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Enhancing recovery: translating evidence into practice

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In this issue of the Malaysian Journal of Anaesthesiology, Kuang *et al.* report a retrospective case series of four bilateral breast reductions who received intertransverse plane block (ITP) incorporating morphine as an adjuvant as part of a multimodal analgesia strategy within the framework of Enhanced Recovery After Surgery (ERAS) protocol. The patients had better surgical pain outcomes, fewer opioid side effects, and reduced postoperative opioid doses with early mobilisation and better recovery. The authors also discussed an older case series of 18 breast reduction surgeries but without any regional block, resulting in a higher opioid requirement postoperatively.[1]

ERAS is a complex intervention of a multidisciplinary perioperative care pathway aimed at improving the recovery of patients undergoing surgery. This is achieved through the implementation of evidence-based practices with the objectives of reducing surgical stress and preserving homeostasis.[2]

The ERAS Society, a global non-profit professional organisation dedicated to the promotion, development, and implementation of ERAS programmes, issues updated surgery-specific guidelines. These guidelines reflect a paradigm shift in perioperative care, transitioning from overnight fasting to complex carbohydrate drinks two hours before surgery, favouring minimally invasive approaches over large incisions, optimising fluid balance rather than administering liberal intravenous fluids, and avoiding or expeditiously removing drains and tubes. Patients are encouraged to mobilise early and resume oral intake, often on the day of surgery. The impact has been substantial as demonstrated by reduced hospital length of stay by 30–50%, with parallel reductions in postoperative complications, readmission rates, and overall costs.[3]

The ERAS protocol described by the authors broadly aligns with the ERAS Society recommendations for breast reconstruction,[4] though early postoperative feeding was not explicitly addressed. Regarding the “balanced general anaesthesia”

employed by Kuang *et al.* to mitigate postoperative nausea and vomiting (PONV) and delirium, the precise anaesthetic technique remains undescribed. The ERAS Society consensus statement on anaesthesia recommends processed electroencephalography monitoring not only to prevent intraoperative awareness but also to guard against anaesthetic overdose, particularly in older patients, thereby facilitating prompt recovery. Total intravenous anaesthesia and opioid-sparing analgesic strategies are further emphasised as cornerstones of effective PONV prophylaxis.[5]

The intraoperative multimodal protocol adopted in the case series was the ITP block, intravenous dexamethasone, magnesium sulphate and ketamine, while the postoperative protocol was per oral paracetamol, tramadol, and celecoxib. In a recent meta-analysis on opioid-free versus opioid-inclusive anaesthesia with or without regional anaesthesia for postoperative pain, de Cavarlho *et al.* concluded regional anaesthesia was the primary factor in enhancing surgical pain management, while intraoperative opioids offered minimal supplementary advantage when regional methods ensured sufficient analgesia. In the absence of regional anaesthesia, neither opioid-free nor opioid-inclusive approaches demonstrated consistent analgesic superiority.[6]

The compliance of the subscribed ERAS protocols by Kuang *et al.* was not shared. The benefits of ERAS pathways are a result of the cumulative synergy of multiple components rather than any single element. Most ERAS protocols comprise 15–24 components spanning the preoperative, intraoperative, and postoperative continuum, and their effectiveness is directly proportional to the degree of protocol adherence. Unlike low compliance, robust adherence to ERAS standards has been consistently associated with shorter hospital stays and a lower incidence of postoperative complications.[7]

Successful implementation of ERAS, an inherently complex intervention, hinges on several interdependent enablers: identifying dedicated clinical champions, engaging multidisciplinary stakeholders, rigorously assessing and adapting protocols to local contexts, partnering with patients as active participants, delivering universal education across the healthcare workforce, and underpinning the entire programme with a robust audit and feedback infrastructure.[8]

The evidence supporting ERAS is both robust and compelling. The imperative now is not further deliberation, but decisive implementation.

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