesia and then eat normal hospital food and, in doing so, spontaneously consume ≈ 1200 –

1500 kcal/day.^{188,189} This is safe. RCTs of early enteral or oral feeding *versus* 'nil by mouth' show that early feeding reduces the risk of infection and LOSH, and is not associated with an increased risk of anastomotic dehiscence.^{190–192} However, with early oral feeding, the risk of vomiting increases, especially in the absence of multimodal anti-ileus therapy.

Different combinations of diets containing components aimed to enhance immune function in surgical patients have been studied. These diets, often called 'immunonutrition' (IN) usually contain combinations of arginine, glutamine, omega-3 fatty acids, and nucleotides. Several meta-analyses have been published on the clinical effectiveness of IN (two recent with references to most others).^{193,194} Overall, most studies show that there is clinical benefit from this treatment due to a reduction in the prevalence of complications and shortened LOSH in the context of traditional care, but results are heterogeneous. There is evidence suggesting that the treatment is most effective in malnourished patients, and there are no trials of the effectiveness of these formulae in an ERAS setting if stress is minimised.

Summary and recommendation: Patients should be screened for nutritional status and, if deemed to be at risk of under-nutrition, given active nutritional support. For the standard ERAS patient, preoperative fasting should be minimised and postoperatively patients should be encouraged to take normal food as soon as possible after surgery. ONS can be used to supplement total intake.

Evidence level: Postoperative early enteral feeding, safety: High

Improved recovery and reduction of morbidity: Low (study quality, extrapolated data)

Perioperative ONS (well-fed patient): Low (study quality, extrapolated data)

Perioperative ONS (malnourished patient): Low (study quality, extrapolated data, small effect)

IN: Low (study quality, extrapolated data)

Recommendation grade: Postoperative early feeding and perioperative ONS: Strong

IN: IN could be considered in open colonic colonic resections:

Weak (different formulae, timing, dose).

3.19. Postoperative control of glucose

Insulin resistance is the cause of postoperative hyperglycaemia. Increasing insulin resistance¹⁹⁵ and glucose levels⁸⁷ have been shown to be associated with complications and mortality after major abdominal surgery, and also when adjusted for key confounders. This risk increases with higher insulin resistance and/or higher glucose levels. These data are primarily from glucose values during the day of surgery and postoperative day 1 with minimal food intake (i.e., not typical ERAS settings).

There are very little data on glucose control in an ERAS setting when patients are eating. However, available data with patients undergoing colorectal surgery in an ERAS protocol eating 1500 kcal from day 1 after elective colorectal surgery show that, as expected, glucose levels are higher after food intake compared with morning fasting levels.¹⁸⁸ Patients with higher preoperative levels of glycated haemoglobin (HbA1c) remain ≈ 1 mmol/l higher compared with patients with normal preoperative HbA1c levels, and they also develop more complications. A small study combining epidural, preoperative carbohydrate and postoperative continuous complete enteral tube feeding after major colorectal surgery showed that glucose levels were maintained at normal levels without the need for insulin in the first 3 postoperative days.¹⁸¹ Several treatments in the ERAS protocol affect insulin action/resistance^{196,197} and hence glucose levels directly or indirectly (bowel preparation prolonging preoperative fasting; preoperative carbohydrate treatment instead

of overnight fasting). The prophylaxis and treatment of PONV to support nutritional intake involves: avoiding fasting; maintenance of fluid balance to support bowel movements; epidural anaesthesia to reduce the endocrine stress response from the adrenal glands; avoiding the use of opioids disturbing bowel movements; avoiding anti-inflammatory treatments to reduce stress; avoiding tubes and drains; and active mobilisation. None of these treatments carry the risk of hypoglycaemia.

Treatment of hyperglycaemia in surgical patients in the Intensive Care Unit (ICU) consistently shows improved results in that complications are avoided.^{198–201} Any reduction in hyperglycaemia, regardless of the degree or level, improves outcomes. At levels >10–12 mmol/l, the risk of osmotic diuresis increases and causes additional disturbances in fluid balance.²⁰² However, using intravenous insulin carries the risk of hypoglycaemia,¹⁹⁹ especially in the ward setting.

Summary and recommendation: Hyperglycaemia is a risk factor for complications and should therefore be avoided. Several interventions in the ERAS protocol affect insulin action/resistance, thereby improving glycaemic control with no risk of causing hypoglycaemia. For ward-based patients, insulin should be used judiciously to maintain blood glucose as low as feasible with the available resources.

Evidence level: Using stress reducing elements of ERAS to minimise hyperglycaemia: Low (study quality, extrapolations).

Insulin treatment in the ICU: Moderate (inconsistency, uncertain target level of glucose).

Glycaemic control in the ward setting: Low (inconsistency, extrapolations)

Recommendation grade: Using stress reducing elements of ERAS to minimise hyperglycaemia: Strong

Insulin treatment in the ICU (severe hyperglycaemia): Strong

Insulin treatment in the ICU (mild hyperglycaemia): Weak (uncertain target level of glucose)

Insulin treatment in the ward setting: Weak (risk of hypoglycaemia, evidence level)

3.20. Early mobilisation

Early mobilisation has been postulated to reduce chest complications and may counteract insulin resistance from immobilisation.⁹ Combining forced mobilisation with nutritional support results in improved muscle strength but only during the early postoperative phase.²⁰³ Another RCT in 119 patients showed that postoperative muscle training had little effect of long-term postoperative outcomes.²⁰⁴ A recent review confirmed these earlier results.²⁰⁵ Conversely, prolonged bed rest has several negative effects, including reduced work capacity.²⁰⁶ Also, a multivariate linear regression analysis of data collected during the LAFA trial,¹¹¹ supported the notion that mobilisation on postoperative days 1–3 is a factor significantly associated with a successful outcome of ERAS. Conversely, failure to mobilise on the first postoperative day may be due to inadequate control of pain, continued intravenous intake of fluids, indwelling urinary catheter, patient motivation, and pre-existing co-morbidities. In a recent study in Yeovil, failure to mobilise was one of the most common reasons for ERAS deviation and was associated with prolonged LOSH.²⁰⁷

Summary and recommendation: Available RCTs do not support the direct beneficial clinical effects of postoperative mobilisation. Prolonged immobilisation, however, increases the risk of pneumonia, insulin resistance, and muscle weakness. Patients should therefore be mobilised.

Evidence level: Low (extrapolated data, weak effect)

Recommendation grade: Strong

3.21. Audit

Measuring standards and auditing the quality of healthcare drive continue to improve practice.²⁰⁸ Auditing compliance is shown to be a key instrument to assist clinicians implementing the ERAS programme.²⁰⁹

Auditing ERAS can be discussed under three domains: (i) measuring clinical outcomes of ERAS such as LOSH, readmission rates and complications (as reviewed above) (ii) determining functional recovery and patient experience and (iii) measuring compliance with (or deviation from) the ERAS protocol.

The original clinical outcome of ERAS programmes as described by Kehlet et al. resulting in a reduction of median LOSH after open colonic resection to 2 days¹ have not been reproduced widely. However, there is now robust evidence to support the benefits of ERAS over traditional postoperative care. This has been demonstrated in several meta-analyses in terms of shorter postoperative LOSH, lower complication rates, and acceptable readmission rates.^{210–213} Hence, these measures of clinical outcome should be included in the clinical audit.

Measuring patients' experiences with ERAS, however, has not been investigated very thoroughly. This is mostly due to the lack of reliable and valid tools that can be used widely across many centres to report patients' experiences. Nevertheless, in the literature on this subject, ERAS does not seem to adversely influence quality of life (QoL) or psychomotor functions such as sleep quality, pain and fatigue levels after surgery.²¹⁴ In a recent unpublished Delphi consensus in the UK, measuring patient experience has been highlighted as a fundamental element of ERAS.

Measuring compliance has proven to be an instrumental factor in investigating the success of ERAS.²⁰⁹ By auditing the details of the key elements of the clinical pathway, it is often easier to understand the occurrence of certain failures that lead to complications. In addition, measuring compliance helps to direct future education and the modification of other interventions (if necessary). ERAS-care outcomes were reported in relation to compliance to the ERAS protocol in a large cohort study of nearly 1000 consecutive patients.²⁰⁹ This study concluded that the proportion of patients with postoperative morbidity and symptoms delaying discharge and readmission to hospital were significantly reduced (38–69%) with higher levels of ERAS compliance. Nearly all of the pre and perioperative ERAS-items influenced the different outcomes in a beneficial way. However, only intravenous fluid management and intake of preoperative carbohydrate drink were identified as independent predictors of outcome.

In the LAFA study,¹¹¹ overall compliance to ERAS-items of 60% was reported in laparoscopic and open colonic surgery. A follow-up study²¹⁵ showed that enforced advancement of oral intake, early mobilisation, laparoscopic surgery and female gender was independent determinants of early recovery. However, two of the variables determining outcomes – postoperative oral intake and mobilisation – could also be regarded as outcomes and dependent on the pre and postoperative care. A third study investigating factors influencing outcomes in an ERAS setting⁶ reported that fluid overload and non-functioning epidural analgesia were independent predictors of postoperative complications. It is difficult to compare the three studies except that all show that compliance with certain care elements known to improve outcomes also does so in the ERAS setting. The importance of the individual elements is likely to be influenced by variation in compliance in any given study situation.

There are several tools to audit compliance and ERAS outcomes. Within the ERAS society, a systematic process of audit has been built into the ERAS Interactive Audit System and data collection system to facilitate implementation of ERAS (www.erassociety.org).²¹⁶ The ERAS database differs from other common audit tools

in that it collects data on patient demographics, treatment and outcomes. Additionally included in the ERAS system is the recording of compliance using a series of evidence-based treatment interventions that have been shown to influence outcomes. A raft of measures which provide information on different aspects of post-operative recovery (and potential factors delaying it) is incorporated into the dataset to allow interrogation of the care process. The ERAS audit system also provides relevant feedback on clinical outcomes that are important for patients, healthcare providers and other decision-makers. Within England, there are various local systems and one national toolkit to record ERAS elements and outcomes. The Enhanced Recovery Partnership Programme (ERPP) has designed a toolkit to measure compliance in ERAS

Summary and recommendation: A systematic audit is essential to determine clinical outcome and measure compliance to establish successful implementation of the care protocol. The system should also report patient experience and functional recovery, but validated tools are required for this aspect.

Evidence level: Systematic audit: Moderate (extrapolation, study quality)

Patient experience/functional recovery: Very low (lack of valid tools)

Recommendation grade: Strong

4. Outcomes of ERAS

4.1. Eras versus traditional care in elective colonic surgery: clinical outcomes

Several studies have demonstrated that the ERAS programmes compared with traditional perioperative care is associated with earlier recovery and discharge after colonic resection.^{1,2,217–222} Recently, the effect of perioperative treatment with the ERAS protocol on four outcome parameters (mortality, morbidity, LOSH, hospital readmissions) after mainly colonic surgery was reported in two systematic reviews: Spanjersberg et al.,²²³ and Varadhan et al.²¹³ Different variations of the ERAS programme were compared with traditional perioperative care based on 4 and 6 RCTs, respectively (^{4,5,221,224} ($n = 237$) and ^{4–6,221,224,225} ($n = 452$)).

The mortality in patients undergoing surgery within an ERAS programme was 0.4% and 1.3% in patients within traditional perioperative care. The difference was not significant, RR, 0.53 (0.12–2.38)²²³ and RR, 0.53 (0.09–2.15).²¹³ However, there was a significant reduction in RR for postoperative morbidity in patients undergoing surgery within an ERAS programme of 48%, RR, 0.52 (0.38–0.71)²²³ and 47%, RR, 0.53 (0.41–0.69),²¹³ respectively. Furthermore, LOSH after surgery was significantly shorter in patients within an ERAS protocol compared with patients undergoing surgery within traditional perioperative care, –2.94 days (–3.92 to –2.19),²²³ –2.51 days (–3.54 to –1.47).²¹³ Finally, there was no difference in hospital readmissions among patients within an ERAS programme (3.3–4.4% versus 4.2–5.7%) in patients within traditional care (RR, 0.87 (0.08–9.39),²²³ RR, 0.80 (0.32–1.98)).²¹³ In a third meta-analysis (Adamina et al.)²²⁶ investigating the same 6 randomised studies as in the meta-analysis of Varadhan et al.,²¹³ these results were confirmed.

Summary and recommendation: ERAS protocols should be used in elective colonic surgery. Using more evidence-based elements of perioperative care from an ERAS protocol is likely to improve outcomes further.

Evidence level: LOSH: High

Morbidity: Low (inconsistency, study quality, low rate of difference) **Hospital readmissions:** Low (inconsistency)

Recommendation grade: Strong

4.2. Effect of ERAS on health economics and QoL

The literature examining the impact of ERAS on health economics and QoL after colonic surgery is sparse. Two cohort studies collected data on the cost before and after the introduction of ERAS. The first,²²⁷ analysed cost during the 3-months after intervention in 60 patients undergoing surgery for colon cancer or rectal cancer within an ERAS protocol. This was compared with a tight control group of 86 individuals treated by the same surgeon and who were recruited immediately before the introduction of the ERAS protocol. There were non-significant reductions in hospital, indirect, and total costs after the introduction of ERAS. The second study²²⁸ looked at cost savings within a university hospital in New Zealand using a case-matched comparison of 50 patients in each group. After the introduction of enhanced recovery, 30-day costs were reduced by a mean of €4240 per patient, even taking into account start-up costs. A review containing US cost analyses indicated a saving of ≈2000 USD per patient.²²⁶ Recently, the Dutch multicenter LAFA trial¹¹¹ examined in-hospital costs after colonic resection within and outside an ERAS protocol, finding (surprisingly) that there were no significant differences between groups. Despite the limited evidence for ERAS reducing the cost of care within the literature, the fact that it reduces the prevalence of complications and postoperative stay in RCTs lends support to the notion that it imparts cost benefits.

QoL was assessed before 2006 by King and colleagues,²²⁷ who reported only non-significant trends after introduction of ERAS. Fatigue was measured by the New Zealand group in a separate case-controlled prospective study,²²⁹ which elicited similar results to those reported by Jakobsen et al.²³⁰ Patients within an ERAS programme suffered less fatigue ≤30 days after surgery, and there were reduced consequences of fatigue even at 60 days in the New Zealand study. The lack of blinding and randomisation weakened the results of both studies, but there are clear methodological problems blinding patients to ERAS. More recently, the LAFA trial¹¹¹ randomised between ERAS and standard perioperative care but did not identify improvements in health-related QoL – one explanation for this having been discussed above. A recent review²¹⁴ did not find consistent disadvantages to ERAS care during colonic surgery if recovery was measured using QoL instruments. This is possibly because the tools used are not sufficiently sensitive to detect the improvements in clinical recovery that clinicians perceive are present. Delaney et al. addressed this problem by designing a novel postoperative scoring system,²³¹ which may be of use in this area.

Summary and recommendation: ERAS can be recommended because it is likely to reduce the cost of colorectal surgery and improve the quality of recovery.

Evidence level: Cost reduction: Very low (inconsistency, few studies)

Quality of recovery: Very low (inconsistency, few studies)

Recommendation grade: Weak

5. Comment

The practice of surgery and anaesthesia is continuously changing. This creates the need for regular updates of the knowledge base and for continuous training of those involved in the treatment of surgical patients. The ERAS Society for Perioperative Care (www.erassociety.org) was initiated by the former ERAS Study Group and was formed in 2010 to support these processes. The Society participates in the improvement of perioperative care by developing new knowledge through research, education and also by being involved in the implementation of best practice.

Table 1

Guidelines for perioperative care in elective colonic surgery: Enhanced Recovery After Surgery (ERAS®) Society recommendations.

Item	Recommendation	Evidence level	Recommendation grade
Preoperative information, education and counselling	Patients should routinely receive dedicated preoperative counselling.	Low	Strong
Preoperative optimisation	Preoperative medical optimisation is necessary before surgery. Smoking and alcohol consumption (alcohol abusers) should be stopped four weeks before surgery.	Alcohol: Low Smoking: High	Strong
Preoperative bowel preparation	Mechanical bowel preparation should not be used routinely in colonic surgery.	High	Strong
Preoperative fasting and carbohydrate treatment	Clear fluids should be allowed up to 2 h and solids up to 6 h prior to induction of anaesthesia. Preoperative oral carbohydrate treatment should be used routinely. In diabetic patients carbohydrate treatment can be given along with the diabetic medication.	Solids and fluids: Moderate Carbohydrate loading, overall: Low Carbohydrate loading, diabetic patients: Very low	Fasting guidelines: Strong Preoperative carbohydrate drinks: Strong Preoperative carbohydrate drinks, diabetic patients: Weak
Preanaesthetic medication	Patients should not routinely receive long- or short-acting sedative medication before surgery because it delays immediate postoperative recovery.	High	Strong
Prophylaxis against thromboembolism	Patients should wear well-fitting compression stockings, have intermittent pneumatic compression, and receive pharmacological prophylaxis with LMWH. Extended prophylaxis for 28 days should be given to patients with colorectal cancer.	High	Strong
Antimicrobial prophylaxis and skin preparation	Routine prophylaxis using intravenous antibiotics should be given 30–60 min before initiating surgery. Additional doses should be given during prolonged operations according to half-life of the drug used. Preparation with chlorhexidine-alcohol should be used.	High	Strong
Standard anaesthetic protocol	A standard anaesthetic protocol allowing rapid awakening should be given. The anaesthetist should control fluid therapy, analgesia and haemodynamic changes to reduce the metabolic stress response. Open surgery: mid-thoracic epidural blocks using local anaesthetics and low-dose opioids. Laparoscopic surgery: spinal analgesia or morphine PCA is an alternative to epidural anaesthesia.	Rapid awakening: Low Reduce stress response: Moderate Open surgery: High Laparoscopic surgery: Moderate	Strong
PONV	A multimodal approach to PONV prophylaxis should be adopted in all patients with ≥ 2 risk factors undergoing major colorectal surgery. If PONV is present, treatment should be given using a multimodal approach.	Low	Strong
Laparoscopy and modifications of surgical access	Laparoscopic surgery for colonic resections is recommended if the expertise is available.	Oncology: High Morbidity: Low Recovery/LOSH: Moderate	Strong
Nasogastric intubation	Postoperative nasogastric tubes should not be used routinely. Nasogastric tubes inserted during surgery should be removed before reversal of anaesthesia.	High	Strong
Preventing intraoperative hypothermia	Intraoperative maintenance of normothermia with a suitable warming device and warmed intravenous fluids should be used routinely to keep body temperature $>36^{\circ}\text{C}$.	High	Strong
Perioperative fluid management	Patients should receive intraoperative fluids (colloids and crystalloids) guided by flow measurements to optimise cardiac output. Vasopressors should be considered for intra- and postoperative management of epidural-induced hypotension provided the patient is normovolaemic. The enteral route for fluid postoperatively should be used as early as possible, and intravenous fluids should be discontinued as soon as is practicable.	Balanced crystalloids: High Flow measurement in open surgery: High Flow measurement in other patients: Moderate Vasopressors: High Early enteral route: High	Strong
Drainage of peritoneal cavity after colonic anastomosis	Routine drainage is discouraged because it is an unsupported intervention that is likely to impair mobilisation.	High	Strong

Table 1 (continued)

Item	Recommendation	Evidence level	Recommendation grade
Urinary drainage	Routine transurethral bladder drainage for 1–2) days is recommended. The bladder catheter can be removed regardless of the usage or duration of thoracic epidural analgesia.	Low	Routine bladder drainage: Strong Early removal if epidural used: Weak
Prevention of postoperative ileus	Mid-thoracic epidural analgesia and laparoscopic surgery should be utilised in colonic surgery if possible. Fluid overload and nasogastric decompression should be avoided. Chewing gum can be recommended, whereas oral magnesium and alvimopan may be included.	Thoracic epidural, laparoscopy: High Chewing gum: Moderate Oral magnesium, alvimopan: Low	Thoracic epidural, fluid overload, nasogastric decompression, chewing gum and alvimopan: Strong Oral magnesium: Weak
Postoperative analgesia	Open surgery: TEA using low-dose local anaesthetic and opioids. Laparoscopic surgery: an alternative to TEA is a carefully administered spinal analgesia with a low-dose, long-acting opioid.	TEA, open surgery: High Local anaesthetic and opioid: Moderate TEA not mandatory in laparoscopic surgery: Moderate	Strong
Perioperative nutritional care	Patients should be screened for nutritional status and if at risk of under-nutrition given active nutritional support. Perioperative fasting should be minimised. Postoperatively patients should be encouraged to take normal food as soon as lucid after surgery. ONS may be used to supplement total intake.	Postoperative early enteral feeding, safety: High Improved recovery and reduction of morbidity: Low Perioperative ONS (well-fed patient): Low Perioperative ONS (malnourished patient): Low IN: Low	Postoperative early feeding and perioperative ONS: Strong IN could be considered in open colonic resections: Weak
Postoperative glucose control	Hyperglycaemia is a risk factor for complications and should therefore be avoided. Several interventions in the ERAS protocol affect insulin action/resistance, thereby improving glycaemic control with no risk of causing hypoglycemia. For ward-based patients, insulin should be used judiciously to maintain blood glucose as low as feasible with the available resources.	Using stress reducing elements of ERAS to minimise hyperglycaemia: Low Insulin treatment in the ICU: Moderate Glycaemic control in the ward setting: Low	Using stress reducing elements of ERAS to minimise hyperglycaemia: Strong Insulin treatment in the ICU (severe hyperglycaemia): Strong Insulin treatment in ICU (mild hyperglycaemia): Weak Insulin treatment in the ward setting: Weak
Early mobilisation	Prolonged immobilisation increases the risk of pneumonia, insulin resistance and muscle weakness. Patients should therefore be mobilised.	Low	Strong

Current recommendations from the ERAS Society for clinical perioperative care of patients undergoing elective colonic surgery are based on evidence evaluated according to the GRADE system. The evidence-based recommendations present the ERAS protocol interventions separately and overall, and are intended to be used by units undertaking colonic surgery to implement and upgrade to what the current literature shows to be best practice: the ERAS protocol.

Current recommendations are a development of the previous two versions published by the ERAS Study Group.^{8,9} We used a more stringent system for the evaluation of the evidence and recommendations. The currently used grading of the evidence is very demanding, and it may seem to the reader that some of the protocol items have weak levels of evidence. Simultaneously, current review of the evidence must be put into the perspective of the level of evidence in general for common medical practices and treatments. The evidence for components in the ERAS protocol is at a level that is commonly in use throughout medicine today. A summary of the guidelines is shown in Table 1.

Funding source

The ERAS Society has support from Nutricia Research via an unrestricted educational grant.

Statement of authorship

Scientific input, critical revision and final approval of manuscript: all authors coordinated writing and revision and edited this contribution.

Conflicts of Interests

The ERAS Society® receives an unrestricted grant from Nutricia. OL has served as an external advisor to Nutricia and has occasionally received travel and lecture honoraria from Nutricia, Fresenius-Kabi, Braun, Baxter and Nestle. OL also previously held a patent for a preoperative carbohydrate drink formerly licenced to Nutricia. OL initiated a company that runs the ERAS society data by contract with the ERAS society. DNL has received unrestricted research funding, travel grants and speaker's honoraria from Baxter Healthcare, Fresenius Kabi and BBraun. All other authors declare no conflicts of interests.

Acknowledgements

The ERAS Society has support from Nutricia Research via an unrestricted educational grant.

References

- Basse L, Hjort Jakobsen D, Billesbolle P, Werner M, Kehlet H. A clinical pathway to accelerate recovery after colonic resection. *Ann Surg* 2000;**232**(1): 51–7.
- Basse L, Raskov HH, Hjort Jakobsen D, Sonne E, Billesbolle P, Hendel HW, et al. Accelerated postoperative recovery programme after colonic resection improves physical performance, pulmonary function and body composition. *Br J Surg* 2002;**89**(4):446–53.
- Wind J, Hofland J, Preckel B, Hollmann MW, Bossuyt PM, Gouma DJ, et al. Perioperative strategy in colonic surgery; LAParoscopy and/or FAST track multimodal management versus standard care (LAFA trial). *BMC Surg* 2006;**6**:16.
- Khoo CK, Vickery CJ, Forsyth N, Vinall NS, Eyre-Brook IA. A prospective randomized controlled trial of multimodal perioperative management protocol in patients undergoing elective colorectal resection for cancer. *Ann Surg* 2007;**245**(6):867–72.
- Serclova Z, Dytrych P, Marvan J, Nova K, Hankeova Z, Ryska O, et al. Fast-track in open intestinal surgery: prospective randomized study (Clinical Trials Gov Identifier no. NCT00123456). *Clin Nutr* 2009;**28**(6):618–24.
- Muller S, Zalunardo MP, Hubner M, Clavien PA, Demartines N. A fast-track program reduces complications and length of hospital stay after open colonic surgery. *Gastroenterology* 2009;**136**(3):842–7.
- Kehlet H, Dahl JB. Anaesthesia, surgery, and challenges in postoperative recovery. *Lancet* 2003;**362**(9399):1921–8.
- Fearon KC, Ljungqvist O, Von Meyenfeldt M, Revhaug A, Dejong CH, Lassen K, et al. Enhanced recovery after surgery: a consensus review of clinical care for patients undergoing colonic resection. *Clin Nutr* 2005;**24**(3):466–77.
- Lassen K, Soop M, Nygren J, Cox PB, Hendry PO, Spies C, et al. Consensus review of optimal perioperative care in colorectal surgery: Enhanced Recovery After Surgery (ERAS) Group recommendations. *Arch Surg* 2009;**144**(10):961–9.
- Verhagen AP, de Vet HC, de Bie RA, Kessels AG, Boers M, Bouter LM, et al. The Delphi list: a criteria list for quality assessment of randomized clinical trials for conducting systematic reviews developed by Delphi consensus. *J Clin Epidemiol* 1998;**51**(12):1235–41.
- Guyatt GH, Oxman AD, Vist GE, Kunz R, Falck-Ytter Y, Alonso-Coello P, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. *BMJ* 2008;**336**(7650):924–6.
- Guyatt GH, Oxman AD, Kunz R, Vist GE, Falck-Ytter Y, Schunemann HJ. What is “quality of evidence” and why is it important to clinicians? *BMJ* 2008;**336**(7651):995–8.
- Guyatt GH, Oxman AD, Kunz R, Falck-Ytter Y, Vist GE, Liberati A, et al. Going from evidence to recommendations. *BMJ* 2008;**336**(7652):1049–51.
- Egbert LD, Battit GE, Welch CE, Bartlett MK. Reduction of postoperative pain by encouragement and instruction of patients. A study of doctor-patient rapport. *N Engl J Med* 1964;**270**:825–7.
- Kiecolt-Glaser JK, Page GG, Marucha PT, MacCallum RC, Glaser R. Psychological influences on surgical recovery. Perspectives from psychoneuroimmunology. *Am Psychol* 1998;**53**(11):1209–18.
- Kahokehr A, Broadbent E, Wheeler BR, Sammour T, Hill AG. The effect of perioperative psychological intervention on fatigue after laparoscopic cholecystectomy: a randomized controlled trial. *Surg Endosc* 2012;**26**(6): 1730–6.
- Broadbent E, Kahokehr A, Booth RJ, Thomas J, Windsor JA, Buchanan CM, et al. A brief relaxation intervention reduces stress and improves surgical wound healing response: a randomised trial. *Brain Behav Immun* 2012;**26**(2):212–7.
- Halaszynski TM, Juda R, Silverman DG. Optimizing postoperative outcomes with efficient preoperative assessment and management. *Crit Care Med* 2004;**32**(4 Suppl):S76–86.
- Forster AJ, Clark HD, Menard A, Dupuis N, Chernish R, Chandok N, et al. Effect of a nurse team coordinator on outcomes for hospitalized medicine patients. *Am J Med* 2005;**118**(10):1148–53.
- Disbrow EA, Bennett HL, Owings JT. Effect of preoperative suggestion on postoperative gastrointestinal motility. *West J Med* 1993;**158**(5):488–92.
- Arthur HM, Daniels C, McKelvie R, Hirsh J, Rush B. Effect of a preoperative intervention on preoperative and postoperative outcomes in low-risk patients awaiting elective coronary artery bypass graft surgery. A randomized, controlled trial. *Ann Intern Med* 2000;**133**(4):253–62.
- Carli F, Charlebois P, Stein B, Feldman L, Zavorsky G, Kim DJ, et al. Randomized clinical trial of prehabilitation in colorectal surgery. *Br J Surg* 2010;**97**(8): 1187–97.
- Dronkers JJ, Lamberts H, Reutelingsperger IM, Naber RH, Dronkers-Landman CM, Veldman A, et al. Preoperative therapeutic programme for elderly patients scheduled for elective abdominal oncological surgery: a randomized controlled pilot study. *Clin Rehabil* 2010;**24**(7):614–22.
- Hoogbeem TJ, Dronkers JJ, van den Ende CH, Oosting E, van Meeteren NL. Preoperative therapeutic exercise in frail elderly scheduled for total hip replacement: a randomized pilot trial. *Clin Rehabil* 2010;**24**(10):901–10.
- Hulzebos EH, Helder PJ, Favie NJ, De Bie RA, Brutel de la Riviere A, Van Meeteren NL. Preoperative intensive inspiratory muscle training to prevent postoperative pulmonary complications in high-risk patients undergoing CABG surgery: a randomized clinical trial. *JAMA* 2006;**296**(15):1851–7.
- Weidenhielm L, Mattsson E, Brostrom LA, Wersall-Robertsson E. Effect of preoperative physiotherapy in unicompartmental prosthetic knee replacement. *Scand J Rehabil Med* 1993;**25**(1):33–9.
- Weiner P, Zeidan F, Zamir D, Pelled B, Waizman J, Beckerman M, et al. Prophylactic inspiratory muscle training in patients undergoing coronary artery bypass graft. *World J Surg* 1998;**22**(5):427–31.
- Tonnesen H, Kehlet H. Preoperative alcoholism and postoperative morbidity. *Br J Surg* 1999;**86**(7):869–74.
- Tonnesen H, Rosenberg J, Nielsen HJ, Rasmussen V, Hauge C, Pedersen IK, et al. Effect of preoperative abstinence on poor postoperative outcome in alcohol misusers: randomised controlled trial. *BMJ* 1999;**318**(7194):1311–6.
- Sorensen LT, Karlsmark T, Gottrup F. Abstinence from smoking reduces incisional wound infection: a randomized controlled trial. *Ann Surg* 2003;**238**(1):1–5.
- Bluman LG, Mosca L, Newman N, Simon DG. Preoperative smoking habits and postoperative pulmonary complications. *Chest* 1998;**113**(4):883–9.
- Lindstrom D, Sadr Azodi O, Wladis A, Tonnesen H, Linder S, Nasell H, et al. Effects of a perioperative smoking cessation intervention on postoperative complications: a randomized trial. *Ann Surg* 2008;**248**(5):739–45.
- Thomsen T, Villebro N, Moller AM. Interventions for preoperative smoking cessation. *Cochrane Database Syst Rev* 2010;(3). CD002294.
- Holte K, Nielsen KG, Madsen JL, Kehlet H. Physiologic effects of bowel preparation. *Dis Colon Rectum* 2004;**47**(8):1397–402.
- Jung B, Lannerstad O, Pahlman L, Arodeli M, Unosson M, Nilsson E. Preoperative mechanical preparation of the colon: the patient's experience. *BMC Surg* 2007;**7**:5.
- Mahajna A, Krausz M, Rosin D, Shabtai M, Hershko D, Ayalon A, et al. Bowel preparation is associated with spillage of bowel contents in colorectal surgery. *Dis Colon Rectum* 2005;**48**(8):1626–31.
- Guenaga KF, Matos D, Castro AA, Atallah AN, Wille-Jorgensen P. Mechanical bowel preparation for elective colorectal surgery. *Cochrane Database Syst Rev* 2003;(2). CD001544.
- Zmora O, Lebedev A, Hoffman A, Khaikin M, Munz Y, Shabtai M, et al. Laparoscopic colectomy without mechanical bowel preparation. *Int J Colorectal Dis* 2006;**21**(7):683–7.
- Ljungqvist O, Soreide E. Preoperative fasting. *Br J Surg* 2003;**90**(4):400–6.
- Brady M, Kinn S, Stuart P. Preoperative fasting for adults to prevent perioperative complications. *Cochrane Database Syst Rev* 2003;(4). CD004423.
- Eriksson LI, Sandin R. Fasting guidelines in different countries. *Acta Anaesthesiol Scand* 1996;**40**(8 Pt 2):971–4.
- Practice guidelines for preoperative fasting and the use of pharmacologic agents to reduce the risk of pulmonary aspiration: application to healthy patients undergoing elective procedures: a report by the American Society of Anesthesiologists Task Force on Preoperative Fasting. *Anesthesiology* 1999;**90**(3):896–905.
- Soreide E, Eriksson LI, Hirlekar G, Eriksson H, Henneberg SW, Sandin R, et al. Pre-operative fasting guidelines: an update. *Acta Anaesthesiol Scand* 2005;**49**(8):1041–7.
- Smith I, Kranke P, Murat I, Smith A, O'Sullivan G, Soreide E, et al. Perioperative fasting in adults and children: guidelines from the European Society of Anaesthesiology. *Eur J Anaesthesiol* 2011;**28**(8):556–69.
- Harter RL, Kelly WB, Kramer MG, Perez CE, Dzwonczyk RR. A comparison of the volume and pH of gastric contents of obese and lean surgical patients. *Anesth Analg* 1998;**86**(1):147–52.
- Maltby JR, Pytko S, Watson NC, Cowan RA, Fick GH. Drinking 300 mL of clear fluid two hours before surgery has no effect on gastric fluid volume and pH in fasting and non-fasting obese patients. *Can J Anaesth* 2004;**51**(2):111–5.
- Kong MF, Horowitz M. Diabetic gastroparesis. *Diabet Med* 2005;**22**(Suppl. 4): 13–8.
- Breuer JP, von Dossow V, von Heymann C, Griesbach M, von Schickfus M, Mackh E, et al. Preoperative oral carbohydrate administration to ASA III–IV patients undergoing elective cardiac surgery. *Anesth Analg* 2006;**103**(5): 1099–108.
- Gustafsson UO, Nygren J, Thorell A, Soop M, Hellstrom PM, Ljungqvist O, et al. Pre-operative carbohydrate loading may be used in type 2 diabetes patients. *Acta Anaesthesiol Scand* 2008;**52**(7):946–51.
- Hausel J, Nygren J, Lagerkranser M, Hellstrom PM, Hammarqvist F, Almstrom C, et al. A carbohydrate-rich drink reduces preoperative discomfort in elective surgery patients. *Anesth Analg* 2001;**93**(5):1344–50.
- Nygren J, Soop M, Thorell A, Efendic S, Nair KS, Ljungqvist O. Preoperative oral carbohydrate administration reduces postoperative insulin resistance. *Clin Nutr* 1998;**17**(2):65–71.
- Crowe PJ, Dennison A, Royle GT. The effect of pre-operative glucose loading on postoperative nitrogen metabolism. *Br J Surg* 1984;**71**(8):635–7.
- Svanfeldt M, Thorell A, Hausel J, Soop M, Rooyackers O, Nygren J, et al. Randomized clinical trial of the effect of preoperative oral carbohydrate treatment on postoperative whole-body protein and glucose kinetics. *Br J Surg* 2007;**94**(11):1342–50.
- Yuill KA, Richardson RA, Davidson HI, Garden OJ, Parks RW. The administration of an oral carbohydrate-containing fluid prior to major elective upper-gastrointestinal surgery preserves skeletal muscle mass postoperatively—a randomised clinical trial. *Clin Nutr* 2005;**24**(1):32–7.
- Henriksen MG, Hessel I, Dela F, Hansen HV, Haraldsted V, Rodt SA. Effects of preoperative oral carbohydrates and peptides on postoperative endocrine response, mobilization, nutrition and muscle function in abdominal surgery. *Acta Anaesthesiol Scand* 2003;**47**(2):191–9.

56. Noblett SE, Watson DS, Huang H, Davison B, Hainsworth PJ, Horgan AF. Preoperative oral carbohydrate loading in colorectal surgery: a randomized controlled trial. *Colorectal Dis* 2006;**8**(7):563–9.
57. Nygren J, Thorell A, Ljungqvist O. Preoperative oral carbohydrate nutrition: an update. *Curr Opin Clin Nutr Metab Care* 2001;**4**(4):255–9.
58. Noblett SE, Snowden CP, Shenton BK, Horgan AF. Randomized clinical trial assessing the effect of Doppler-optimized fluid management on outcome after elective colorectal resection. *Br J Surg* 2006;**93**(9):1069–76.
59. Walker KJ, Smith AF. Premedication for anxiety in adult day surgery. *Cochrane Database Syst Rev* 2009;(4). CD002192.
60. Fleming FJ, Kim MJ, Salloum RM, Young KC, Monson JR. How much do we need to worry about venous thromboembolism after hospital discharge? A study of colorectal surgery patients using the National Surgical Quality Improvement Program database. *Dis Colon Rectum* 2010;**53**(10):1355–60.
61. Amaragiri SV, Lees TA. Elastic compression stockings for prevention of deep vein thrombosis. *Cochrane Database Syst Rev* 2000;(3). CD001484.
62. Hill J, Treasure T. Reducing the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism) in patients admitted to hospital: summary of the NICE guideline. *Heart* 2010;**96**(11):879–82.
63. Kwon S, Meissner M, Symons R, Steele S, Thirlby R, Billingham R, et al. Perioperative pharmacologic prophylaxis for venous thromboembolism in colorectal surgery. *J Am Coll Surg* 2011;**213**(5):596–603. 603 e1.
64. van Dongen CJ, MacGillavry MR, Prins MH. Once versus twice daily LMWH for the initial treatment of venous thromboembolism. *Cochrane Database Syst Rev* 2005;(3). CD003074.
65. Cook TM, Counsell D, Wildsmith JA. Major complications of central neuraxial block: report on the Third National Audit Project of the Royal College of Anaesthetists. *Br J Anaesth* 2009;**102**(2):179–90.
66. Breivik H, Bang U, Jalonen J, Vigfusson G, Alahuhta S, Lagerkranser M. Nordic guidelines for neuraxial blocks in disturbed haemostasis from the Scandinavian Society of Anaesthesiology and Intensive Care Medicine. *Acta Anaesthesiol Scand* 2010;**54**(1):16–41.
67. Vandermeulen EP, Van Aken H, Vermeylen J. Anticoagulants and spinal-epidural anesthesia. *Anesth Analg* 1994;**79**(6):1165–77.
68. Bergqvist D, Lindblad B, Matzsch T. Risk of combining low molecular weight heparin for thromboprophylaxis and epidural or spinal anesthesia. *Semin Thromb Hemost* 1993;**19**(Suppl. 1):147–51.
69. Rasmussen MS, Jorgensen LN, Wille-Jorgensen P. Prolonged thromboprophylaxis with low molecular weight heparin for abdominal or pelvic surgery. *Cochrane Database Syst Rev* 2009;(1). CD004318.
70. Verheijen PM, Stevenson AR, Stitz RW, Clark DA, Clark AJ, Lumley JW. Prolonged use of thromboprophylaxis may not be necessary in laparoscopic colorectal surgery. *Int J Colorectal Dis* 2011;**26**(6):755–9.
71. Geerts WH, Bergqvist D, Pineo GF, Heit JA, Samama CM, Lassen MR, et al. Prevention of venous thromboembolism: American College of Chest Physicians Evidence-based Clinical Practice Guidelines (8th edition). *Chest* 2008;**133**(6 Suppl):381S–453S.
72. Nelson RL, Glenn AM, Song F. Antimicrobial prophylaxis for colorectal surgery. *Cochrane Database Syst Rev* 2009;(1). CD001181.
73. Steinberg JP, Braun BI, Hellinger WC, Kusek L, Bozikis MR, Bush AJ, et al. Timing of antimicrobial prophylaxis and the risk of surgical site infections: results from the Trial to Reduce Antimicrobial Prophylaxis Errors. *Ann Surg* 2009;**250**(1):10–6.
74. Fujita S, Saito N, Yamada T, Takii Y, Kondo K, Ohue M, et al. Randomized, multicenter trial of antibiotic prophylaxis in elective colorectal surgery: single dose vs 3 doses of a second-generation cephalosporin without metronidazole and oral antibiotics. *Arch Surg* 2007;**142**(7):657–61.
75. Guenaga KF, Matos D, Castro AA, Atallah AN, Wille-Jorgensen P. Mechanical bowel preparation for elective colorectal surgery. *Cochrane Database Syst Rev* 2005;(1). CD001544.
76. Darouiche RO, Wall Jr MJ, Itani KM, Otterson MF, Webb AL, Carrick MM, et al. Chlorhexidine-Alcohol versus povidone-iodine for surgical-site antisepsis. *N Engl J Med* 2010;**362**(1):18–26.
77. Rocos B, Donaldson LJ. Alcohol skin preparation causes surgical fires. *Ann R Coll Surg Engl* 2012;**94**(2):87–9.
78. Tanner J, Norrie P, Melen K. Preoperative hair removal to reduce surgical site infection. *Cochrane Database Syst Rev* 2011;(11). CD004122.
79. Punjasawadwong Y, Boonjeungmonkol N, Phongchiewboon A. Bispectral index for improving anaesthetic delivery and postoperative recovery. *Cochrane Database Syst Rev* 2007;(4). CD003843.
80. Levy BF, Scott MJ, Fawcett WJ, Day A, Rockall TA. Optimizing patient outcomes in laparoscopic surgery. *Colorectal Dis* 2011;**13**(Suppl. 7):8–11.
81. Block BM, Liu SS, Rowlingson AJ, Cowan AR, Cowan Jr JA, Wu CL. Efficacy of postoperative epidural analgesia: a meta-analysis. *JAMA* 2003;**290**(18):2455–63.
82. Werawatganon T, Charuluxanun S. Patient controlled intravenous opioid analgesia versus continuous epidural analgesia for pain after intra-abdominal surgery. *Cochrane Database Syst Rev* 2005;(1). CD004088.
83. Jorgensen H, Wetterslev J, Moineche S, Dahl JB. Epidural local anaesthetics versus opioid-based analgesic regimens on postoperative gastrointestinal paralysis, PONV and pain after abdominal surgery. *Cochrane Database Syst Rev* 2000;(4). CD001893.
84. Popping DM, Elia N, Marret E, Remy C, Tramer MR. Protective effects of epidural analgesia on pulmonary complications after abdominal and thoracic surgery: a meta-analysis. *Arch Surg* 2008;**143**(10):990–9. discussion 1000.
85. Uchida I, Asoh T, Shirasaka C, Tsuji H. Effect of epidural analgesia on post-operative insulin resistance as evaluated by insulin clamp technique. *Br J Surg* 1988;**75**(6):557–62.
86. Blixt C, Ahlstedt C, Ljungqvist O, Isaksson B, Kalman S, Rooyackers O. The effect of perioperative glucose control on postoperative insulin resistance. *Clin Nutr* 2012;**31**(5):676–81.
87. Jackson RS, Amdur RL, White JC, Macsata RA. Hyperglycemia is associated with increased risk of morbidity and mortality after colectomy for cancer. *J Am Coll Surg* 2012;**214**(1):68–80.
88. Lipshutz AK, Gropper MA. Perioperative glycemic control: an evidence-based review. *Anesthesiology* 2009;**110**(2):408–21.
89. Abbas SM, Hill AG. Systematic review of the literature for the use of oesophageal Doppler monitor for fluid replacement in major abdominal surgery. *Anaesthesia* 2008;**63**(1):44–51.
90. Lobo DN. Fluid overload and surgical outcome: another piece in the jigsaw. *Ann Surg* 2009;**249**(2):186–8.
91. Gould TH, Grace K, Thomas M. Effect of thoracic epidural anaesthesia on colonic blood flow. *Br J Anaesth* 2002;**89**(3):446–51.
92. Levy BF, Scott MJ, Fawcett W, Fry C, Rockall TA. Randomized clinical trial of epidural, spinal or patient-controlled analgesia for patients undergoing laparoscopic colorectal surgery. *Br J Surg* 2011;**98**(8):1068–78.
93. Levy BF, Scott MJ, Fawcett WJ, Rockall TA. 23-hour-stay laparoscopic colectomy. *Dis Colon Rectum* 2009;**52**(7):1239–43.
94. Chatterjee S, Rudra A, Sengupta S. Current concepts in the management of postoperative nausea and vomiting. *Anesthesiol Res Pract* 2011;**2011**:748031.
95. Gan TJ, Meyer TA, Apfel CC, Chung F, Davis PJ, Habib AS, et al. Society for Ambulatory Anesthesia guidelines for the management of postoperative nausea and vomiting. *Anesth Analg* 2007;**105**(6):1615–28. table of contents.
96. Apfel CC, Kranke P, Eberhart LH, Roos A, Roewer N. Comparison of predictive models for postoperative nausea and vomiting. *Br J Anaesth* 2002;**88**(2):234–40.
97. Kranke P, Eberhart LH. Possibilities and limitations in the pharmacological management of postoperative nausea and vomiting. *Eur J Anaesthesiol* 2011;**28**(11):758–65.
98. Chandrakantan A, Glass PS. Multimodal therapies for postoperative nausea and vomiting, and pain. *Br J Anaesth* 2011;**107**(Suppl. 1):i27–40.
99. Greif R, Laciny S, Rapf B, Hickel RS, Sessler DI. Supplemental oxygen reduces the incidence of postoperative nausea and vomiting. *Anesthesiology* 1999;**91**(5):1246–52.
100. Orhan-Sungur M, Kranke P, Sessler D, Apfel CC. Does supplemental oxygen reduce postoperative nausea and vomiting? A meta-analysis of randomized controlled trials. *Anesth Analg* 2008;**106**(6):1733–8.
101. Charlton S, Cyna AM, Middleton P, Griffiths JD. Perioperative transversus abdominis plane (TAP) blocks for analgesia after abdominal surgery. *Cochrane Database Syst Rev* 2010;(12). CD007705.
102. Carlisle JB, Stevenson CA. Drugs for preventing postoperative nausea and vomiting. *Cochrane Database Syst Rev* 2006;(3). CD004125.
103. Karanickolas PJ, Smith SE, Kanbur B, Davies E, Guyatt GH. The impact of prophylactic dexamethasone on nausea and vomiting after laparoscopic cholecystectomy: a systematic review and meta-analysis. *Ann Surg* 2008;**248**(5):751–62.
104. Habib AS, El-Moalem HE, Gan TJ. The efficacy of the 5-HT₃ receptor antagonists combined with droperidol for PONV prophylaxis is similar to their combination with dexamethasone. A meta-analysis of randomized controlled trials. *Can J Anaesth* 2004;**51**(4):311–9.
105. Gan TJ, Apfel CC, Kovac A, Philip BK, Singla N, Minkowitz H, et al. A randomized, double-blind comparison of the NK1 antagonist, aprepitant, versus ondansetron for the prevention of postoperative nausea and vomiting. *Anesth Analg* 2007;**104**(5):1082–9. tables of contents.
106. Abraham NS, Young JM, Solomon MJ. Meta-analysis of short-term outcomes after laparoscopic resection for colorectal cancer. *Br J Surg* 2004;**91**(9):1111–24.
107. Schwenk W, Kehlet H. Meta-analysis of short-term outcomes after laparoscopic resection for colorectal cancer (Br J Surg 2004; 91: 1111–1124). *Br J Surg* 2004;**91**(12):1653–4.
108. Abraham NS, Byrne CM, Young JM, Solomon MJ. Meta-analysis of non-randomized comparative studies of the short-term outcomes of laparoscopic resection for colorectal cancer. *ANZ J Surg* 2007;**77**(7):508–16.
109. Tjandra JJ, Chan MK. Systematic review on the short-term outcome of laparoscopic resection for colon and rectosigmoid cancer. *Colorectal Dis* 2006;**8**(5):375–88.
110. Kennedy GD, Heise C, Rajamanickam V, Harms B, Foley EF. Laparoscopy decreases postoperative complication rates after abdominal colectomy: results from the national surgical quality improvement program. *Ann Surg* 2009;**249**(4):596–601.
111. Vlug MS, Wind J, Hollmann MW, Ubbink DT, Cense HA, Engel AF, et al. Laparoscopy in combination with fast track multimodal management is the best perioperative strategy in patients undergoing colonic surgery: a randomized clinical trial (LAFAS-study). *Ann Surg* 2011;**254**(6):868–75.
112. Lacy AM, Garcia-Valdecasas JC, Delgado S, Castells A, Taura P, Pique JM, et al. Laparoscopy-assisted colectomy versus open colectomy for treatment of non-metastatic colon cancer: a randomised trial. *Lancet* 2002;**359**(9325):2224–9.

113. A comparison of laparoscopically assisted and open colectomy for colon cancer. *N Engl J Med* 2004;**350**(20):2050–9.
114. Leung KL, Kwok SP, Lam SC, Lee JF, Yiu RY, Ng SS, et al. Laparoscopic resection of rectosigmoid carcinoma: prospective randomised trial. *Lancet* 2004;**363**(9416):1187–92.
115. Guillou PJ, Quirke P, Thorpe H, Walker J, Jayne DG, Smith AM, et al. Short-term endpoints of conventional versus laparoscopic-assisted surgery in patients with colorectal cancer (MRC CLASICC trial): multicentre, randomised controlled trial. *Lancet* 2005;**365**(9472):1718–26.
116. Veldkamp R, Kuhry E, Hop WC, Jeekel J, Kazemier G, Bonjer HJ, et al. Laparoscopic surgery versus open surgery for colon cancer: short-term outcomes of a randomised trial. *Lancet Oncol* 2005;**6**(7):477–84.
117. Basse L, Jakobsen DH, Bardram L, Billesbolle P, Lund C, Mogensen T, et al. Functional recovery after open versus laparoscopic colonic resection: a randomized, blinded study. *Ann Surg* 2005;**241**(3):416–23.
118. King PM, Blazeby JM, Ewings P, Franks PJ, Longman RJ, Kendrick AH, et al. Randomized clinical trial comparing laparoscopic and open surgery for colorectal cancer within an enhanced recovery programme. *Br J Surg* 2006;**93**(3):300–8.
119. Buchanan GN, Malik A, Parvaiz A, Sheffield JP, Kennedy RH. Laparoscopic resection for colorectal cancer. *Br J Surg* 2008;**95**(7):893–902.
120. Leong QM, Kim SH. Robot-assisted rectal surgery for malignancy: a review of current literature. *Ann Acad Med Singap* 2011;**40**(10):460–6.
121. Chen WT, Chang SC, Chiang HC, Lo WY, Jeng LB, Wu C, et al. Single-incision laparoscopic versus conventional laparoscopic right hemicolectomy: a comparison of short-term surgical results. *Surg Endosc* 2011;**25**(6):1887–92.
122. Moloo H, Haggar F, Coyle D, Hutton B, Duhaime S, Mamazza J, et al. Hand assisted laparoscopic surgery versus conventional laparoscopy for colorectal surgery. *Cochrane Database Syst Rev* 2010;(10). CD006585.
123. O'Dwyer PJ, McGregor JR, McDermott EW, Murphy JJ, O'Higgins NJ. Patient recovery following cholecystectomy through a 6 cm or 15 cm transverse subcostal incision: a prospective randomized clinical trial. *Postgrad Med J* 1992;**68**(804):817–9.
124. Laurent C, Leblanc F, Bretagnol F, Capdepon M, Rullier E. Long-term wound advantages of the laparoscopic approach in rectal cancer. *Br J Surg* 2008;**95**(7):903–8.
125. Cheatham ML, Chapman WC, Key SP, Sawyers JL. A meta-analysis of selective versus routine nasogastric decompression after elective laparotomy. *Ann Surg* 1995;**221**(5):469–76. discussion 476–8.
126. Nelson R, Tse B, Edwards S. Systematic review of prophylactic nasogastric decompression after abdominal operations. *Br J Surg* 2005;**92**(6):673–80.
127. Rao W, Zhang X, Zhang J, Yan R, Hu Z, Wang Q. The role of nasogastric tube in decompression after elective colon and rectum surgery: a meta-analysis. *Int J Colorectal Dis* 2011;**26**(4):423–9.
128. Kurz A, Sessler DI, Lenhardt R. Perioperative normothermia to reduce the incidence of surgical-wound infection and shorten hospitalization. Study of Wound Infection and Temperature Group. *N Engl J Med* 1996;**334**(19):1209–15.
129. Scott EM, Buckland R. A systematic review of intraoperative warming to prevent postoperative complications. *AORN J* 2006;**83**(5):1090–104. 1107–1113.
130. Frank SM, Fleisher LA, Breslow MJ, Higgins MS, Olson KF, Kelly S, et al. Perioperative maintenance of normothermia reduces the incidence of morbid cardiac events. A randomized clinical trial. *JAMA* 1997;**277**(14):1127–34.
131. Schmied H, Kurz A, Sessler DI, Kozek S, Reiter A. Mild hypothermia increases blood loss and transfusion requirements during total hip arthroplasty. *Lancet* 1996;**347**(8997):289–92.
132. Camus Y, Delva E, Cohen S, Lienhart A. The effects of warming intravenous fluids on intraoperative hypothermia and postoperative shivering during prolonged abdominal surgery. *Acta Anaesthesiol Scand* 1996;**40**(7):779–82.
133. De Witte JL, Demeyer C, Vandemaele E. Resistive-heating or forced-air warming for the prevention of redistribution hypothermia. *Anesth Analg* 2010;**110**(3):829–33.
134. Andrzejowski J, Hoyle J, Eapen G, Turnbull D. Effect of prewarming on post-induction core temperature and the incidence of inadvertent perioperative hypothermia in patients undergoing general anaesthesia. *Br J Anaesth* 2008;**101**(5):627–31.
135. Galvao CM, Marck PB, Sawada NO, Clark AM. A systematic review of the effectiveness of cutaneous warming systems to prevent hypothermia. *J Clin Nurs* 2009;**18**(5):627–36.
136. Wong PF, Kumar S, Bohra A, Whetter D, Leaper DJ. Randomized clinical trial of perioperative systemic warming in major elective abdominal surgery. *Br J Surg* 2007;**94**(4):421–6.
137. Birch DW, Manouchehri N, Shi X, Hadi G, Karmali S. Heated CO₂ with or without humidification for minimally invasive abdominal surgery. *Cochrane Database Syst Rev* 2011;(1). CD007821.
138. Varadhan KK, Lobo DN. A meta-analysis of randomised controlled trials of intravenous fluid therapy in major elective open abdominal surgery: getting the balance right. *Proc Nutr Soc* 2010;**69**(4):488–98.
139. Levy BF, Fawcett WJ, Scott MJ, Rockall TA. Intra-operative oxygen delivery in infusion volume optimized patients undergoing laparoscopic colorectal surgery within an enhanced recovery programme: the effect of different analgesic modalities. *Colorectal Dis* 2012;**14**(7):887–92.
140. Bundgaard-Nielsen M, Secher NH, Kehlet H. 'Liberal' vs. 'restrictive' peri-operative fluid therapy—a critical assessment of the evidence. *Acta Anaesthesiol Scand* 2009;**53**(7):843–51.
141. Giglio MT, Marucci M, Testini M, Brienza N. Goal-directed haemodynamic therapy and gastrointestinal complications in major surgery: a meta-analysis of randomized controlled trials. *Br J Anaesth* 2009;**103**(5):637–46.
142. Senagore AJ, Emery T, Luchtefeld M, Kim D, Dujovny N, Hoedema R. Fluid management for laparoscopic colectomy: a prospective, randomized assessment of goal-directed administration of balanced salt solution or hetastarch coupled with an enhanced recovery program. *Dis Colon Rectum* 2009;**52**(12):1935–40.
143. Marik PE, Cavallazzi R, Vasu T, Hirani A. Dynamic changes in arterial waveform derived variables and fluid responsiveness in mechanically ventilated patients: a systematic review of the literature. *Crit Care Med* 2009;**37**(9):2642–7.
144. Futier E, Constantin JM, Petit A, Chanques G, Kwiatkowski F, Flamein R, et al. Conservative vs restrictive individualized goal-directed fluid replacement strategy in major abdominal surgery: a prospective randomized trial. *Arch Surg* 2010;**145**(12):1193–200.
145. Pearse R, Dawson D, Fawcett J, Rhodes A, Grounds RM, Bennett ED. Changes in central venous saturation after major surgery, and association with outcome. *Crit Care* 2005;**9**(6):R694–9.
146. Holte K, Foss NB, Svensen C, Lund C, Madsen JL, Kehlet H. Epidural anesthesia, hypotension, and changes in intravascular volume. *Anesthesiology* 2004;**100**(2):281–6.
147. Soni N. British consensus guidelines on intravenous fluid therapy for adult surgical patients (GIFTASUP): Cassandra's view. *Anaesthesia* 2009;**64**(3):235–8.
148. Petrowsky H, Demartines N, Rousson V, Clavien PA. Evidence-based value of prophylactic drainage in gastrointestinal surgery: a systematic review and meta-analyses. *Ann Surg* 2004;**240**(6):1074–84. discussion 1084–5.
149. Karliczek A, Jesus EC, Matos D, Castro AA, Atallah AN, Wiggers T. Drainage or nondrainage in elective colorectal anastomosis: a systematic review and meta-analysis. *Colorectal Dis* 2006;**8**(4):259–65.
150. Urbach DR, Kennedy ED, Cohen MM. Colon and rectal anastomoses do not require routine drainage: a systematic review and meta-analysis. *Ann Surg* 1999;**229**(2):174–80.
151. Alpert RA, Roizen MF, Hamilton WK, Stoney RJ, Ehrenfeld WK, Poler SM, et al. Intraoperative urinary output does not predict postoperative renal function in patients undergoing abdominal aortic revascularization. *Surgery* 1984;**95**(6):707–11.
152. Kheterpal S, Tremper KK, Englesbe MJ, O'Reilly M, Shanks AM, Fetterman DM, et al. Predictors of postoperative acute renal failure after noncardiac surgery in patients with previously normal renal function. *Anesthesiology* 2007;**107**(6):892–902.
153. Zaouter C, Kaneva P, Carli F. Less urinary tract infection by earlier removal of bladder catheter in surgical patients receiving thoracic epidural analgesia. *Reg Anesth Pain Med* 2009;**34**(6):542–8.
154. Basse L, Werner N, Kehlet H. Is urinary drainage necessary during continuous epidural analgesia after colonic resection? *Reg Anesth Pain Med* 2000;**25**(5):498–501.
155. McPhail MJ, Abu-Hilal M, Johnson CD. A meta-analysis comparing suprapubic and transurethral catheterization for bladder drainage after abdominal surgery. *Br J Surg* 2006;**93**(9):1038–44.
156. Miedema BW, Johnson JO. Methods for decreasing postoperative gut dysmotility. *Lancet Oncol* 2003;**4**(6):365–72.
157. Marret E, Remy C, Bonnet F. Meta-analysis of epidural analgesia versus parenteral opioid analgesia after colorectal surgery. *Br J Surg* 2007;**94**(6):665–73.
158. Nisanevich V, Felsenstein I, Almog G, Weissman C, Einav S, Matot I. Effect of intraoperative fluid management on outcome after intraabdominal surgery. *Anesthesiology* 2005;**103**(1):25–32.
159. Lobo DN, Bostock KA, Neal KR, Perkins AC, Rowlands BJ, Allison SP. Effect of salt and water balance on recovery of gastrointestinal function after elective colonic resection: a randomised controlled trial. *Lancet* 2002;**359**(9320):1812–8.
160. Hansen CT, Sorensen M, Moller C, Ottesen B, Kehlet H. Effect of laxatives on gastrointestinal functional recovery in fast-track hysterectomy: a double-blind, placebo-controlled randomized study. *Am J Obstet Gynecol* 2007;**196**(4):311.e1–7.
161. Basse L, Madsen JL, Kehlet H. Normal gastrointestinal transit after colonic resection using epidural analgesia, enforced oral nutrition and laxative. *Br J Surg* 2001;**88**(11):1498–500.
162. Hendry PO, van Dam RM, Bukkems SF, McKeown DW, Parks RW, Preston T, et al. Randomized clinical trial of laxatives and oral nutritional supplements within an enhanced recovery after surgery protocol following liver resection. *Br J Surg* 2010;**97**(8):1198–206.
163. Andersen J, Christensen H, Pachler JH, Hallin M, Thaysen HV, Kehlet H. Effect of the laxative magnesium oxide on gastrointestinal functional recovery in fast-track colonic resection: a double-blind, placebo-controlled randomized study. *Colorectal Dis* 2012;**14**(6):776–82.
164. Zingg U, Miskovic D, Pasternak I, Meyer P, Hamel CT, Metzger U. Effect of bisacodyl on postoperative bowel motility in elective colorectal surgery: a prospective, randomized trial. *Int J Colorectal Dis* 2008;**23**(12):1175–83.
165. Delaney CP, Wolff BG, Viscusi ER, Senagore AJ, Fort JG, Du W, et al. Alvimopan, for postoperative ileus following bowel resection: a pooled analysis of phase III studies. *Ann Surg* 2007;**245**(3):355–63.

166. Chan MK, Law WL. Use of chewing gum in reducing postoperative ileus after elective colorectal resection: a systematic review. *Dis Colon Rectum* 2007;**50**(12):2149–57.
167. Veenhof AA, Vlug MS, van der Pas MH, Sietsma C, van der Peet DL, de Lange-de Klerk ES, et al. Surgical stress response and postoperative immune function after laparoscopy or open surgery with fast track or standard perioperative care: a randomized trial. *Ann Surg* 2012;**255**(2):216–21.
168. Neudecker J, Schwenk W, Junghans T, Pietsch S, Böhm B, Müller JM. Randomized controlled trial to examine the influence of thoracic epidural analgesia on postoperative ileus after laparoscopic sigmoid resection. *Br J Surg* 1999;**86**(10):1292–5.
169. Taqi A, Hong X, Mistràletti G, Stein B, Charlebois P, Carli F. Thoracic epidural analgesia facilitates the restoration of bowel function and dietary intake in patients undergoing laparoscopic colon resection using a traditional, nonaccelerated, perioperative care program. *Surg Endosc* 2007;**21**(2):247–52.
170. Senagore AJ, Delaney CP, Mekhail N, Dugan A, Fazio VW. Randomized clinical trial comparing epidural anaesthesia and patient-controlled analgesia after laparoscopic segmental colectomy. *Br J Surg* 2003;**90**(10):1195–9.
171. Virlos I, Clements D, Beynon J, Ratnalikar V, Khot U. Short-term outcomes with intrathecal versus epidural analgesia in laparoscopic colorectal surgery. *Br J Surg* 2010;**97**(9):1401–6.
172. Zafar N, Davies R, Greenslade GL, Dixon AR. The evolution of analgesia in an 'accelerated' recovery programme for resectional laparoscopic colorectal surgery with anastomosis. *Colorectal Dis* 2010;**12**(2):119–24.
173. Klein M, Andersen LP, Harvald T, Rosenberg J, Gogenur I. Increased risk of anastomotic leakage with diclofenac treatment after laparoscopic colorectal surgery. *Dig Surg* 2009;**26**(1):27–30.
174. Klein M, Gogenur I, Rosenberg J. [Risk of anastomotic leakage in postoperative treatment with non-steroidal anti-inflammatory drugs]. *Ugeskr Laeger* 2010;**172**(22):1660–2.
175. Holte K, Andersen J, Jakobsen DH, Kehlet H. Cyclo-oxygenase 2 inhibitors and the risk of anastomotic leakage after fast-track colonic surgery. *Br J Surg* 2009;**96**(6):650–4.
176. Gorissen KJ, Benning D, Berghmans T, Snoeijis MG, Sosef MN, Hulsewe KW, et al. Risk of anastomotic leakage with non-steroidal anti-inflammatory drugs in colorectal surgery. *Br J Surg* 2012;**99**(5):721–7.
177. Hendry PO, Hausel J, Nygren J, Lassen K, Dejong CH, Ljungqvist O, et al. Determinants of outcome after colorectal resection within an enhanced recovery programme. *Br J Surg* 2009;**96**(2):197–205.
178. Smedley F, Bowling T, James M, Stokes E, Goodger C, O'Connor O, et al. Randomized clinical trial of the effects of preoperative and postoperative oral nutritional supplements on clinical course and cost of care. *Br J Surg* 2004;**91**(8):983–90.
179. Fearon KC, Luff R. The nutritional management of surgical patients: enhanced recovery after surgery. *Proc Nutr Soc* 2003;**62**(4):807–11.
180. Henriksen MG, Hansen HV, Hessel I. Early oral nutrition after elective colorectal surgery: influence of balanced analgesia and enforced mobilization. *Nutrition* 2002;**18**(3):263–7.
181. Soop M, Carlson GL, Hopkinson J, Clarke S, Thorell A, Nygren J, et al. Randomized clinical trial of the effects of immediate enteral nutrition on metabolic responses to major colorectal surgery in an enhanced recovery protocol. *Br J Surg* 2004;**91**(9):1138–45.
182. Beattie AH, Prach AT, Baxter JP, Pennington CR. A randomised controlled trial evaluating the use of enteral nutritional supplements postoperatively in malnourished surgical patients. *Gut* 2000;**46**(6):813–8.
183. Waitzberg DL, Saito H, Plank LD, Jamieson GG, Jagannath P, Hwang TL, et al. Postsurgical infections are reduced with specialized nutrition support. *World J Surg* 2006;**30**(8):1592–604.
184. Geerling BJ, Badart-Smoock A, Stockbrugger RW, Brummer RJ. Comprehensive nutritional status in patients with long-standing Crohn disease currently in remission. *Am J Clin Nutr* 1998;**67**(5):919–26.
185. Payette H, Gray-Donald K. Dietary intake and biochemical indices of nutritional status in an elderly population, with estimates of the precision of the 7-d food record. *Am J Clin Nutr* 1991;**54**(3):478–88.
186. Kehlet H. Multimodal approach to control postoperative pathophysiology and rehabilitation. *Br J Anaesth* 1997;**78**(5):606–17.
187. Gianotti L, Braga M, Nespoli L, Radaelli G, Beneduce A, Di Carlo V. A randomized controlled trial of preoperative oral supplementation with a specialized diet in patients with gastrointestinal cancer. *Gastroenterology* 2002;**122**(7):1763–70.
188. Gustafsson UO, Thorell A, Soop M, Ljungqvist O, Nygren J. Haemoglobin A1c as a predictor of postoperative hyperglycaemia and complications after major colorectal surgery. *Br J Surg* 2009;**96**(11):1358–64.
189. Nygren J, Soop M, Thorell A, Hausel J, Ljungqvist O. An enhanced-recovery protocol improves outcome after colorectal resection already during the first year: a single-center experience in 168 consecutive patients. *Dis Colon Rectum* 2009;**52**(5):978–85.
190. Hannemann P, Lassen K, Hausel J, Nimmo S, Ljungqvist O, Nygren J, et al. Patterns in current anaesthesiological peri-operative practice for colonic resections: a survey in five northern-European countries. *Acta Anaesthesiol Scand* 2006;**50**(9):1152–60.
191. Lewis SJ, Egger M, Sylvester PA, Thomas S. Early enteral feeding versus 'nil by mouth' after gastrointestinal surgery: systematic review and meta-analysis of controlled trials. *BMJ* 2001;**323**(7316):773–6.
192. Han-Geurts IJ, Hop WC, Kok NF, Lim A, Brouwer KJ, Jeekel J. Randomized clinical trial of the impact of early enteral feeding on postoperative ileus and recovery. *Br J Surg* 2007;**94**(5):555–61.
193. Marimuthu K, Varadhan KK, Ljungqvist O, Lobo DN. A meta-analysis of the effect of combinations of immune modulating nutrients on outcome in patients undergoing major open gastrointestinal surgery. *Ann Surg* 2012;**255**(6):1060–8.
194. Drover JW, Dhaliwal R, Weitzel L, Wischmeyer PE, Ochoa JB, Heyland DK. Perioperative use of arginine-supplemented diets: a systematic review of the evidence. *J Am Coll Surg* 2011;**212**(3):385–99. 399 e1.
195. Sato H, Carvalho G, Sato T, Lattermann R, Matsukawa T, Schrickler T. The association of preoperative glycemic control, intraoperative insulin sensitivity, and outcomes after cardiac surgery. *J Clin Endocrinol Metab* 2010;**95**(9):4338–44.
196. Ljungqvist O. Insulin resistance and outcomes in surgery. *J Clin Endocrinol Metab* 2010;**95**(9):4217–9.
197. Ljungqvist O, Jonathan E. Rhoads lecture 2011: insulin resistance and enhanced recovery after surgery. *JPN J Parenter Enteral Nutr* 2012;**36**(4):389–98.
198. van den Berghe G, Wouters P, Weekers F, Verwaest C, Bruyninckx F, Schetz M, et al. Intensive insulin therapy in the critically ill patients. *N Engl J Med* 2001;**345**(19):1359–67.
199. Finfer S, Chittock DR, Su SY, Blair D, Foster D, Dhingra V, et al. Intensive versus conventional glucose control in critically ill patients. *N Engl J Med* 2009;**360**(13):1283–97.
200. Furnary AP, Zerr KJ, Grunkemeier GL, Starr A. Continuous intravenous insulin infusion reduces the incidence of deep sternal wound infection in diabetic patients after cardiac surgical procedures. *Ann Thorac Surg* 1999;**67**(2):352–60. discussion 360–2.
201. Krinsley JS. Effect of an intensive glucose management protocol on the mortality of critically ill adult patients. *Mayo Clin Proc* 2004;**79**(8):992–1000.
202. Van den Berghe G, Schetz M, Vlasselaers D, Hermans G, Wilmer A, Bouillon R, et al. Clinical review: intensive insulin therapy in critically ill patients: NICE-SUGAR or Leuven blood glucose target? *J Clin Endocrinol Metab* 2009;**94**(9):1363–70.
203. Henriksen MG, Jensen MB, Hansen HV, Jespersen TW, Hessel I. Enforced mobilization, early oral feeding, and balanced analgesia improve convalescence after colorectal surgery. *Nutrition* 2002;**18**(2):147–52.
204. Houborg KB, Jensen MB, Hessel I, Laurberg S. Little effect of physical training on body composition and nutritional intake following colorectal surgery—a randomised placebo-controlled trial. *Eur J Clin Nutr* 2005;**59**(8):969–77.
205. Jensen MB, Houborg KB, Norager CB, Henriksen MG, Laurberg S. Postoperative changes in fatigue, physical function and body composition: an analysis of the amalgamated data from five randomized trials on patients undergoing colorectal surgery. *Colorectal Dis* 2011;**13**(5):588–93.
206. Convertino VA. Cardiovascular consequences of bed rest: effect on maximal oxygen uptake. *Med Sci Sports Exerc* 1997;**29**(2):191–6.
207. Smart NJ, White P, Allison AJ, Okcirm J, Kennedy RH, Francis NK. Deviation and failure of Enhanced Recovery After Surgery (ERAS) following laparoscopic colorectal surgery: early prediction model. *Colorectal Dis* 2012;**14**(10):e727–34.
208. Jamtvedt G, Young JM, Kristoffersen DT, O'Brien MA, Oxman AD. Audit and feedback: effects on professional practice and health care outcomes. *Cochrane Database Syst Rev* 2006;(2). CD000259.
209. Gustafsson UO, Hausel J, Thorell A, Ljungqvist O, Soop M, Nygren J. Adherence to the enhanced recovery after surgery protocol and outcomes after colorectal cancer surgery. *Arch Surg* 2011;**146**(5):571–7.
210. Wind J, Polle SW, Fung Kon Jin PH, Dejong CH, von Meyenfeldt MF, Ubbink DT, et al. Systematic review of enhanced recovery programmes in colonic surgery. *Br J Surg* 2006;**93**(7):800–9.
211. Eskicioglu C, Forbes SS, Aarts MA, Okrainec A, McLeod RS. Enhanced recovery after surgery (ERAS) programs for patients having colorectal surgery: a meta-analysis of randomized trials. *J Gastrointest Surg* 2009;**13**(12):2321–9.
212. Walter CJ, Collin J, Dumville JC, Drew PJ, Monson JR. Enhanced recovery in colorectal resections: a systematic review and meta-analysis. *Colorectal Dis* 2009;**11**(4):344–53.
213. Varadhan KK, Neal KR, Dejong CH, Fearon KC, Ljungqvist O, Lobo DN. The enhanced recovery after surgery (ERAS) pathway for patients undergoing major elective open colorectal surgery: a meta-analysis of randomized controlled trials. *Clin Nutr* 2010;**29**(4):434–40.
214. Khan S, Wilson T, Ahmed J, Owais J, MacFie J. Quality of life and patient satisfaction with enhanced recovery protocols. *Colorectal Dis* 2010;**12**(12):1175–82.
215. Vlug MS, Bartels SA, Wind J, Ubbink DT, Hollmann MW, Bemelman WA. Which fast track elements predict early recovery after colon cancer surgery? *Colorectal Dis* 2012;**14**(8):1001–8.
216. Maessen J, Dejong CH, Hausel J, Nygren J, Lassen K, Andersen J, et al. A protocol is not enough to implement an enhanced recovery programme for colorectal resection. *Br J Surg* 2007;**94**(2):224–31.
217. Kehlet H, Wilmor DW. Multimodal strategies to improve surgical outcome. *Am J Surg* 2002;**183**(6):630–41.
218. Basse L, Thorbol JE, Lossl K, Kehlet H. Colonic surgery with accelerated rehabilitation or conventional care. *Dis Colon Rectum* 2004;**47**(3):271–7. discussion 277–8.

219. Stephen AE, Berger DL. Shortened length of stay and hospital cost reduction with implementation of an accelerated clinical care pathway after elective colon resection. *Surgery* 2003;**133**(3):277–82.
220. Delaney CP, Fazio VW, Senagore AJ, Robinson B, Halverson AL, Remzi FH. 'Fast track' postoperative management protocol for patients with high comorbidity undergoing complex abdominal and pelvic colorectal surgery. *Br J Surg* 2001;**88**(11):1533–8.
221. Anderson AD, McNaught CE, MacFie J, Tring I, Barker P, Mitchell CJ. Randomized clinical trial of multimodal optimization and standard peri-operative surgical care. *Br J Surg* 2003;**90**(12):1497–504.
222. DiFronzo LA, Yamin N, Patel K, O'Connell TX. Benefits of early feeding and early hospital discharge in elderly patients undergoing open colon resection. *J Am Coll Surg* 2003;**197**(5):747–52.
223. Spanjersberg WR, Reurings J, Keus F, van Laarhoven CJ. Fast track surgery versus conventional recovery strategies for colorectal surgery. *Cochrane Database Syst Rev* 2011;(2). CD007635.
224. Gatt M, Anderson AD, Reddy BS, Hayward-Sampson P, Tring IC, MacFie J. Randomized clinical trial of multimodal optimization of surgical care in patients undergoing major colonic resection. *Br J Surg* 2005;**92**(11):1354–62.
225. Delaney CP, Zutshi M, Senagore AJ, Remzi FH, Hammel J, Fazio VW. Prospective, randomized, controlled trial between a pathway of controlled rehabilitation with early ambulation and diet and traditional postoperative care after laparotomy and intestinal resection. *Dis Colon Rectum* 2003;**46**(7):851–9.
226. Adamina M, Kehlet H, Tomlinson GA, Senagore AJ, Delaney CP. Enhanced recovery pathways optimize health outcomes and resource utilization: a meta-analysis of randomized controlled trials in colorectal surgery. *Surgery* 2011;**149**(6):830–40.
227. King PM, Blazeby JM, Ewings P, Longman RJ, Kipling RM, Franks PJ, et al. The influence of an enhanced recovery programme on clinical outcomes, costs and quality of life after surgery for colorectal cancer. *Colorectal Dis* 2006;**8**(6):506–13.
228. Sammour T, Zargar-Shoshtari K, Bhat A, Kahokehr A, Hill AG. A programme of Enhanced Recovery After Surgery (ERAS) is a cost-effective intervention in elective colonic surgery. *N Z Med J* 2010;**123**(1319):61–70.
229. Zargar-Shoshtari K, Paddison JS, Booth RJ, Hill AG. A prospective study on the influence of a fast-track program on postoperative fatigue and functional recovery after major colonic surgery. *J Surg Res* 2009;**154**(2):330–5.
230. Jakobsen DH, Sonne E, Andreassen J, Kehlet H. Convalescence after colonic surgery with fast-track vs conventional care. *Colorectal Dis* 2006;**8**(8):683–7.
231. Delaney CP, Lindsetmo RO, O'Brien-Ermlich B, Cheruvu VK, Laughinghouse M, Champagne B, et al. Validation of a novel postoperative quality-of-life scoring system. *Am J Surg* 2009;**197**(3):382–5.
232. Liefvers JR, Bathe OF, Fassbender K, Winget M, Baracos VE. Sarcopenia is associated with postoperative infection and delayed recovery from colorectal cancer resection surgery. *Br J Cancer* 2012;**107**(6):931–6.