5th ERAS UK Conference 2015

Chairs: Tom Wainwright Olle Ljungqvist, David McDonald

Presenter: Navraj Nagra

Olle Ljungqvist: Thank you very much a very interesting presentation. I was just wondering with the diversity of what people think is a programme, would you think a guideline would be useful in this case?

Navraj Nagra: We have seen is obviously with the 1000 patient working in Wales and obviously there is some very strong work being done Scotland, again England is lagging behind like we were in the rugby as well, but we have noticed that guidelines do help and they at least give you something to aim for, and I fully respect (I'm a doctor myself) a surgeon or doctors right to autonomy over their patient and how they treat their patients.

It is very good to have a guideline that summaries the evidence base, so you're not constantly having to look up the latest papers in addition to learning the latest surgical technique and having to attend management meetings, it's a never ending list of things that you have to do. It's good to have a guideline there, from someone like the ERAS society, which could potentially give people a default option.

David McDonald: Any other questions? Can I ask you a question? What is clear to me from your talk, I think, was that you said that only about between 40 and 50% adhere to a protocol, and obviously we know it's an evolving situation but despite that, the length of stay in those units were less than national average, is that because they picked out the bits that suit them?

Navraj Nagra: That's an excellent question, I think it's similar, you can make comparisons with (inaudible) talked about the WHO check list. Centres which just had a WHO checklist had less surgical complications. Whether they used it or not.

So it's almost if you have an enhance recovery programme in you centre it will reduce your length of stay. Whether that's because people are more minded or they're reminded more often that actually we need to be getting these patients up quicker, we need to be more aware of their pain, we need to be mobilising quicker, that remains to be seen.

We are still doing some data analysis and we are working to get a publication out, which identifies a few more areas and whether that 40% adhere is to the 40% that matters, so whether it's getting patients mobilises quicker, better pain relief and things like that. I hope that answers your questions?

David McDonald: I'm actually gobsmacked, that everyone in England does not now use tranexamic acid for knee replacements. I'm depressed!

? You were just 15 patient sample, so they are small numbers, you were doing secondary analysis from a prostheses trial and group is that right?

Navraj Nagra: So, yes as I mentioned the numbers are small so we are looking at 15 patients, but we are also looking national as well …, I've just presented data from 23 centres, but the actual whole study looks around 50 centres and some of the statistics are from that. What you can do and we have checked with statisticians that it is completely valid to be making some of the comparisons we have and to make some of the conclusions we have.

Tom Wainwright: I will just finish with one question which I think is interesting. The Danish team have recently published a systematic review about no evidence for reducing length of stay with pre-op education. Should I go being going back to Bournemouth tomorrow and saying should we be stopping our pre-op education group? I think there is no risk to our patients and my experience of ..???.. centres is that patient education is absolutely fundamental. Are you advising we don't have it?

Navraj Nagra: That's a completely valid point and an excellent question I'm glad you raised it. You have to considerer how much money we are spending on things like certain pre-op education programmes. So for instance there was one centre that has a sit down meetings of 5 patients around a table, a surgeon comes and sees them for 2 hours, a anaesthetist comes and sees them for 1 hour and a physio comes and sees them for a couple of hours.

It's a very resource heavy pre-op education system. Whether that money would be better spent in focusing or targeting your education to certain groups and having maybe more generic education tools that remains to be seen. Yes, I think there is definitely scope for a comparative trial to be done on that work.

David McDonald: I just wanted to go on to the pre-operative education because I presume the met analysis is the McDonald (inaudible) systematic review? In that, the vast majority of studies are all done in hip replacements, I think there are only 2 studies in it that are knee replacements and so the conclusion for knee replacements is slightly more positive in that systematic review.

Navraj Nagra: Which only looked at two new.

David McDonald: Yes, so again there is a lack of data for pre-operative education for knee replacements. I think we have to be careful when making statements about it, in most centres it is a very cost effective manner to look at reducing anxiety and laying expectations for patients. But it has to be considered with the evidence base that is out there.

Navraj Nagra: I absolutely agree, and that is why this is a good forum to do these things in, but I also think there is a potential increase use in analgesia as well in those patients and there are lots of studies that need to be done and potential a more cost effective way of teaching our patients what to expect and how to recover after their surgery.

? Thank you.