Implémentation d'un programme de réhabilitation ~~précoce, rapide,~~ améliorée après chirurgie

Recovery after laparoscopic colonic surgery with epidural analgesia, oral nutrition and mobilisation

L Bardram, P Funch-Jensen, P Jensen, M E Crawford, H Kehlet

Lancet 1995; **345:** 763

The first two patients in the programme were not discharged until day 3, despite having normal bowel function on day 2, because of logistic or personal problems. The next six patients followed the scheduled plan and went home on the 2nd postoperative day. 1 month postoperatively all patients were back to normal function. They were very satisifed with the entire perioperative course and all would recommend the procedure to others; no one felt they had been discharged too early.

Réduire l'agression chirurgicale

Chemin clinique en chirurgie colorectale

Préop

- Information
- Prep colique
- Prémedicat°
- Jeûne
- Liquide sucré
- Immuno-nutrition

Perop

- Apport liquid°
- Corticoïdes
- Hypothermie
- AB + Thrombo
- Prév NVPO
- Voie d'abord
- Drains SNG

Postop

- Analgésie multimodale
- Péridurale
- AINS (48H)
- Lever
- Sonde vésicale
- Alimentation

ELSEVIER MASSON

Disponible en ligne sur ScienceDirect www.sciencedirect.com

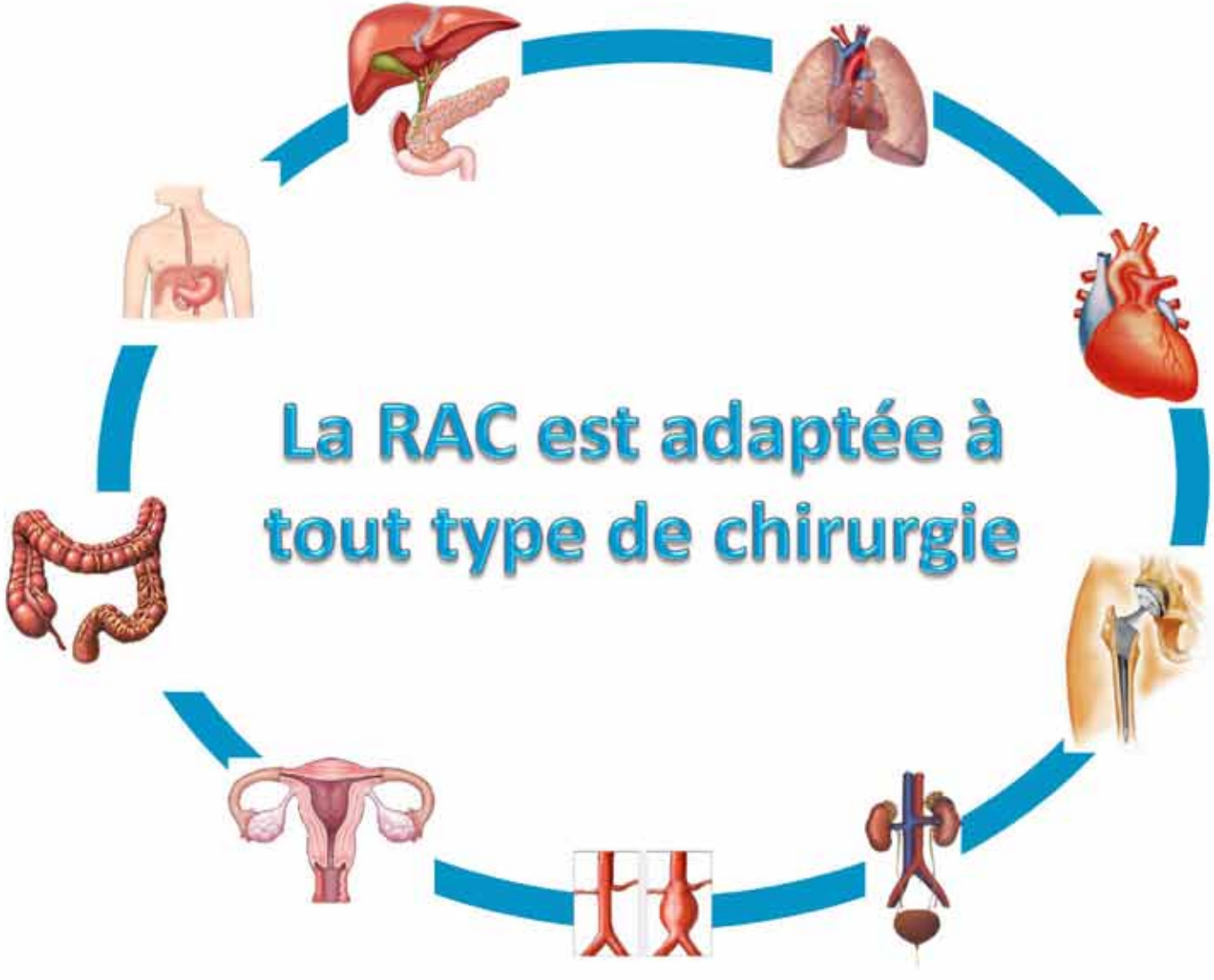
Elsevier Masson France EM|consulte www.em-consulte.com

RECOMMENDATIONS

Réhabilitation rapide après une chirurgie colorectale programmée☆

GRACE

La RAC est adaptée à tout type de chirurgie



Résultats

Séjour PO raccourci

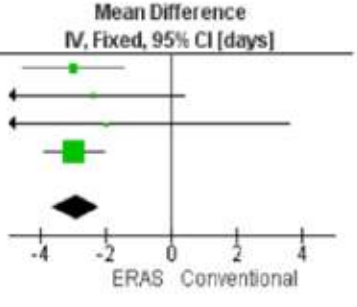
Fast track surgery versus conventional recovery strategies for colorectal surgery (Review)

2011, Issue 2

Figure 10. Forest plot of comparison: 1 Primary analyses ERAS versus conventional, outcome: 1.7 hospital stay [days].

Study or Subgroup	ERAS Mean [days]	ERAS SD [days]	ERAS Total	Conventional Mean [days]	Conventional SD [days]	Conventional Total	Weight	Mean Difference IV, Fixed, 95% CI [days]
Anderson 2003	4	1.8	14	7	2.1	11	23.4%	-3.00 [-4.56, -1.44]
Gatt 2005	6.6	4.4	19	9	4.6	20	7.1%	-2.40 [-5.22, 0.42]
Khoo 2007	5	8.5	35	7	14.75	35	1.8%	-2.00 [-7.64, 3.64]
Serclova 2009	7.4	1.3	51	10.4	3.1	52	67.8%	-3.00 [-3.92, -2.08]
Total (95% CI)			**119**			**118**	**100.0%**	**-2.94 [-3.69, -2.19]**

Heterogeneity: Chi² = 0.27, df = 3 (P = 0.97); I² = 0%
Test for overall effect: Z = 7.65 (P < 0.00001)



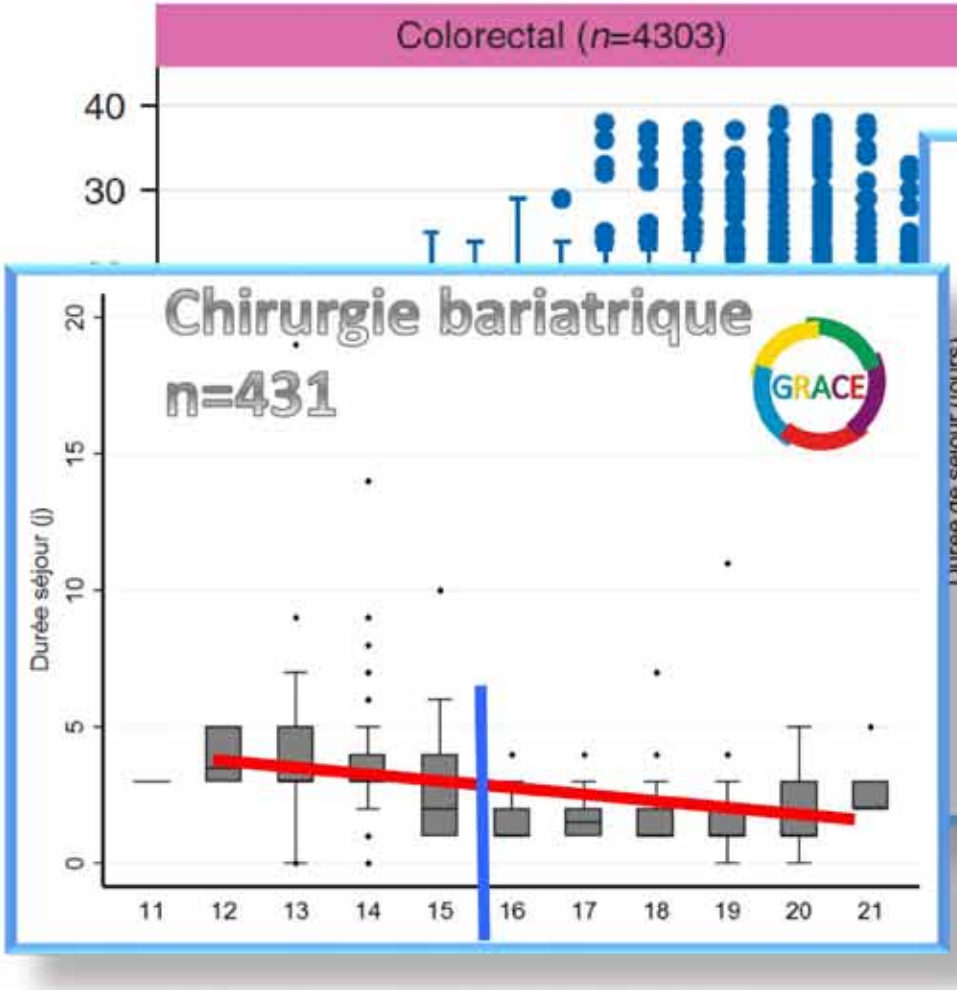
+ 7 autres méta-analyses
+ 2 grandes études de cohorte

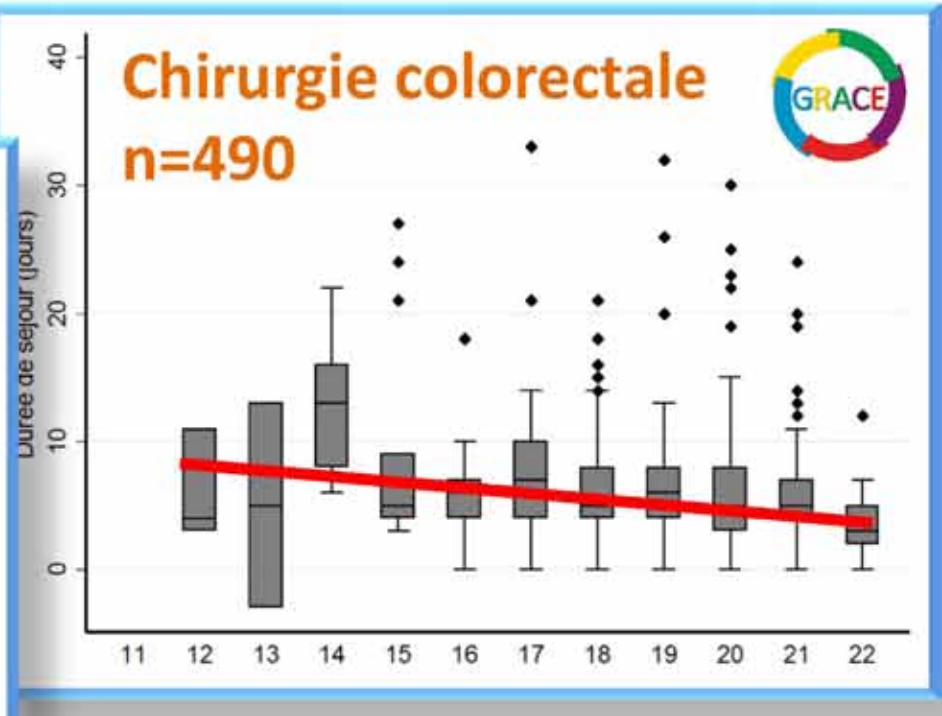
Enhanced recovery from surgery in the UK: an audit of the enhanced recovery partnership programme 2009–2012

J. C. Simpson[1], S. R. Moonesinghe[1,2], M. P. W. Grocott[1,2,3], M. Kuper[4], A. McMeeking[5], C. M. Oliver[1,2], M. J. Galsworthy[1,2], and M. G. Mythen[1,*] on behalf of the National Enhanced Recovery Partnership Advisory Board[†]

BJA

Graph to show length of stay by enhanced recovery protocol compliance





Il n'y a pas
que la durée

Il y a
aussi la qualité

Fast track surgery versus conventional recovery strategies for colorectal surgery (Review)

2011, Issue 2

Spanjersberg WR, Reurings J, Keus F, van Laarhoven CJHM

Important

arison: 1 Primary analyses ERAS versus conventional, outcome: 1.2 All complications.

			onventional			Risk Ratio	Risk Ratio
		Events	Total	Weight	M-H, Random, 95% CI	M-H, Random, 95% CI
	5	14	7	11	14.1%	0.56 [0.24, 1.29]	
	9	19	15	20	33.9%	0.63 [0.37, 1.08]	
Khoo 2007	9	35	18	35	23.3%	0.50 [0.26, 0.96]	
Serclova 2009	11	51	27	52	28.6%	0.42 [0.23, 0.75]	
Total (95% CI)		**119**		**118**	**100.0%**	**0.52 [0.38, 0.71]**	
Total events	34		67				

Heterogeneity: Tau² = 0.00; Chi² = 1.17, df = 3 (P = 0.76); I² = 0%

Test for overall effect: Z = 4.07 (P < 0.0001)

-50%

0.1 0.2 0.5 1 2 5 10

Favours eras Favours conventiona

Analysis shows a reduction in overall complications,

but major complications not reduced.

Length of stay was reduced significantly.

Qual Life Res (2015)

Short-term quality of life in patients undergoing colonic surgery using enhanced recovery after surgery program versus conventional perioperative management

Hao Wang[1,2] · Dexiang Zhu[1] · Li Liang[3] · Lechi Ye[1] · Qi Lin[1] · Yunshi Zhong[1] · Ye Wei[1] · Li Ren[1] · Jianmin Xu[1] · Xinyu Qin[1]

Table 3 QOL assessment (comparison of the changed scores) — continued

	ERAS group	Control group					Estimate	SE	Wald statistics	P
QLQ-C30										
Global quality of life[a]										
ΔPOD3	−10.9 ± 2.9	−18.7 ± 7.0								
ΔPOD6	−6.1 ± 4.9	−16.7 ± 5.1	0.000	ΔPOD21	15.0 ± 4.0	15.7 ± 4.6				
ΔPOD10	−3.0 ± 4.6	−11.5 ± 3.6	0.002	ΔPOD28	13.8 ± 3.2	14.0 ± 3.8				
ΔPOD14	−1.8 ± 3.8	−8.2 ± 3.9	0.013	Nausea and vomiting[b]						
ΔPOD21	−0.5 ± 2.3	−5.3 ± 5.0	0.041	ΔPOD3	10.5 ± 3.7	10.0 ± 3.2				
ΔPOD28	0.5 ± 2.3	−1.8 ± 3.9	0.106	ΔPOD6	1.6 ± 4.3	4.8 ± 3.7				
Functioning scales				ΔPOD10	−0.9 ± 4.2	−1.1 ± 4.1				
Physical functioning[a]				ΔPOD14	−0.6 ± 5.2	0.2 ± 4.9				
ΔPOD3	−11.9 ± 4.0	−24.8 ± 5.7	0.000	ΔPOD21	−1.0 ± 3.0	−1.2 ± 3.3				
ΔPOD6	−7.5 ± 4.3	−22.7 ± 5.1	0.000	ΔPOD28	−1.7 ± 4.2	−1.4 ± 4.3				
ΔPOD10	−4.9 ± 5.0	−14.3 ± 5.0	0.000	Pain[b]						
ΔPOD14	−3.5 ± 4.8	−10.3 ± 1.8	0.009	ΔPOD3	24.6 ± 4.3	22.2 ± 3.8				
ΔPOD21	−2.6 ± 4.4	−7.8 ± 4.2	0.029	ΔPOD6	19.9 ± 4.0	20.0 ± 3.2				
ΔPOD28	−2.3 ± 4.2	−4.8 ± 5.0	0.077	ΔPOD10	15.5 ± 5.2	18.8 ± 3.7				
Role functioning[a]				ΔPOD14	11.3 ± 5.4	15.6 ± 4.3				
ΔPOD3										
ΔPOD6										
ΔPOD10										
ΔPOD14										
ΔPOD21										
ΔPOD28										
Emotional functioning										
ΔPOD3										
ΔPOD6										
ΔPOD10										
ΔPOD14										
ΔPOD21	18.1 ± 4.0	13.7 ± 4.9	0.035	ΔPOD6	6.4 ± 4.4	9.4 ± 4.9				
ΔPOD28	19.5 ± 2.3	19.0 ± 3.0	0.819	ΔPOD10	4.1 ± 4.4	6.7 ± 4.1				
Cognitive functioning[a]				ΔPOD14	2.3 ± 5.2	2.8 ± 4.9				
ΔPOD3	−11.1 ± 3.2	−15.8 ± 3.4	0.033	ΔPOD21	0.1 ± 4.8	0.1 ± 5.1				
ΔPOD6	−7.6 ± 4.1	−11.9 ± 3.9	0.039	ΔPOD28	−1.2 ± 4.1	−1.7 ± 3.8				
ΔPOD10	−4.3 ± 3.3	−7.4 ± 4.8	0.051	Appetite loss[b]						
ΔPOD14	−2.1 ± 3.1	−3.4 ± 4.3	0.347	ΔPOD3	6.5 ± 3.8	13.3 ± 4.5				
ΔPOD21	0.6 ± 2.8	−1.1 ± 3.2	0.161	ΔPOD6	2.5 ± 4.6	8.7 ± 5.1				
ΔPOD28	1.8 ± 3.5	0.8 ± 4.1	0.410	ΔPOD10	1.3 ± 3.9	5.3 ± 4.3				
Social functioning[a]				ΔPOD14	1.3 ± 5.1	2.7 ± 4.2				
ΔPOD3	−29.6 ± 7.1	−34.2 ± 5.0	0.033	ΔPOD21	0.6 ± 5.2	1.1 ± 4.0				
ΔPOD6	−23.2 ± 4.7	−29.0 ± 3.0	0.019	ΔPOD28	−0.5 ± 3.6	−0.6 ± 4.1				
ΔPOD10	−11.1 ± 3.1	−25.0 ± 5.0	0.000	Constipation[b]						
ΔPOD14	−7.4 ± 4.4	−16.5 ± 4.8	0.000	ΔPOD3	5.9 ± 3.9	12.1 ± 3.4				
ΔPOD21	−3.3 ± 4.8	−10.0 ± 5.2	0.012	ΔPOD6	0.1 ± 4.4	7.5 ± 5.6				
ΔPOD28	−0.5 ± 2.3	−4.0 ± 4.9	0.047	ΔPOD10	−1.1 ± 5.0	5.4 ± 5.2				
Symptom scales				ΔPOD14	−0.6 ± 3.5	2.7 ± 3.8				
Fatigue[b]				ΔPOD21	−1.9 ± 4.4	0.5 ± 3.7				
ΔPOD3	40.1 ± 3.2	35.5 ± 2.5	0.051	ΔPOD28	−0.6 ± 4.3	−0.5 ± 5.1				

Sex	−0.862	0.422	4.197	0.214
BMI	0.119	0.150	0.629	0.428
ASA grade	0.876	0.514	2.904	0.088
Tumor location	−0.269	0.535	0.254	0.614
Tumor size	−0.265	0.714	0.137	0.711
pTNM stage	0.600	0.726	0.683	0.409
Recovery program	6.051	0.441	188.562	0.000
Length of time after surgery	0.576	0.026	505.655	0.000
Physical functioning				
Intercept	−29.219	4.034	52.467	0.000
Age	0.010	0.079	0.015	0.903
Sex	−0.203	0.525	0.150	0.698
BMI	0.247	0.161	2.358	0.125
ASA grade	0.394	0.607	0.421	0.516
Tumor size	0.173	1.018	0.029	0.865
pTNM stage	0.171	0.965	0.031	0.860
Recovery program	8.638	0.609	201.182	0.000
Length of time after surgery	1.240	0.023	3024.852	0.000
Emotional functioning				
Intercept	−1.384	7.668	0.033	0.857
Age	0.043	0.149	0.083	0.773
Sex	−0.123	1.164	0.011	0.916
BMI	−0.165	0.404	0.167	0.683
ASA grade	−1.961	1.342	2.134	0.144
Tumor location	0.611	1.389	0.194	0.660
Tumor size	1.361	1.692	0.647	0.421
pTNM stage	−1.039	1.575	0.435	0.509
Recovery program	5.270	1.088	23.472	0.000
Length of time after surgery	0.860	0.034	626.593	0.000
Social functioning				
Intercept	−35.993	3.667	96.348	0.000
Age	0.115	0.072	2.522	0.112
Sex	−0.149	0.470	0.100	0.752

	−0.247	0.157	2.480	0.115
	−0.443	0.571	0.604	0.437
	−0.996	0.608	2.684	0.101
Tumor size	−0.512	0.789	0.421	0.516
pTNM stage	0.340	0.761	0.504	0.478
Recovery program	7.314	0.485	227.369	0.000
Length of time after surgery	1.162	0.025	2194.624	0.000
Gastrointestinal tract problems				
Intercept	−5.320	4.223	1.587	0.208
Age	−0.136	0.079	2.978	0.084
Sex	−0.256	0.564	0.207	0.649
BMI	0.391	0.172	5.188	0.023
ASA grade	0.950	0.671	2.004	0.157
Tumor location	0.447	0.663	0.455	0.500
Tumor size	−0.683	0.964	0.502	0.479
pTNM stage	1.166	0.926	1.588	0.208
Recovery program	−1.158	0.563	4.232	0.040
			62.317	0.000
			4.241	0.029
			0.037	0.847
			0.150	0.698
			0.945	0.331
			0.310	0.578
			0.373	0.541
			0.342	0.706
			0.000	0.986
			23.564	0.001
			17.879	0.000

Conclusion Short-term QOL in patients undergoing colonic cancer using ERAS program was better than that using conventional management.

Whether the ERAS could be universally applied is an important issue. As it is advocated and popularize mainly in Europe and North America, some researchers may doubt whether ERAS could be feasible in eastern countries. Our previous study has proved its feasibility [15]. In addition, in this series, 95 % of the patients fulfilled the entire ERAS program and presented a better perioperative outcome and QOL. Therefore, as to our experience, ERAS could also be suitable for Chinese patients, in despite of the diversity of race and custom.

In summary, this study showed that the short-term QOL in patients undergoing colonic resection using ERAS program was better than that using conventional management. These results may provide another descriptive dimension for the recommendation of ERAS in the surgery of colonic cancer. However, the main limitation of this study was the single institution participated and non-randomized.

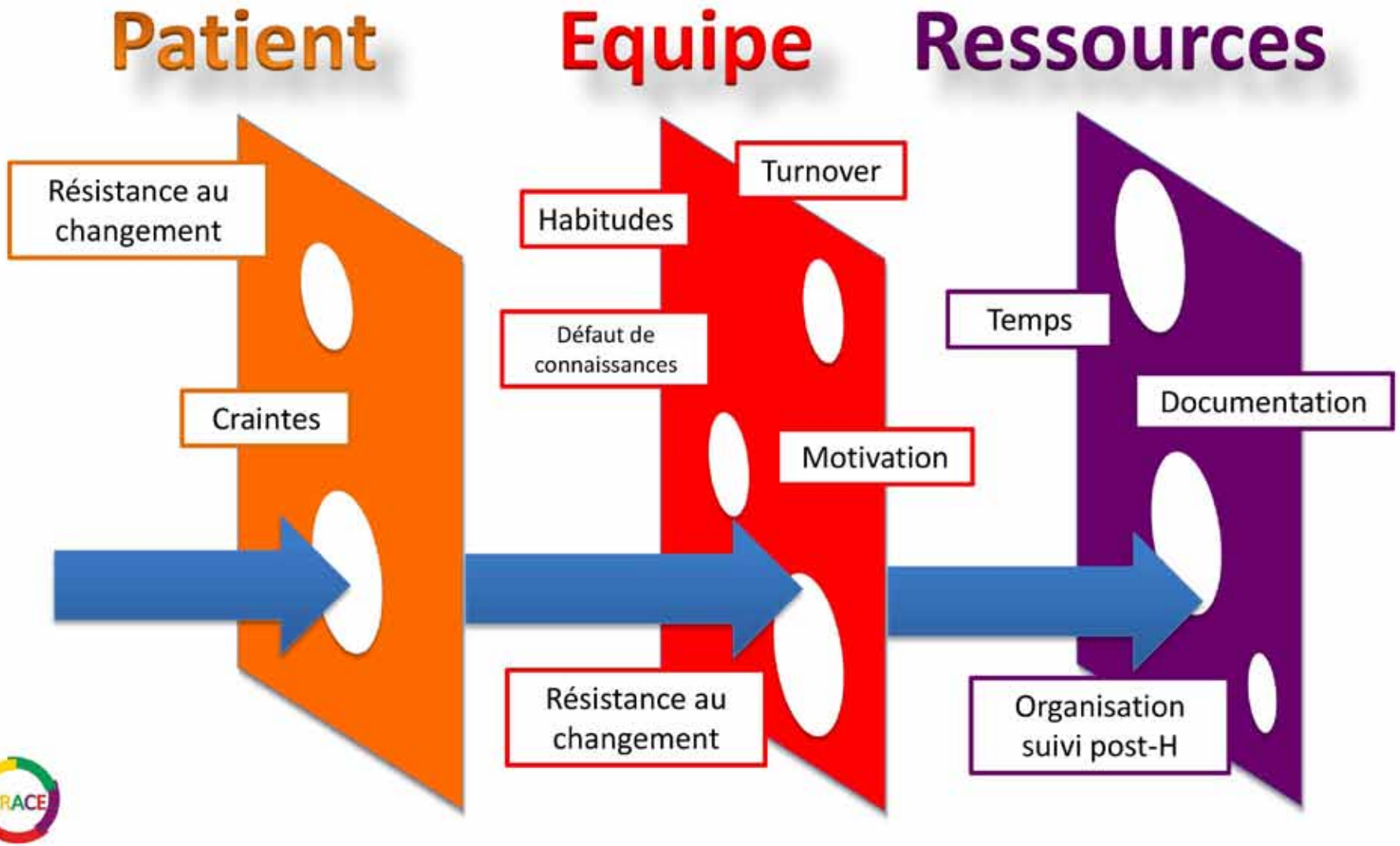
Groupe francophone de Réhabilitation
Améliorée après Chirurgie

Implémentation

La réhabilitation améliorée peut être considérée comme une innovation

Freins & Solutions

Freins & Solutions



Freins & Solutions

Leaders convaincus

Esprit d'équipe

Protocoles

Information

Formation

Freins & Solutions

Difficultés ?

Implémenter progressivement

100%

05

04

03

Convaincre

40%

02

www.grace-asso.fr

Réunions

Compagnonnage

01

Démontrer par l'exemple

Accès documentation

Audit


GRACE
Ce que voit le patient

Le patient devient ACTEUR de ses soins

Exemple

Pré-opératoire

- Information et éducation du patient
- Préhabilitation
- Apports de carbohydrates préopératoires
- Pas de jeûne préopératoire
- Antibioprophylaxie
- Thromboprophylaxie
- Pas de prémédication

Per-opératoire

- Corticothérapie
- Agents anesthésiques à durée de vie courte
- Pas de drains system
- Apport limité ou adapté de solutés
- Prévention de l'hypothermie
- Compression pneumatique

Post-opératoire

- Analgésie multimodale
- Pas de sonde nasogastrique
- Prévention des NVPO
- Usage modéré des apports liquidiens
- Retrait précoce des cathéters
- VNI
- Ré alimentation précoce
- Lever précoce

- Participation du patient obèse

HAS
HAUTE AUTORITÉ DE SANTÉ

RECOMMANDATIONS

Éducation thérapeutique du patient

Définition, finalités et organisation

Adapter l'ETP (conçue pour les maladies chroniques) à la période péri-opératoire

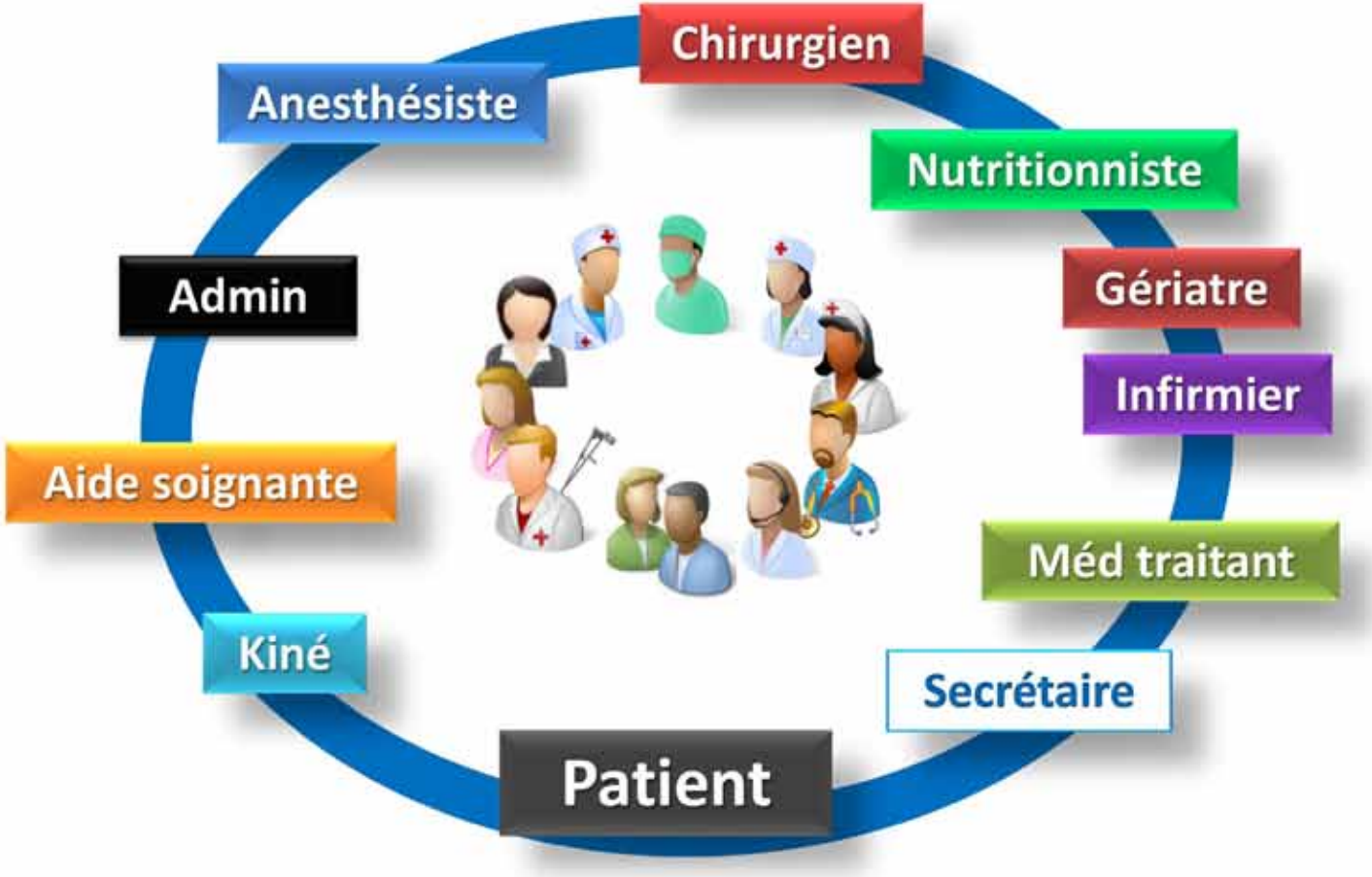
Un patient qui en a été informé avant la chirurgie, qui n'a ni douleur, ni nausée, ni tuyau, ni complication grave… ACCEPTE volontiers de quitter le fond du lit !!

Une anecdote…


IMPORTANT
Préparer
la sortie avant
l'entrée…

L'équipe

Réhabilitation améliorée

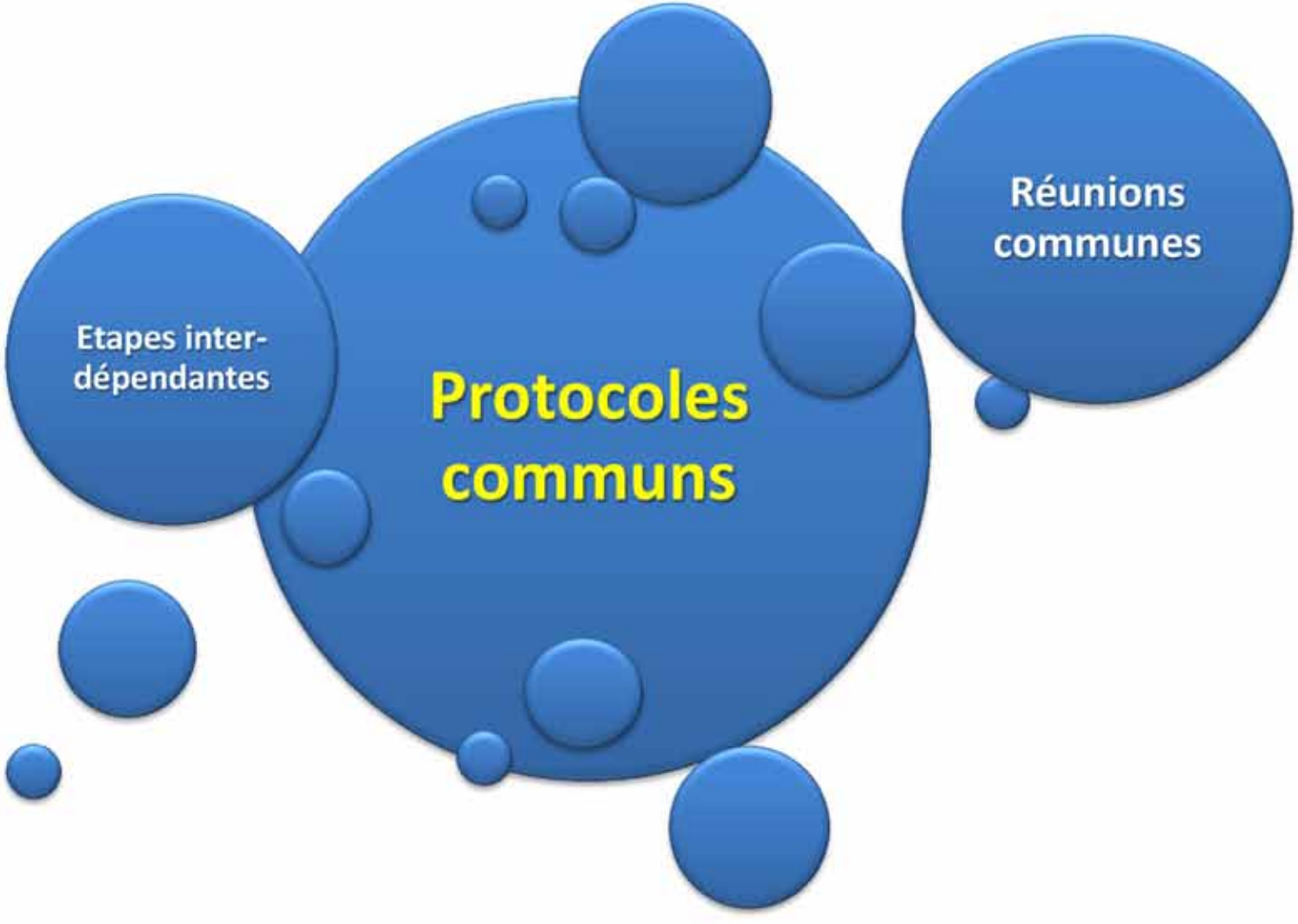


Esprit d'équipe

Trinôme leader

Anesthésiste + Chirurgien + Infirmier

Avantages pour l'équipe



Chemin clinique en chirurgie colorectale

Préop

- Information
- Prep colique
- Prémedicat°
- Jeûne
- Liquide sucré
- Immuno-nutrition

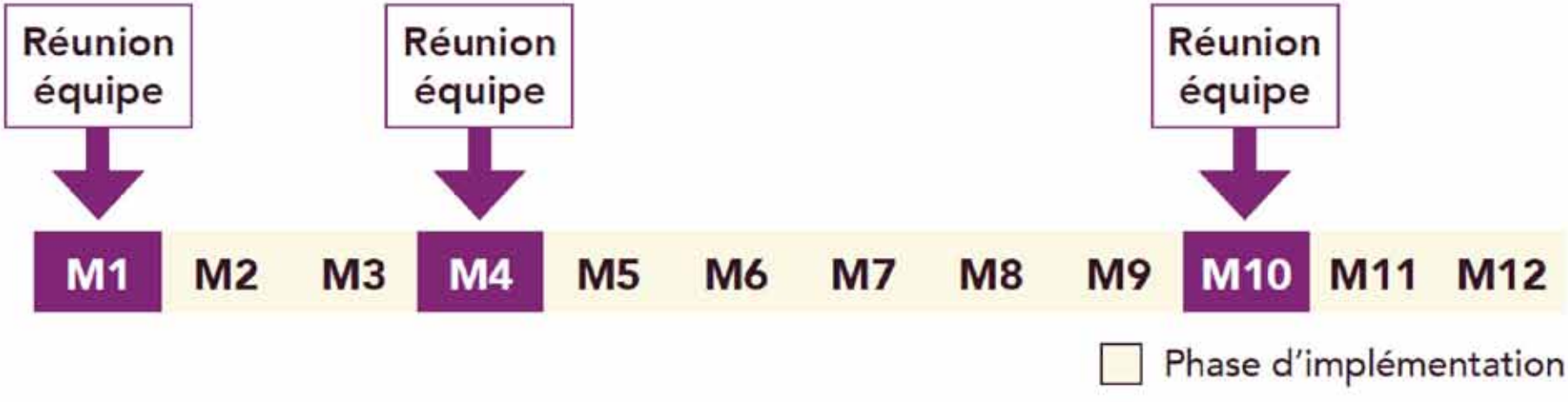
Perop

- Apport liquid°
- Corticoïdes
- Hypothermie
- AB + Thrombo
- Prév NVPO
- Voie d'abord
- Drains SNG

Postop

- Analgésie multimodale
- Péridurale
- AINS
- Lever
- Sonde vésicale
- Alimentation

Programme proposé



Do team processes really have an effect on clinical performance? A systematic literature review

J. Schmutz* and T. Manser

COMMUNIQUER POUR améliorer la qualité des soins

Clinical Surgery-American

Surgical team behaviors and patient outcomes

Nouveau paradigme

Journal of Visceral Surgery (2015) xxx, xxx–xxx

ELSEVIER MASSON

Available online at ScienceDirect www.sciencedirect.com

Elsevier Masson France EM|consulte www.em-consulte.com/en

RECOMMENDATIONS

Risk management in ambulatory and short-stay gastrointestinal surgery☆

K. Slim[a,*], A. Theissen[b], M. Raucoules-Aimé[c], Fédération de chirurgie viscérale et digestive (FCVD)[1] Groupe francophone de réhabilitation améliorée après chirurgie (GRACE)[2]

[1] A. Deleuze (Alès, France), J.-F. Gravié (Toulouse, France), M. Mathonnet (Limoges, France), B. Millat (Montpellier, France), [illegible] Raibaud (Le CISS, Paris, France). [illegible] Paris, France), C. [illegible] (Montpellier, France), [illegible] (Annecy, France), B. [illegible] (Lyon, France), J. Joris (Liège, Belgium), D. Léonard (Brussels, Belgium), S. Ostermann (Geneva, Switzerland), O. Raspado (Lyon, France).

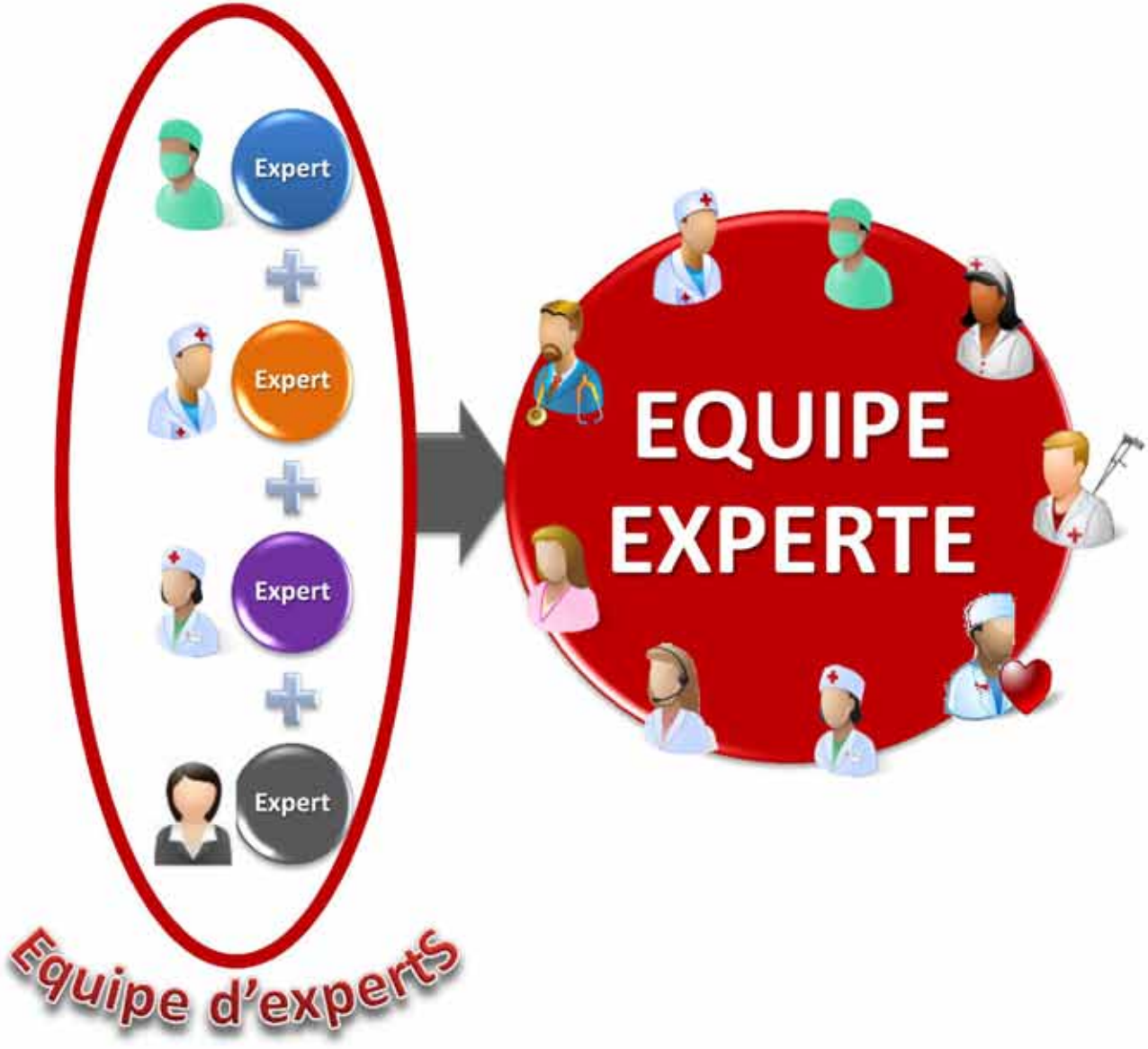
L'esprit d'équipe est essentiel

À toutes les étapes

péri-opératoires

Un protocole de réhabilitation améliorée

partagé et adopté par tous


Expert
Expert
Expert
Expert
EQUIPE
EXPERTE
Equipe d'experts

A côté des bénéfices objectifs (durée de séjour, morbidité), la réhabilitation améliorée EST AUSSI :

Le patient acteur de sa santé

L'esprit d'équipe

Enjeux pour la Société

Implementation Costs of an Enhanced Recovery After Surgery Program in the United States: A Financial Model and Sensitivity Analysis Based on Experiences at a Quaternary Academic Medical Center

Alexander B Stone, BA, Michael C Grant, MD, Claro Pio Roda, MHS, Deborah Hobson, BSN, Timothy Pawlik, MD, PhD, FACS, Christopher L Wu, MD, Elizabeth C Wick, MD, FACS

Direct variable cost pre-ERAS, $	10,933
Direct variable cost with ERAS, $	9,036
Annual ERAS cases, n	500
Total cost savings of ERAS program, $	948,500
Costs of ERAS program, $	552,783
Net savings of ERAS program, $	395,717

experience, projects that investment in an ERAS program can also lead to net financial savings for US hospitals. (J Am Coll Surg 2016;222:219–225. © 2016 by the American College of

Cost-effectiveness of the implementation of an enhanced recovery protocol for colorectal surgery

British Journal of Surgery 2013;

D. Roulin[1], A. Donadini[1], S. Gander[2], A.-C. Griesser[3], C. Blanc[2], M. Hübner[1], M. Schäfer[1] and N. Demartines[1]

Table 4 Total individual costs of primary hospital stay

	Mean cost per patient (€)*			
	Enhanced recovery ($n = 50$)	Standard care ($n = 50$)	Mean difference (€)†	P‡
Total intraoperative costs				
D				
A				
Total p				
In				
M				
N				
P				
M				
Blood transfusion and testing	261 (163, 373)	393 (223, 583)	−132 (−373, 93)	0·261
Laboratory	476 (367, 592)	993 (718, 1334)	−517 (−845, −238)	0·006
Radiology	143 (77, 214)	422 (265, 611)	−279 (−475, −93)	0·012
Housing and administration	2538 (2219, 2893)	2789 (2358, 3357)	−251 (−891, −388)	0·429

	Mean cost per patient (€)		
	Enhanced recovery ($n = 50$)	Standard care ($n = 50$)	Mean difference (€)*
Enhanced recovery implementation	1011	0	1011
Intraoperative cost	10 573	8801	1772
Preoperative + postoperative costs	13 735	18 169	[illegible]
Total costs	25 319	26 970	−1651

Aspects économiques de la réhabilitation améliorée après chirurgie

Véronique Faujour[a,*], Karem Slim[b]

Tableau 4 Bilan économique pour une initialisation.

	En €	Coût € à l'unité
Mobilisation personnel dédié ERAS	225 000	45 000
Temps rédaction protocole	36 750	5250
Système d'information, outils de suivi	35 000	5000
Initialisation et formation	6000	1200
Développement lien réseau ville	8400	1200
Sous total dépenses d'implémentation	311 150	
Gains sur journées	513 000	180
Résultat	201 850	195
Résultat hors dépenses d'initialisation	288 000	

288 000 €

Le Praticien en anesthésie réanimation (2015)

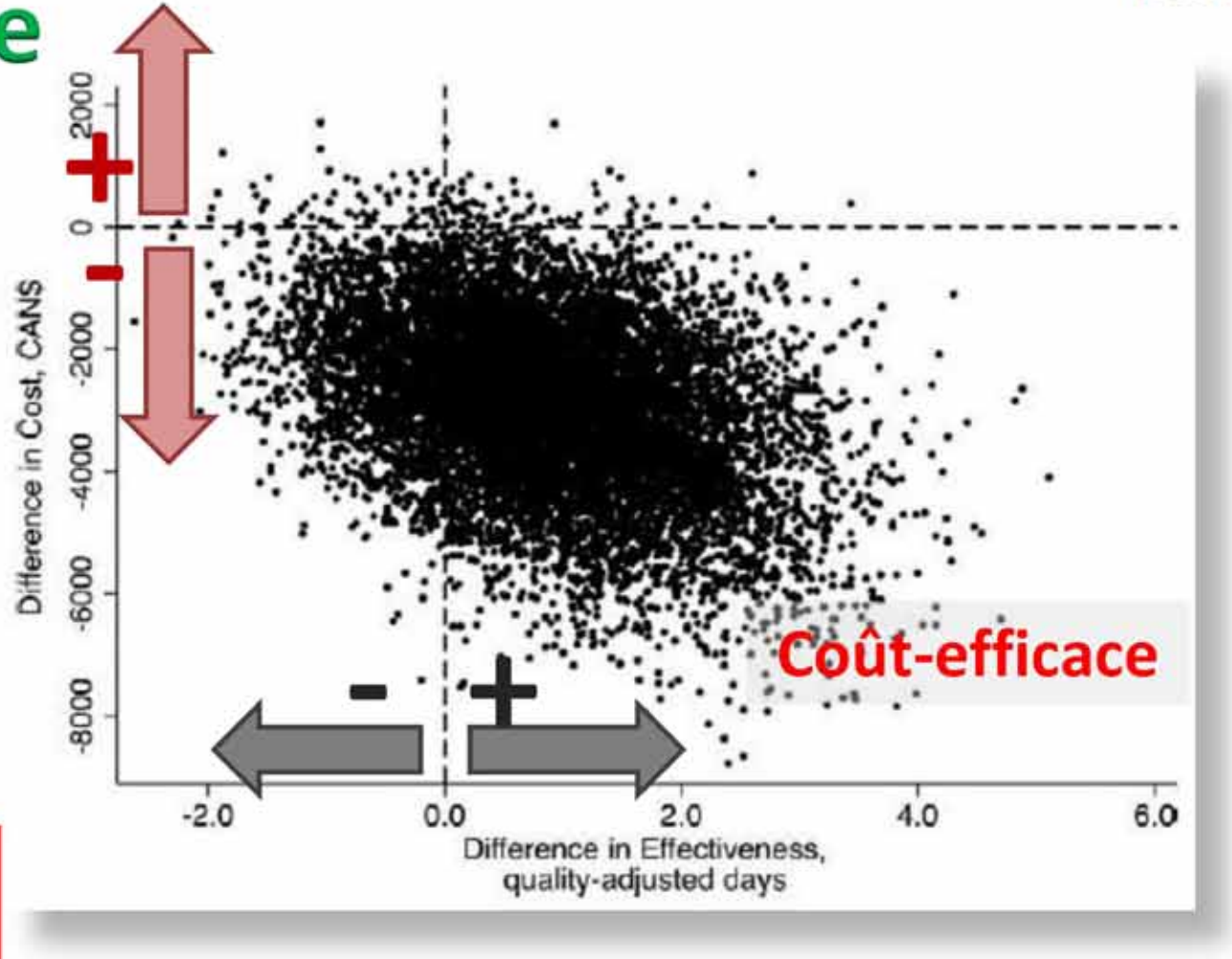
GRACE

Même après la sortie

Cost-effectiveness of Enhanced Recovery Versus Conventional Perioperative Management for Colorectal Surgery

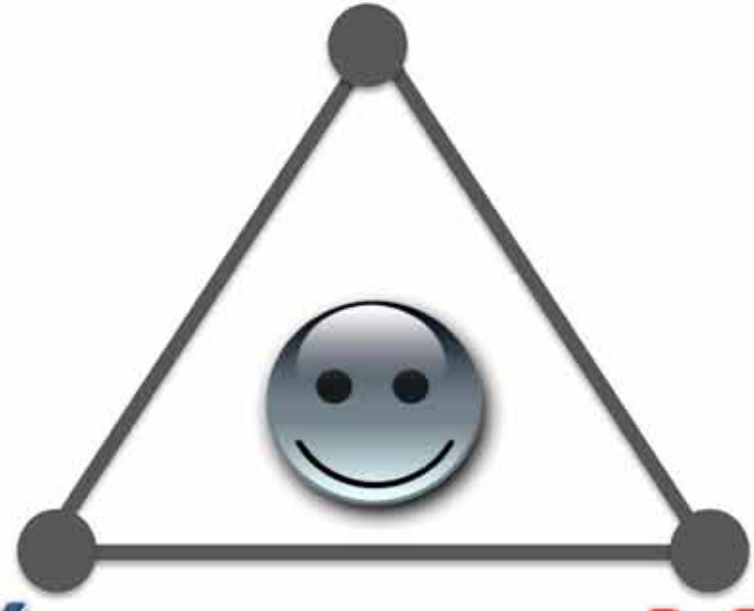
Lawrence Lee, MD, MSc, Juan Mata, MD,* Gabriela A. Ghitulescu, MD,† Marylise Boutros, MD,† Patrick Charlebois, MD,* Barry Stein, MD,* A. Sender Liberman, MD,* Gerald M. Fried, MD,* Nancy Morin, MD,† Franco Carli, MD, MPhil,‡ Eric Latimer, PhD,§ and Liane S. Feldman, MD**

December 2015



GRACE

Notoriété



Qualité des soins

Moindre coût

Rôle de GRACE ?

73 Centres GRACE au 23 mars 2016

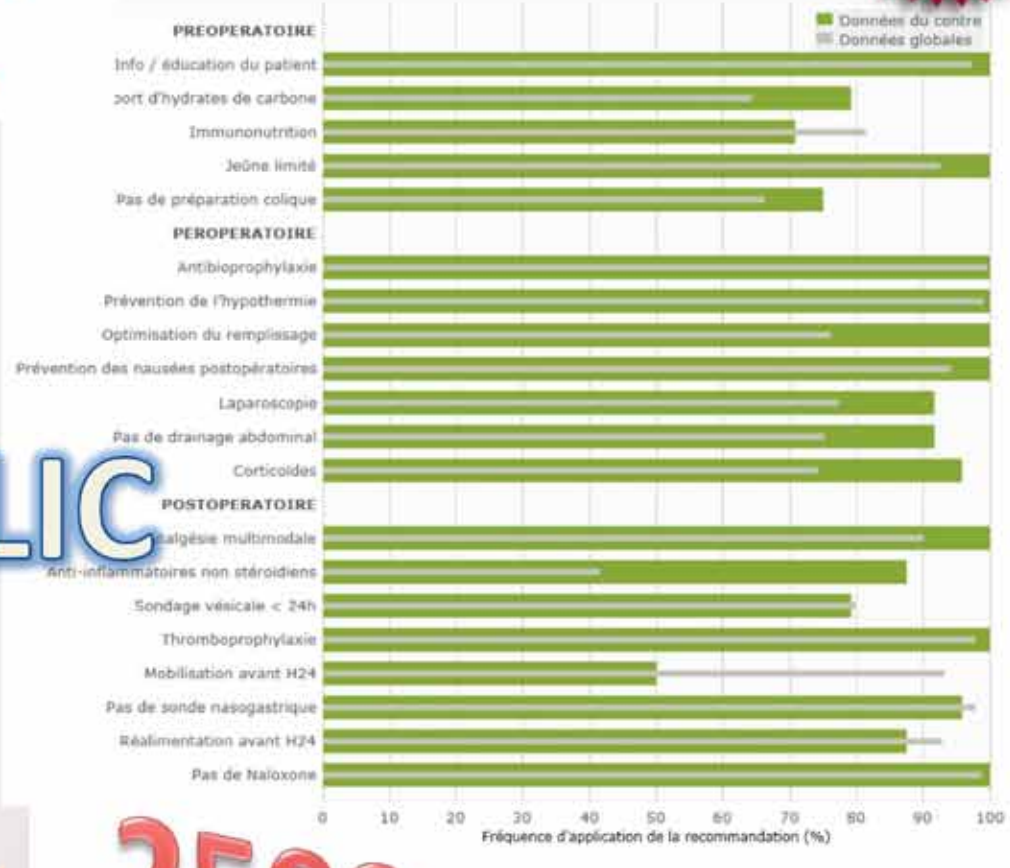
Carte des centres GRACE

www.grace-asso.fr

AUDIT

gratuit

l'Assurance Maladie
Caisse Nationale



UN CLIC

audit

2500 patients

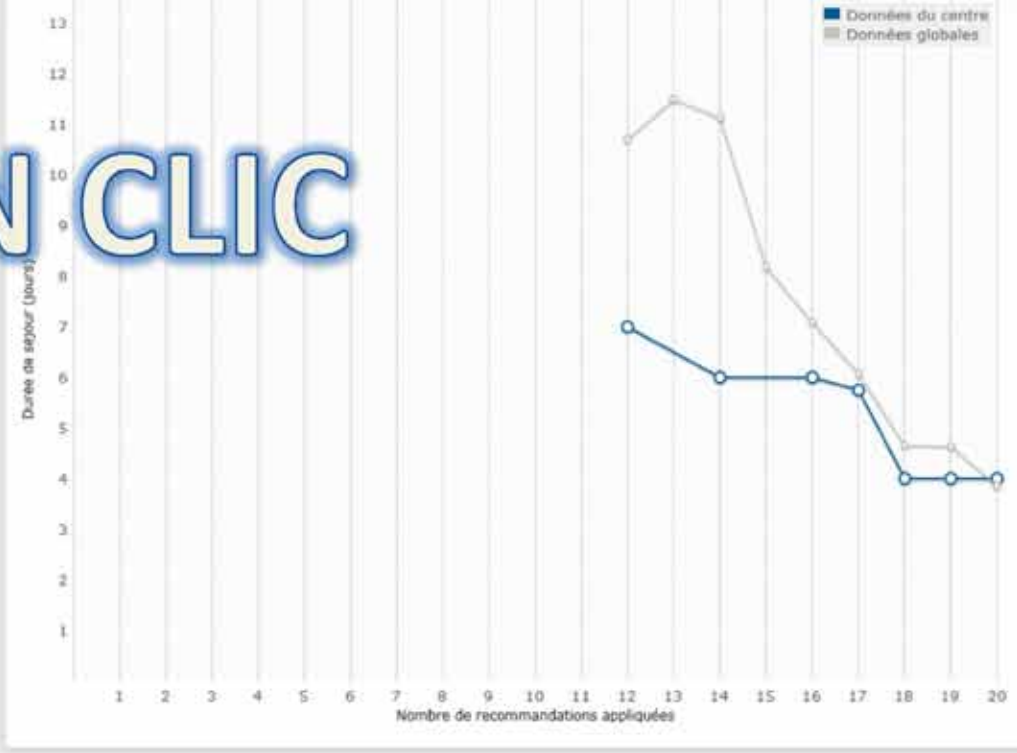
Durée moyenne réelle de séjour : **4.7 jours [4.0 - 7.0]**

Durée moyenne théorique* de séjour : **3.9 jours** ** durée au bout de laquelle tous les critères de sortie étaient réunis*

Taux de réadmission dans le premier mois : **8.3 %**

Impact des recommandations sur la durée de séjour

Afficher les stats de l'ensemble des centres ☑



UN CLIC

GRACE

Groupe francophone de Réhabilitation Améliorée après Chirurgie

Comment j'implémente LA RÉHABILITATION AMÉLIORÉE EN CHIRURGIE dans mon établissement ?

LIVRET PRATIQUE

GRACE

KIT-GRACE

- DIAPORAMA
- LIVRET
- MANUEL (détaillé)
- OUTILS INTERNET
- PASSEPORT PATIENT

GRACE

Merci!