PREPARATION

Fast recovery after gynaecological surgery: how the ERAS programme works

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No prolonged fasting or bowel preparation, and back on your feet the same evening after surgery. We explain what an enhanced recovery programme consists of and what it achieved for women after removal of the uterus.

Not long ago, a woman facing open gynaecological surgery was kept fasting for a full day beforehand, given a cleansing enema, and then advised to stay in bed for several days. Today this approach is being abandoned. It has been replaced by the ERAS programme (Enhanced Recovery After Surgery), also known as fast track. Its essence is simple: every stage of treatment is chosen so that the body goes through the operation with minimal stress and returns to normal life sooner.

Below is what the programme actually involves and what results it showed in a Ukrainian study of women who had their uterus removed because of fibroids.

Where the idea came from

The fast-track concept was formulated by the Danish surgeon Henrik Kehlet. He noticed that complications after planned operations are often caused not by the incision itself but by the body’s reaction to everything that comes with it: hunger, dehydration, pain, opioids, prolonged bed rest, drains and catheters. Remove what is unnecessary, and recovery speeds up while complications become fewer.

ERAS is not a single procedure but a set of fifteen to twenty small decisions made before, during and after surgery. Each one contributes only a little, but together they noticeably change the course of the post-operative period.

efore surgery: information instead of anxiety

- A conversation with the surgeon and the anaesthetist. The authors of the review call this a key element: when a patient knows in advance what will happen to her, how her pain will be managed, and when she will be able to drink, eat and get up, her anxiety is noticeably lower and her satisfaction with treatment is higher.
- Outpatient tests. Blood tests and consultations are completed before admission, so that no extra days are spent in hospital.
- Risk assessment. The doctor pays attention to weight, blood pressure, endocrine conditions, a tendency to thrombosis and the state of the heart.
- Correcting anaemia. Low haemoglobin is corrected before surgery, including with iron preparations, so that a blood transfusion is not needed.
- Stopping smoking and, where possible, “prehabilitation”: exercise and nutrition.
- No cleansing enemas. Mechanical bowel preparation is not used in the programme.
- No prolonged fasting. Solid food is stopped 6 hours before surgery, fluids 2 hours before. A carbohydrate drink is often given a few hours before the operation.

During surgery

- Minimally invasive access — laparoscopic, or vaginal with laparoscopic assistance, wherever possible.
- A limited volume of drips. Excess fluid causes tissue swelling and slows the bowel, so exactly as much is given as is needed.
- Keeping warm — warmed fluids and monitoring of body temperature.
- Preventing thrombosis — intermittent pneumatic compression of the legs and compression stockings.
- Reducing blood loss. The review cites data on tranexamic acid, which in studies reduced the need for blood transfusion by 72% without an increase in thrombosis.

After surgery: drinking, eating and getting up

- Pain relief without opioids or with as few as possible. Several drugs with different modes of action are combined with local anaesthetics. Fewer opioids mean less nausea and constipation.
- Early water and food. Drinking is allowed within a few hours, eating from the first day.
- Early mobilisation. In the study, women in the ERAS group were ready to get up as early as 7 hours after surgery.
- As few tubes as possible. The urinary catheter, drains and venous catheters are removed as early as possible, and are not placed at all unless needed.
- Preventing thrombosis — anticoagulants and compression hosiery.

What the study showed

Researchers from Bogomolets National Medical University, Ivano-Frankivsk National Medical University and Precarpathian University compared two groups of women who had their uterus removed because of fibroids: 82 patients were treated under the ERAS programme, 78 under the standard approach. The average age was about 46, and the groups did not differ in weight, coexisting conditions or reasons for surgery.

The differences between the groups:

- blood loss — 269 versus 358 ml, a quarter less
- nausea and vomiting — 3.7% versus 12.2%
- bowel paresis (the bowel “fails to start”) — 2.4% versus 8.9%
- need for opioids — 10.9% versus 39.7%
- stay in intensive care — 17.1% versus 62.8%
- length of hospital stay — 4.6 versus 6.5 days
- first sip of water — on average after 5 hours instead of almost a full day.

In the first 6–12 hours after surgery, complete absence of pain occurred 1.6 times more often in the ERAS group, and severe pain almost half as often (19.5% versus 34.6%). The urinary catheter was removed twice as early, drains 2.7 times earlier, and bowel function recovered almost twice as fast.

The authors obtained the best results with laparoscopically assisted vaginal hysterectomy: physical functioning on the SF-36 quality-of-life scale was about 26 points higher in these women than after open surgery. It is this technique, combined with ERAS, that the researchers describe as optimal.

What to know in advance

Getting back on your feet quickly does not mean forgetting about the operation quickly. A year after surgery, 39% of women were fully satisfied with their condition; the rest reported improvement but had complaints: urinary problems (35%), sexual dysfunction (14%), pelvic floor muscle weakness or vaginal vault prolapse (13%). So after a hysterectomy it is worth asking your doctor about pelvic floor rehabilitation, and not putting off a visit if something is bothering you.

Frequently asked questions

Can I really drink before surgery? Clear fluids, yes — up to 2 hours before the operation, unless the anaesthetist has advised otherwise. Prolonged fasting does not make anaesthesia safer, but it does increase weakness and stress.

Isn't it too early to get up on the day of surgery? No. Early mobilisation reduces the risk of thrombosis, pneumonia and bowel paresis. The first time, you get up with the help of a nurse.

Is ERAS suitable for everyone? Most of its elements are, but the programme is tailored to each patient: coexisting conditions, the extent of surgery, the type of pain relief.

If you have been offered surgery, start with a consultation with a gynaecologist — the doctor will explain the extent of the procedure and how to prepare for it. For planned operations at the clinic, see the surgery section; you can book by phone using the numbers in the contacts section.

Sources

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This article is for information only and does not replace a consultation with a doctor. The treatment approach is decided by a doctor after an in-person examination and tests.