The Canadian Gynaecologic Oncology Perioperative Management Survey: Baseline Practice Prior to Implementation of Enhanced Recovery After Surgery (ERAS) Society Guidelines

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Abstract

Objective: To survey the current practice of Society of Gynecologic Oncology of Canada (GOC) members about preoperative, intraoperative, and postoperative phases of care. The survey was carried out prior to publication of the Enhanced Recovery After Surgery (ERAS) Society gynaecologic/oncology guidelines.

Methods: A survey was developed by the GOC and distributed to all surgical members between September and December 2015.

Results: The survey was completed by 77 of 92 practising gynaecologic oncologists (84%), representing 19 centres in 16 cities across Canada. Only 14.3% of respondents counselled their patients to stop smoking and drinking four weeks before surgery, while 41.6% routinely counselled patients to stop taking oral contraceptive pills. Approximately half of respondents (44.7%) prescribed preoperative mechanical bowel preparation. Over two thirds (67.5%) asked their patients not to eat solid foods after midnight on the day of surgery, and 19.5% recommended carbohydrate loading. Venous thromboembolism prophylaxis was given prior to laparotomy by 85.7% of participants overall, and by 67.6% prior to laparoscopy. The majority of respondents did not routinely use nasogastric tubes or intra-abdominal drains. The preferred modality for postoperative pain control after laparotomy was patient-controlled analgesia with narcotics (66.2%); only 29.9% chose epidural analgesia. Over half of respondents (56.6%) prescribed a progressive diet after surgery, while 42.1% recommended starting on an immediate standard diet postoperatively.

Conclusion: The responses to this survey show wide variations in practice in the perioperative phases of surgical care. Implementation of the ERAS Society gynaecologic/oncology guidelines should help integrate evidence-based knowledge into practice, align perioperative care, and minimize practice variations, resulting in improved outcomes for patients.

Key Words: Enhanced recovery, evidence-based perioperative care

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Résumé

Objectif : Rendre compte, à l'aide d'un sondage, des pratiques actuelles des membres de la Société de gynéco-oncologie du Canada (GOC) pendant les périodes préopératoire, peropératoire et postopératoire. Le sondage a été mené avant la publication des lignes directrices de l'ERAS Society (Enhanced Recovery After Surgery – récupération postchirurgicale améliorée) en matière de gynécologie et d'oncologie.

Méthodologie : Un sondage a été élaboré par la GOC, puis distribué à tous les membres pratiquant la chirurgie, entre septembre et décembre 2015.

Résultats : Le sondage a été rempli par 77 des 92 gynécologues oncologues en exercice (84 %) de la GOC. Les répondants travaillaient dans 19 centres différents situés dans 16 villes canadiennes. Seuls 14,3 % d'entre eux recommandaient d'arrêter de fumer et de consommer de l'alcool quatre semaines avant la chirurgie, et 41,6 % recommandaient couramment de cesser la prise de contraceptifs oraux. Environ la moitié des répondants (44,7 %) prescrivaient une préparation mécanique de l'intestin. Plus des deux tiers (67,5 %) demandaient d'éviter les aliments solides le jour de la chirurgie, à partir de minuit, et 19,5 % recommandaient une surcharge glucidique. En outre, 85,7 % des répondants ont dit administrer une thromboprophylaxie avant une laparotomie, et 67,6 %, avant une laparoscopie. La majorité n'utilisait pas systématiquement de sonde nasogastrique ou de drain intra-abdominal. Toujours selon notre sondage, la méthode de prise en charge de la douleur la plus répandue après une laparotomie était l'analgésie narcotique contrôlée par la patiente (66,2 %); seuls 29,9 % des gynécologues oncologues préféraient l'analgésie péridurale. Enfin, plus de la moitié des répondants (56,6 %) recommandaient

un retour progressif à l'alimentation normale après la chirurgie, tandis que 42,1 % recommandaient un retour immédiat.

Conclusion : Les réponses au sondage indiquent une grande variabilité des pratiques périopératoires. L'utilisation des lignes directrices en matière de gynécologie et d'oncologie de l'ERAS Society faciliterait l'application concrète des connaissances fondées sur des données probantes, uniformiserait la prestation de soins périopératoires et réduirait au minimum la variabilité des pratiques, ce qui améliorerait les résultats cliniques des patientes.

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INTRODUCTION

The advancement of evidence-based perioperative care protocols, such as those developed in conjunction with the Enhanced Recovery After Surgery Society, has resulted in an average reduction in length of hospital stay of 2.5 days and a 50% decrease in complications.[1,2] These benefits are achieved primarily through minimizing the stress response to surgery (with attempts to maintain normal physiology), enhancing mobilization after surgery, and speeding up functional recovery of bowel activity.[3] Use of enhanced recovery protocols has also resulted in cost savings that range between US$2806 and US$5898 per patient within colorectal surgery,[4] thereby achieving significant cost benefits to the health care system during times of economic constraint. To date, ERAS protocols have been published for colorectal, urological, pancreatic, and gastric surgeries[2,5–8] and most recently for gynaecologic/oncology surgery.[9,10]

The goal of standardizing perioperative care is to help ensure that all patients receive optimal treatment and, at the same time, decrease unnecessary interventions that may increase morbidity. With this in mind, the aim of our study was to survey the current practices of Society of Gynecologic Oncology of Canada members related to the preoperative, intraoperative, and postoperative phases of surgical care. This was done prior to publication of the ERAS Society gynaecologic/oncology guidelines to assess the baseline utilization of evidence-based perioperative protocols within Canada.

ABBREVIATIONS

ERAS	Enhanced Recovery After Surgery
GOC	Society of Gynecologic Oncology of Canada
VTE	Venous thromboembolism

METHODS

A survey was created and developed through the GOC Education Committee and the Communities of Practice forum. It was then distributed to all surgical gynaecologic oncology members of GOC between September and December 2015. All questions were developed based on the ERAS gynaecologic/oncology guidelines.[9,10] Specifically, this questionnaire focused on enhanced recovery strategies that could be more independently controlled by the surgeon (as opposed to those elements of perioperative care controlled by the anaesthesiologist). Survey participation was voluntary and several reminder emails were sent through a central communication system between September and December 2015. All responses were collected centrally at the GOC office and data were reported anonymously.

The questionnaire is provided in the online Appendix.

The study was screened with the Alberta Research Ethics Community Consensus Initiative ethics tool and was assigned a score of 0, indicating this to be a quality improvement/program evaluation study with no risk to patients. Ethics approval was therefore not required.

RESULTS

The survey was completed by 77 of 92 practising gynaecologic oncologists (an 84% response rate) representing 19 academic centres in 16 cities across Canada. Most practitioners worked at an academic centre (93.2%) and had been in practice less than 10 years (59.3%) (Table).

Only 14.3% of respondents indicated that they routinely counsel their patients to stop smoking and drinking alcohol four weeks prior to surgery. When asked about oral contraceptive pills, 41.6% routinely counselled patients to stop their use preoperatively, with 6.3% of respondents recommending stopping for one week, 34.4% for two to three weeks, and 59.4% for four weeks. Most respondents routinely administered prophylactic antibiotics 30-60 minutes preoperatively (94.8%), and 92.2% would give an additional dose for prolonged surgery. Use of a preoperative warming device was reported by 67.5% of respondents.

Approximately half of respondents prescribed preoperative mechanical bowel preparation (9.2% routinely, 35.5% occasionally), while the remaining half (55.3%) reported that they did not. The most commonly cited reasons for bowel preparation included planning debulking surgery, expected bowel surgery, planning laparoscopy, and planning