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Preoperative Preparation in Colorectal Surgery

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1. Introduction

In August 1954 Robert J. Gosling Read said at the 59th Annual Convention of the National Medical Association, Washington, D.C. “...Through the personal knowledge of the patient’s life history and interest he (the good family physician) has offered advice based on common sense rather than specialized training. This is the concept of accelerated recovery...”

This was the first time in the literature the concept was used. Interesting enough, several points of today’s enhanced recovery are also common sense since all items are not evidence based. Evidence-based medicine is defined as the integration of best research evidence with clinical expertise and patient values to optimise clinical outcomes and quality of life.1

The concept returned in surgery in 1990. Krohn et al2 published from Good Samaritan Hospital in Los Angeles a four days discharge from hospital after open-heart surgery. He called it rapid sustained recovery. This was the first paper on enhanced recovery after surgery (ERAS).

In 1994 Hartford Hospital and Baystate Medical Center3 introduced the term “fast-track surgery” which included: 1: preoperative education, 2: early extubation, 3: methylprednisolone sodium succinate before surgery followed by dexamethasone for 24 hours postoperatively, 4: prophylactic digitalization, metoclopramide HCL, docusate sodium, and ranitidine HAL, 5: accelerated rehabilitation, 6: early discharge, 7: a dedicated fast-track coordinator to perform both daily telephone contact and a 1-week postoperative examination and 8: a routine 1-month postoperative visit with a PA or MD. This showed a systematically control of all patients and a multimodal focus to enhance the recovery time. But all the interventions were not evidence based and the study was an observational study.

Why didn’t the literature focus on recovery before1990?

One reason was that until the 1980’s the preoperative preparation was optimizing the organ function medically to tolerate the narcosis, bowel preparation to avoid anastigmatic leakage and infection and disinfection of the surgeons’ hands and the patients’ skin. There were no systematic antibiotics given, no thrombi-prophylaxis and no epidural anaesthetics.

Another reason was the lack of methodical trials and evidence based medicine on ancillary procedures. Variations in surgical procedures and peri-operative care have been recognised since the early 1980s and are generally interpreted as evidence of uncertainty among practitioners regarding optimal care.4 How different surgeons or hospitals provided the procedures varied enormously, leading to and “expertise bias”. They tended to be accepted.
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In recent years, significant progress in colorectal surgery has been made which includes laparoscopic techniques, pre-operative management, emergency colorectal surgery, fast track multimodal recovery, management of complex wound problems and colorectal cancer follow-up. “Contemporary Issues in Colorectal Surgical Practice” aims to bridge the gap between the journal article and the traditional textbook in these areas.

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