

Standardization of the Classification of Impaired Postoperative Gastric Function Within the Enhanced Recovery Pathways

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Colorectal surgery is currently one of the most common procedures performed in the United States.¹ One of the main factors contributing to morbidity and length of stay after colorectal surgery is return of gastrointestinal function. Once thought to be inevitable after colorectal surgery, ileus is now increasingly recognized to be a potentially preventable condition. Adoption of enhanced recovery pathways (ERPs), which include multimodal analgesia and judicious use of opioid analgesia, has been associated with a decrease in the incidence of postoperative ileus.^{2,3}

In this issue of *Anesthesia & Analgesia*, the American Society for Enhanced Recovery and Perioperative Quality Initiative (POQI) Joint Consensus Statement on Postoperative Gastrointestinal Dysfunction Within an Enhanced Recovery Pathway for Elective Colorectal Surgery present a framework by which we can define postoperative gastric dysfunction (POGD) and provide an evidence-based consensus statement with best practices to prevent and treat postoperative gastric dysfunction POGD.⁴

Comprised of a group of international experts in anesthesiology, nursing, nutrition, perioperative medicine, and surgery, the POQI initiative has already produced several evidence-based consensus recommendations on various ERP-related topics. In the current initiative, this POQI group of experts has advanced the field by developing a classification scheme that identifies the spectrum of impaired postoperative gastric function into 3 basic categories based on the newly created gastrointestinal (GI) tract scoring system based on the assessment of intake, feeling nauseated, emesis, physical exam, and duration of symptoms. The 3

categories proposed are: (1) normal, (2) postoperative GI intolerance (POGI), and (3) POGD.

This novel GI tract scoring system was devised to account for the clinical presentation, factors that affect management decisions, and levels of GI dysfunction that correlate with increased complications/costs. Ideally, the intake, feeling nauseated, emesis, physical exam, and duration of symptoms scoring system will provide a consistent objective definition of POGD. However, as noted by the authors, further testing for validity and reliability will need to be performed.

The POQI group has also made several evidence-based recommendations for the prevention of GI dysfunction. For example, the use of opioid-sparing analgesia, including regional analgesia techniques, to decrease POGD is a standard component of all ERPs.^{5,6} ERP programs may decrease the perioperative use of opioids and potentially facilitate the decreased prescribing of opioids on hospital discharge.^{7,8} Other evidence-supported measures to prevent POGD include maintenance of euvolemia, avoiding nasogastric tubes, and, when appropriate, the use of minimally invasive surgery.⁹⁻¹¹ Likewise, evidence supports recommending a risk-based strategy to prevent postoperative nausea and vomiting, the immediate resumption of oral intake, and use of gum chewing as an adjunct in promoting recovery of GI function.^{12,13} The POQI group also has recommended the use of alvimopan, but it should be noted that this would only be used if an opioid-based analgesic regimen were to be used. The potential benefits of this drug may be nonexistent in patients undergoing laparoscopic colectomy within an ERP utilizing multimodal analgesia.^{14,15}

With the current POQI group's consensus recommendations for preventing postoperative ileus, we must move beyond guideline development and publication and translate this evidence into practice, consistently, for every patient undergoing colorectal surgery in the United States. To do this, we need to develop integrated care delivery models for surgical patients that break down silos among surgery, nursing, anesthesia, pharmacy, and rehabilitation, among other disciplines, and foster an environment where evidence-based care is delivered by interdisciplinary teams partnered with and held accountable by senior leaders to always deliver the right, data-driven, evidence-based care to their patients.

To help accelerate this transition in surgical and perioperative care delivery, the American College of Surgeons and the Johns Hopkins Armstrong Institute for Patient Safety

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and Quality have launched the Improving Surgical Care and Recovery Program, funded and guided by the Agency for Healthcare Research and Quality. This 5-year national collaborative aims to enroll and support hospitals to implement perioperative pathways, in a sustainable way, that encompass the principles of enhanced recovery and best practices for surgical site infection, venous thromboembolism, and catheter-associated urinary tract infection in 5 procedure areas with colorectal, orthopedics, bariatrics, gynecology, and emergency general surgery. The principles set forth by the current POQI Consensus Statement can serve as a cornerstone for these pathways. Enrollment for the Improving Surgical Care and Recovery Program colorectal and orthopedics ERPs will begin in spring 2018, and we welcome all hospitals that want to commit to consistent evidence-based perioperative care to join us. ■■

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Contribution: This author helped in conception and design, analysis and interpretation of data, drafting of the article, critical revision of the article for important intellectual content.

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