

## ERA(S) protocols in the pandemic era: need of the hour



Dear Editor,

Enhanced Recovery After Surgery (ERAS) protocol has conceptualised the idea of creating Perioperative Surgical Homes (PSH) with the objective of maintaining physiological continuum from admission to discharge, corroborating as shorter Length of Stay (LOS) and lesser complication rate.<sup>1</sup> It is a set of evidence-based multidisciplinary perioperative care pathways challenging the preceding methodology centered at preemptively controlling events resulting in surgical stress response and prolonged post-surgical recovery. Since its inception, each individual surgical subspecialties have recommended their own plausible modifications to the protocol and conducted trials as well as meta-analysis confirming its superiority over the traditional standards.<sup>2,3</sup>

However, there exists a stark difference between the level of awareness and implementation of these protocols worldwide. Various ongoing challenges have been to overcome resistance from members of core team owing to failure in demonstrating clinically significant benefit with regards to all elements of the protocol and its operationality in emergency procedures, institution-specific barriers, as well as interdepartmental collaboration and compliance to the cause.<sup>4</sup> The slow and staggered progress in this field with lack of worldwide propagation and commitment to the new development has made ERAS merely an experimental option rather than a new primary approach to perioperative medicine.

Now that the pandemic has changed day-to-day functioning of hospitals, the patient footfall in COVID-19 suspect, confirmed and non-COVID-19 areas is being improvised with minimum cross-exposure. All tertiary care centers across nations have become a potential source of transmission of COVID-19 infection with great emphasis laid on minimum period of exposure in crowded outpatient departments and wards. In the current scenario, it is even more pertinent to strongly consider ERAS in elective and emergency surgical procedures. This will not only reduce per-patient exposure but also curb perisurgical humoral, metabolic, inflammatory, and immune response which shall improve outcome especially in COVID-19 infected symptomatic patients, asymptomatic carriers by preventing cytokine storm. An initiation in this regard can be made by forming an alliance with all surgical departments and propose to adopt the methodology in an integrative manner throughout perioperative course. Discussing the benefits of surgical and anesthetic aspects of ERAS, including minimally invasive surgical approach, preoperative nutritional optimization, premedication to allay anxiety, carbohydrate loading, short-acting anesthetic drugs and opioid-sparing pain management

techniques, perioperative normothermia and normoxia, as well as prevention of postoperative nausea/vomiting, ileus and early mobilization, shall help in affirmation of dire need to enforce the change.<sup>5</sup> The checklist of ERAS protocols can be put up in patient files to be ticked by perioperative care team to ensure compliance. Clinical trials and observational studies in this regard shall further make evolutionary modifications to standardize pandemic-specific ERAS protocol. Indeed, it is important to fast-track perioperative course in the COVID-19 hospitals and this can only be achieved by the pre-existing evidence protocolized in the form of ERAS.

### Conflicts of interest

The authors declare no conflicts of interest.

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