The Perioperative Quality Initiative (POQI) Consensus Conferences
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ERAS for Gynecologic Surgery

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President’s Message
By Tong J (TJ) Gan, MD, MHS, FRCA, President

As I am writing this message, Chinese communities have just celebrated the Year of the Rooster. According to the Chinese zodiac, there are 5 types of roosters, based on the 5 elements: wood, fire, metal, water and gold. 2017 is the Fire Rooster Year. What does “Fire Rooster Year” Mean?

Some characteristics of the rooster are energetic, determined, perseverant and forward-looking. I believe these characteristics represent the membership of ASER. We are here to promote enhanced recovery after surgery and help hospitals implement enhanced recovery pathways to improve patient care.

The US healthcare system is going through a period of uncertainty with the current administration. It is unclear what the future direction holds. Regardless, enhanced recovery principles are here to stay and will benefit patients, physicians and hospitals irrespective of what the models of healthcare turn out to be. I encourage all of you to be active participants in ASER activities.

We have a few exciting events over the next several months. The upcoming ASER/EBPOM Congress will be held on April 27-29, 2017 at the Hyatt Regency Washington on Capitol Hill in Washington DC. Dr. Timothy Miller, the scientific program Chair, has put together a superb and scientifically robust program covering multiple surgical disciplines in the context of enhanced recovery and perioperative medicine.

We have successfully conducted two leadership forums in Louisville, KY and Miami, FL and have received great feedback. ASER and The Detroit Medical Center Perioperative Institute For Surgical Excellence (PISE) co-hosted a symposium on Healthcare Reform and Innovation in Perioperative Musculoskeletal Care in Detroit in December 2016, with more than 200 attendees.

Last fall, ASER participated in the “Plan Against Pain” campaign to promote awareness regarding the many options of analgesics for perioperative pain management, using a multimodal approach to reduce opioid related side effects and potential opioid abuse and addiction. You can read the details in this newsletter.

The second PeriOperative Quality Initiative (POQI) conference was successfully held in Stony Brook, NY on December 2-3, 2016. A summary on the POQI activities in the past year as well as future meeting is presented in this newsletter.

Many of our committees have been extremely active, providing great ideas to expand membership and moving
the society forward. I would like to thank the Newsletter Committee for their diligence and hardwork in producing this content rich newsletter.

Last but not least, it is a great time to be in Washington DC during the spring season. Look forward to seeing you at the ASER/EBPOM Congress. ■

Tong J (TJ) Gan, MD, MHS, FRCA
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American Society for Enhanced Recovery

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The American Society of Enhanced Recovery (ASER) is a Multispecialty Nonprofit Organization with a Growing Global Following.

ASER is committed to improving peri-operative patient outcomes by advancing the practice and application of enhanced recovery pathways after surgery. Our goal is to promote the growth of enhanced recovery through encouraging research, education, public policies, and scientific progress.

ASER supports patient care, keeping you up to date in information on best practices, ongoing research, and practice guidelines pertaining to enhanced recovery. We also provide implementation guidance and shared experiences so as to help make your hospital’s implementation of enhanced recovery go smoother.

The ASER mission is simple. We support the growth of enhanced recovery and perioperative medicine so that our surgical patients can benefit from a faster recovery, fewer complications and a quicker return to pre-operative functional status.

Help us in supporting this mission and support ASER. Below are some of the membership benefits offered by ASER.

• **Network with Experts in Enhanced Recovery and Perioperative Medicine**
  You will have the opportunity to meet and stay connected with experts in the field.

• **Implementation Guidance, Consultation and Resource Access**
  Get help with your hospital’s enhanced recovery implementation process by participating in the ASER Leadership Forum. At this Leadership Forum, a team of implementation experts will give advice and guidance so as to ensure your hospital’s transition goes as smoothly as possible.

ASER provides a variety of implementation resources such as the ASER Enhanced Recovery Implementation Guide and our Enhanced Recovery for Major Abdominal Surgery book. You will also have access to a variety of enhanced recovery patient booklets and pathways examples.

• **Access to Enhanced Recovery Best Practices and Ongoing Research**
  Gain access to Perioperative Medicine, the official journal of ASER, our newsletter ASER Alert, and presentations on enhanced recovery principles, guidelines and ongoing research.

• **Professional Development**
  Receive CME credit at our ASER Annual Congress Meeting where experts and health professionals from all over the world share their experiences. Members will receive annual meeting discounts.

• **Get involved**
  Join the many committees that ASER has to offer.

**Member Bring a Member Campaign**

ASER members will get 10% off of their next year’s membership for every one new member recruited. This 10% deduction is additive for each new member recruited for the year.

If 10 new members are brought in by a member, the member will get a free ASER membership for that following year.

New members recruited must indicate the ASER member’s name that referred them. This can be done under the referral section located on the ASER membership application form.
The numbers continue to validate the severity of the opioid epidemic – keeping this issue center stage among patients, physicians and the media. In fact, the CDC reports that 91 people die every day in the United States from an opioid overdose.1 And it’s not just overdose – but addiction contributing to the problem. Recent research found that an alarming 10 percent of patients reported becoming addicted or dependent on opioids following surgery.2 Concerns over addiction and dependence are weighing on patients as 37 percent report that addiction is a top concern when scheduling a surgery. The concern is more prevalent in men, with 41 percent of men and 34 percent of women concerned about becoming addicted to opioids.3

Reducing the risk of opioid use, abuse and dependence is a conversation that should remain at the forefront of this epidemic for both in the consumer and clinical space. There are several ways to mitigate opioid use, including education, offering alternatives and assessing the perioperative medicine model.

The perioperative discussion has become even more important in recent years as additional options have become available to minimize postsurgical pain before a surgeon even finishes his or her procedure. Easing patients’ concerns about postsurgical pain cannot be lost in this conversation, however. Patients and physicians are eager and open to trying non-opioid options. According to the Choices Matter survey, 79 percent of patients reported that they would choose a non-opioid option over opioids and 70 percent of surgeons would do the same if they knew it could effectively manage their patient’s pain.4 By collaborating together, patients and physicians can develop pain management plans and implement contracts that allow physicians to prescribe fewer painkillers and reduce opioid risks that can occur in short term usage.

We acknowledge that some surgical procedures are needed immediately and some require opioids post-surgery; however having a conversation and discussing options, when available, is important since research finds some patients are delaying surgery due to fear of pain. Patients and physicians deserve a choice – which thematically was a cornerstone of the Choices Matter campaign that the American Society for Enhanced Recovery and Pacira Pharmaceuticals embarked on last year. The unbranded education campaign was developed to empower and activate patients, caregivers and physicians to proactively discuss postsurgical pain management, including non-opioid options before surgery.

It is imperative that the medical community continue to work together to change the perioperative and post-operative experience and create viable alternatives to effectively manage pain. To do so, collaboration among patients, physicians and the community at-large will need to continue to work together on the front lines of this epidemic to combat it head on and educate one another on the non-opioid options available to reduce the risks of opioid addiction. If an option is not available, having the conversation about postsurgical pain (how it will be managed before, during and after surgery) is still a great way to start.

References
The Perioperative Quality Initiative (POQI) Consensus Conferences

By Timothy E Miller, MD; Julie K Thacker, MD & Tong J Gan, MD, FHS, FRCA

The Perioperative Quality Initiative (POQI) is a recently formed international, multidisciplinary non-profit organization whose intent is to organize a series of consensus conferences on topics of interest related to perioperative medicine. Each consensus conference will aim to provide an objective, dispassionate distillation of the literature related to the chosen topics, and then to produce a consensus statement that interprets the available data, identifies unanswered questions and most importantly offers recommendations to improve patient care.

The POQI consensus conference process consists of three stages: pre-conference planning, conference, and post-conference.¹

During the pre-conference phase, the POQI conference directors select topics for which there is an apparent need for a consensus statement from a group of international experts to offer recommendations for patient care. Work groups are then assembled to review each topic. The work group consists of a chair, co-chair, and several delegates who are experts in at least one of the topics that will be discussed. Each work group will thoroughly review the literature, generate a bibliography of relevant literature, and identify a list of important questions to be addressed in the final consensus manuscript.

The POQI conference itself is an intensive 2-day interactive face-to-face meeting where delegates debate and question the key issues in each topic. Post-conference, each workgroup finalizes a consensus statement on their topic for publication in a peer-reviewed journal. Delegates are expected to contribute to the preparation of each manuscript during the process.

The first two POQI Consensus Conferences were supported by the American Society for Enhanced Recovery (ASER) and Evidence-Based Perioperative Medicine (EBPOM). The 1st POQI Consensus Conference took place in Durham, NC on March 4th-5th 2016. The conference focused on “Enhanced Recovery for colorectal surgery”. The four discussion topics chosen were:

1. Perioperative fluid management – how can we best manage fluid within an Enhanced Recovery Pathways (ERP) for colorectal surgery²
2. Perioperative analgesia – how can we best manage pain within an ERP for colorectal surgery?
3. Preventing nosocomial infection – how can we best prevent nosocomial infection within an ERP for colorectal surgery
4. Measurement and quality – how can we measure the quality of care within an ERP for colorectal surgery

These manuscripts have all been accepted for publication, and at the time of print are either published or will be published shortly in Perioperative Medicine

https://perioperativemedicinejournal.biomedcentral.com

The 2nd POQI Consensus Conference took place at Stony Brook University in Stony Brook, NY on December 2nd-3rd 2016, and was entitled “Key Concepts within Enhanced Recovery Pathways.”

The three chosen topics were:

1. Perioperative nutrition - how can we best manage preoperative and postoperative nutritional status within an ERP?
2. Patient reported outcomes - what Patient Reported Outcomes should be measured within an ERP?

3. Postoperative Gastrointestinal Dysfunction – how can be best prevent and manage postoperative gastrointestinal dysfunction within an ERP

The 3rd POQI Consensus Conference will occur in London in July 2017. The subject of the conference will be perioperative blood pressure management.

The key figures and manuscript will be made available whenever possible on the POQI website, poqi.us.

The POQI process aims to combine a “thorough review of the literature” with “expert appraisal and debate” to offer practical advice that is sometimes missing from consensus statements that purely review the literature. It is based on the longstanding Acute Dialysis Quality Initiative (ADQI) that has been particularly successful in generating consensus definitions and classification systems (including the RIFLE classification for Acute Kidney Injury).

Whilst this approach is not without criticism, we believe that this methodology provides the best of both methods, and hopefully the POQI manuscripts that are supported by ASER will provide practical consensus statements and recommendations to guide practice.

References


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References


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Engage With Primary Care Providers

By Chad M. Craig, MD, FACP

Enhanced recovery programs surrounding surgery have the potential to assist with more than successful surgical outcomes alone. Enhanced Recovery Programs fall under the umbrella of Perioperative Surgical Homes, and integration of care between such programs and outpatient providers have the opportunity to strongly influence the trajectory of patients’ health beyond the surgical episode.¹

An enormous amount of information is often gathered during the preoperative phase of care, including for example new diagnoses of anemia, type 2 diabetes mellitus, kidney disease, or cardiopulmonary disease. Such information is useful to the perioperative team, but often not reliably communicated during short-term transitions of care to rehabilitation facilities, or to outpatient primary care providers. This holds true for information gathered during the operative and post-operative periods as well, for example: a short run of atrial fibrillation intraoperatively that self-resolves and is of unclear clinical significance. At many hospitals there is a significant reliance on traditional discharge summaries from the index hospital stay, without verbal handoff of key information, or a reliable way to know if select information was reviewed and acted upon by a primary provider or specialist.

Enhanced recovery programs have identified and bundled key interventions that are known to influence the success of surgical and patient outcomes.² Functionality, pain, and quality-of-life are three key issues addressed in such programs, and this holds true for a wide range of surgical specialties: oncologic, orthopaedic, cardiovascular, and general surgery. These three issues are likewise of enormous importance to patients and primary care providers in the outpatient setting over the long term. Programs that optimize nutrition, and focus on healthy diets may translate in to long term healthy eating behaviors. Tobacco cessation programs, diabetes education, exercise, home safety, biofeedback and psychological health, and multimodal pain management programs are additional examples that have the potential to significantly impact how patients engage in and manage their longer term health. These are costly interventions and it would be a shame if we were to consider them one-and-done interventions surrounding the surgical episode. Many surgical-focused hospitals have invested enormous financial resources into programs to aide patients in achieving successful outcomes. Outpatient practices may not have the same resources, and could greatly benefit from information gathered by the former. Additionally, it often takes repeated clinical encounters with patients before unhealthy behaviors are altered, as for example with tobacco smoking cessation. From a longitudinal health viewpoint, one might view Enhanced Recovery Programs as similar to community health fairs: excellent opportunities to employ select high-impact health interventions, and change the trajectory of short and long term health.

For large integrated health systems, the components and resources dedicated to Enhanced Recovery Programs will often overlap with the goals of other providers within the same system.³ However, within much of the United States patient care remains fragmented between multiple providers. For those select centers that are optimizing patient care around the time of surgery and providing excellent outcomes through Enhanced Recovery Programs, there is a real opportunity for them to feedback that information and patient education strategies (where successful) with outpatient providers. This is especially true for geriatric patients, in whom medical comorbidity rates are high, and new medical issues are often identified in the setting of surgical stressors. A number of phone-based applications are increasingly offering an easy platform for such communication between providers.

Proactive, goal-directed behavior that is often highlighted as part of Enhanced Recovery Programs, supports the concept of patients engaging in shared-decision making and playing an overall proactive role in their health.⁴ Patients should also proactively identify their support team before surgery, an overlooked area of importance highlighted by both patients and investigators alike in one study.⁵ The transition home is identified frequently by patients as one of the most stressful periods of perioperative care,⁶ and having adequate resources identified proactively, as well as effective hand-off to primary providers may aide in alleviating such anxiety.

Engaging primary care providers directly in a consistent and systematic manner, during the preoperative and postoperative phases of care, is one practical strategy that may aide with such communication, and often yield additional pertinent health information not previously disclosed by patients. Additional strategies that ease the communication between Enhanced Recovery Program providers and primary outpatient providers would be welcome to this field. This is an area that would benefit from additional research, and no-doubt would be highly utilized in various health system structures throughout the country.
References


References:


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ERAS for Gynecologic Surgery

By Anna Strohl, MD; Jeffrey Huang, MD & Shireen Ahmad, MD

Introduction

Enhanced Recovery After Surgery (ERAS) is a standardized, highly coordinated interdisciplinary perioperative surgical care program that incorporates evidence-based interventions to minimize surgical stress, improve physiological and functional recovery, reduce complications, and facilitate earlier discharge from the hospital and reduced cost of care.1

Several protocols and guidelines have been designed for the management of patients undergoing colorectal surgeries incorporating the ERAS principles. More recently, growing evidence supports the expansion of ERAS protocols to include women undergoing gynecologic surgery.

Clinical Evidence

Despite the significant number of randomized controlled trials (RCTs) in the colorectal literature, there is no evidence from randomized control trials (RCTs) to support or refute the use of ERAS in gynecologic surgery.2 Existing data examining clinical pathways aimed at improving postoperative recovery in gynecologic surgery include small cohort studies; however, these data report similar findings to those published in the colorectal literature, suggesting that ERAS protocols can be expanded to gynecologic subspecialty surgery.

A recent review of ERAS programs in general gynecologic surgery demonstrated that ERAS-driven protocols reduce length of stay (LOS) without increasing complication or readmission rates.3 Dickson et al. demonstrated that an ERAS pathway in 400 women undergoing abdominal hysterectomy for benign disease decreased median LOS from 3 days to 1 day following implementation (p<0.001) without an increase in complications.4 A separate study compared 136 patients on an ERAS pathway with 211 historical controls using a conventional protocol and found that the median LOS decreased from 3 to 2 days (p=0.007) while also reducing complications rates from 40.2% to 21.3% (p=0.004).5

The benefits ERAS protocols are not limited to woman undergoing hysterectomy for benign disease. Carter et al. reviewed a 22-point ERAS program in 389 women undergoing laparotomy for suspected or confirmed gynecologic malignancy. This study found a median LOS of 3 days with a readmission rate of 4%.6 Kalogera et al. included women with gynecologic malignancy in a retrospective study evaluating the implementation of an ERAS study in laparotomy for complex gynecologic surgery. This study found that median LOS was 4 days less in the ERAS group than in the conventional group (8.7 vs 11.9 days, p<0.001).7 While few data exist on ERAS programs specifically in women with gynecologic cancer, a systematic review of seven cohort studies found that enhanced recovery pathways in gynecologic cancer patients is safe and reduces length of stay, as well as cost.8

Due to the extensive data in support of ERAS programs from the colorectal literature, as well as the growing data from gynecologic surgery, the Society for Gynecologic Oncology (SGO) has endorsed the implementation of ERAS-driven programs in women undergoing gynecologic surgery in an effort to improve postoperative outcomes.9 Future studies need to focus on the development of consistent, comprehensive ERAS programs in order to truly evaluate its impact on gynecologic surgery outcomes.9,10

Recommended Preoperative Management:

Patient education establishes expectations and promotes active participation of the patient in his/her own care and is strongly recommended.11 Preoperative cessation of smoking and alcohol consumption for at least 4 weeks and preoperative medical optimization reduces complications and is recommended.

Routine preoperative mechanical bowel preparation lacks evidence of benefit in the gynecologic population and is not recommended. Patients without risks for delayed gastric emptying, should refrain from solids for 6 hours and liquids for 2 hours prior to surgery. The evidence supports preoperative carbohydrate loading to prevent postoperative insulin resistance and increased complications.12

In order to facilitate early ambulation and feeding routine administration of long acting sedatives is discouraged. Prophylactic anticoagulation and the use of pneumatic compression
stockings decrease the incidence of venous thromboembolism and is recommended.15
Intravenous antibiotics and antimicrobial skin preparation is strongly recommended to prevent surgical site infections. Preoperative iron therapy in anemic patients reduces the need for perioperative transfusion, which along with erythropoiesis stimulating agents is associated with increased tumor recurrences.

**Recommended Intra-operative Management:**

Opioid sparing anesthetic techniques and lung protective ventilation are recommended. Due to the high incidence of postoperative nausea and vomiting in the gynecologic population multimodal antiemetic prophylaxis is recommended.

Minimally invasive surgery improves patient outcomes and is strongly recommended. Nasogastric tubes increase postoperative pulmonary complications and patient discomfort and are strongly discouraged.10 Temperature monitoring and use of active warming devices is mandatory to prevent hypothermia and its consequences on coagulation, infection and cardiac complications.

Maintaining normovolemia with goal directed fluid therapy has been demonstrated to reduce morbidity in the colorectal surgery and is strongly recommended. Balanced salt solutions are preferable to normal saline solutions. Advanced hemodynamic monitoring facilitates optimizing of patients volumes status in high risk patients or patients having extensive surgeries.15

**Recommended Postoperative Management:**

Thromboprophylaxis is recommended for 30 days postoperatively due to a high incidence of venous thrombosis in gynecologic oncology patients.16 It is strongly recommended that intravenous fluids be discontinued within 24 hours after surgery and oral diet and analgesics commenced.

Multimodal analgesia with scheduled administration of non-steroidal anti-inflammatory agents, and acetaminophen is strongly recommended.17 A recent review of patients undergoing hysterectomy found that gabapentin has effective in reducing pain and opioid adverse effects. Dexamethasone is recommended for the analgesic and anti-emetic effects.18

The evidence supporting the use of epidural analgesia is weak, and, it may result in impaired mobilization and need for a urinary catheter. Systemic lidocaine analgesia is associated with opioid sparing effects and is gaining popularity, but the optimum dosage has to be determined.19

**Conclusions**

These recommendations are based on current scientific literature and are subject to change(s) as additional institutions adopt the principles of ERAS and the number of high quality randomized controlled studies that incorporate ERAS principles increases.

**References**

Ambulatory Corner

By Katherine H. Dobie, MD

It is estimated that more than 70% of surgery today is performed in the outpatient setting, with a forecasted 16% growth in outpatient volumes and a 3% decline of inpatient discharges in the next ten years. When considered within the context of the current trend to enhance our value proposition across all of healthcare, this rapidly changing landscape requires that we carefully consider our role in the outpatient perioperative space. As we embrace and navigate the advent of perioperative medicine and enhanced recovery, we must remain committed to applying the principles of this practice in the ambulatory setting.

Ambulatory surgery has seen tremendous advances in the last ten years, with an increase in medically complex patients undergoing more difficult procedures safely at free-standing Ambulatory Surgery Centers (ASCs). Interestingly, the success of this evolution has relied squarely on some of the basic tenets of perioperative care, the same concepts that we are now applying inside the walls of the hospital.

Ambulatory perioperative care by definition is an enhanced recovery program, with a prescribed, multidisciplinary protocol designed to deliver a fixed patient disposition: to home, pain controlled, great experience, and back to their baseline as soon as possible. ASCs are less expensive, have higher patient experience ratings, less complications, and most patients return to at least some functionality day of surgery. While we as perioperative physicians will need to lead the care that enhances the aforementioned metrics inside the walls of the hospital, it will be essential that we also remain focused on the surgical outpatient, and recognize that our ability to continue to innovate in this space will add immensely to our value proposition. It’s exciting to consider what cases we will be doing at free-standing surgery centers with a plan to discharge to home on the day of surgery in ten years. Ambulatory physicians are the gatekeepers of ASCs, holding the future of perioperative innovation in free standing centers in our hands.

Look for our “Ambulatory Corner” in the next newsletter, where we will expand on the challenges and opportunities facing Ambulatory Physicians in the context of Enhanced Recovery!

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LEARNING OBJECTIVES

- Discuss the various elements of an enhanced recovery pathway
- Appreciate the current evidence base, as well as gaps in understanding and controversies
- Understand new care delivery models and approaches, and how to apply these models in their hospital to improve outcomes

ACCREDITATION STATEMENT

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCMCE) through the joint providership of the Amedco and the American Society of Enhanced Recovery. Amedco is accredited by ACCME to provide continuing medical education for physicians. This activity is co-provided by Amedco and The American Association of Nurse Anesthetists. Credit approval is pending.

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Amedco is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation. This course is co-provided by Amedco and the American Society of Enhanced Recovery. Maximum of 17.75 contact hours.

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THURSDAY, APRIL 27TH 2017

SESSION 1: ENHANCED RECOVERY – INTRODUCTION SESSION
Moderator: Timothy Miller, MD

0800 – 0810 Introduction
Timothy Miller, MD

0810 – 0825 ERAS and ASER in 2016
Tong J. Gan, MD, MHS, FRCA

0825 – 0840 Perioperative Medicine – A Global Perspective
Mike Grocott, MD, FFCIM, MBBS, FRCP, FRCA, BSc

0840 – 0900 ERAS – Results, Successes and Challenges
Julie Thacker, MD

0900 – 0930 System Wide Implementation
Clifford Y. Ko, MD, MS, MSHS, FACS, FACRS

0930 – 1000 Break with Sponsors and Exhibitors

SESSION 2: ASER AND POQI CONSENSUS STATEMENTS – PATIENTS FOCUSED AND SCIENCE BASED
Moderators: Andrew Shaw, MB, FRCA, FCCM, FFICM; Anthony Senagore, MD, MBA

1000 – 1020 Perioperative Fluid Management within ERPs
Robert Thiele, MD

1020 – 1040 Perioperative Analgesia within ERPs
Matthew D. McEvoy, MD

1040 – 1100 Prevention of Postoperative Infection within ERPs
Stefan Holubar MD, MS, FACS, FASCRS

1100 – 1120 Patient Reported Outcomes
Elliot Bennett–Guerrero, MD

1120 – 1200 Panel Discussion


SESSION 3: OPTIMIZATION PROGRAMS
Moderators: Solomon Aronson, MD, MBA, FACC, FCCP, FAHA, FASE; Matthew McEvoy, MD

1330 – 1350 Perioperative Nutrition
Paul Wischmeyer, MD

1350 – 1410 POSH – Perioperative Optimization of Senior Health
Mitchell T. Heflin, MD

1410 – 1430 Fit – 4 – Surgery School
Mark Edwards, MRCP, FRCA, MD(Res)

1430 – 1450 Prehabilitation and Exercise Programs
Mike Grocott, BSc, MBBS, MD, FRCA, FRCP, FFICM

1450 – 1515 Panel Discussion

1515 – 1545 Break with Sponsors and Exhibitors

SESSION 4: INNOVATIONS TO IMPROVE QUALITY
Moderators: Maxime Cannesson, MD, PhD; Stefan Holubar, MD, MS, FACS, FASCRS

1545 – 1605 Wearable Technologies and Digital Innovations for ERPs
Frederic Michard, MD, PhD

1605 – 1625 Measurement to Maintain and Improve Quality of ERPs
Mike Grocott, BSc, MBBS, MD, FRCA, FRCP, FFICM

1625 – 1645 EHRs and ERAS: The Challenges of Data Collection and Automation
Julie Thacker, MD

1645 – 1705 There’s an App for That: Connecting with Patients Where They Are
Bethany Sarosiek, RN, MSN, MPH, CNL

1705 – 1715 Panel Discussion

1715 – 1730 Annual Business Meeting

1730 – 1900 Opening Reception and Poster Presentations

FRIDAY, APRIL 28TH 2017

SESSION 5: ERAS RESCUE: CONTINGENCY PLANS TO KEEP PATIENTS ON TRACK
Moderators: Julie Thacker, MD; Roy Soto, MD

0800 – 0820 Postoperative ileus
Traci Hedrick, MD

0820 – 0840 Should We Be Obsessed with Readmissions?
Christopher Mantyh, MD

0840 – 0900 Discharge Criteria
Krishen Ban, MD

0900 – 0930 Panel Discussion

SESSION 5B: ANESTHESIA WORKSHOP

0930 – 1000 Break with Sponsors and Exhibitors

SESSION 6: THE FUTURE
Moderators: Tong J. Gan, MD, MHS, FRCA; Timothy Miller, MD

1000 – 1005 Poster Winner Announcement

Henrik Kehlet, MD, PhD
1040 – 1110 Volume to Value Transition in the USA
Lee Fleisher, MD

1110 – 1140 Five Phases of Care for Best Surgical Outcomes
David Hoyt, MD, FACS

1140 – 1200 Panel Discussion

1200 – 1330 LUNCH & Mallinckrodt Pharmaceuticals
Symposia: Multimodal Analgesia in the Era of Enhanced Recovery and the Perioperative Surgical Home

SESSION 7A: EB POM 1 – BIG DATA AND BIG TRIALS
Moderators: Andrew Shaw, MB, FRCA, FCCM, FFICM; Lee Fleisher, MD

1330 – 1355 Large Trials in Perioperative Medicine in the UK: What’s New and What’s in the Pipeline
Rupert Pearse, MD, FRCA, FFICM

1355 – 1420 Perioperative Myocardial Injury – Can it be Prevented? Recent Evidence from Large Trials
Daniel Sessler, MD

1420 – 1455 Challenges of Big Data – The NSQIP Experience
Julie Thacker, MD

1455 – 1515 Panel Discussion

1515 – 1545 Break with Sponsors and Exhibitors

SESSION 7B: MAKING IT ALL HAPPEN
Moderator: Bethany Sarosiek, RN, MSN, MPH, CNL

1330–1350 Implementation Basics: It’s More Than Just an Order Set
Robin Anderson RN, BSN

1350–1410 The Change Adoption Triad – A Straightforward Approach for the Enhanced Recovery Multi-Disciplinary Team
Desiree Chappell, CRNA, MSNA

1410–1430 Innovative & Engaging Approaches for Educating Patients
Lindsey Koshansky, RN, BSN

1430–1515 Q&A/Panel discussion

1515–1545 Break with Sponsors and Exhibitors

SESSION 8A: EMERGENCY SURGERY
Moderator: Mike Grocott, MD, FFICM, MBBS, FRCP, FRCA, BSc

1545–1610 Fractured Neck of Femur
Jeff Gadsden, MD, FRCP, FANZCA

1610–1635 Emergency Laparotomy
Rupert Pearse, MD, FRCA, FFICM

1635–1715 Surgery May Not Be the Right Option – The Elephant in the Room Panel Discussion
Jeff Gadsden, MD, FRCP, FANZCA; Terrence Loftus, MD; Rupert Pearse, MD, FRCA, FFICM; Julie Thacker, MD

SESSION 8B: THEN WHAT? – HOW DO WE KEEP MOVING FORWARD?
Moderator: Robin Anderson RN, BSN

1545–1610 Tracking Process Measure Compliance – Does it Help with Sustainability?
Deborah Hobson, RN, BSN

1610–1635 Nursing Led Research and Enhanced Recovery
Vicki Morton, DNP, AGNP–BC

1635–1715 Panel Discussion: Sustainability and Growth – Managing the Spread
Robin Anderson RN, BSN; Deborah Hobson, RN, BSN; Bethany Sarosiek, RN, MSN, MPH, CNL; Vicki Morton, DNP, AGNP–BC

Saturdays, April 29th 2017

0630 – 0800 Breakfast Symposia

SESSION 9: PROCEDURE SPECIFIC CASE DISCUSSIONS

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<td>Orthopedic</td>
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<td>Colorectal/cystectomy</td>
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<td>HPB</td>
<td>Orthopedic</td>
<td>Real-life</td>
<td>Colorectal/cystectomy</td>
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FACULTY:
HPB – Moderator: Michael Scott, MB, ChB, FRCP, FFICM
Panelists: Robert S. Isaak, DO; Adam King, MD; Sabino Zani Jr., MD

Orthopedic – Moderator: Jeff Gadsden, MD, FRCP, FANZCA
Panelists: James Nicholson, MD; Syed A. Azim, MD; Margaret Holtz, MD

Implementation – Moderator: Julie Thacker, MD
Panelists: Robin Anderson, RN, BSN; Terrence Loftus, MD; Amy McCutchan, MD

Colorectal/Cystectomy – Moderator: Stephan Holubar, MD, MS, FACS, FASCRS
Panelists: Anoushka Afonso, MD; Desiree Chappell, CRNA, MSNA; Ruchir Gupta, MD

1230 – 1330 LUNCH

SATURDAY AFTERNOON WORKSHOPS

1330–1630 Ultrasound - Guided Infiltration Workshop

1330–1630 Workshop - Topic TBD
ONLINE REGISTRATION  www.aserhq.org

Online registration accepted until Friday, April 14, 2017

MAIL OR FAX REGISTRATION FORM
This is how your name will appear on your name badge. *Required fields.

*FIRST NAME: __________________________ *LAST NAME: __________________________

PROFESSION: __________________________ *HIGHEST DEGREE(S): __________________________

*COMPANY/INSTITUTIONAL AFFILIATION: __________________________

*ADDRESS: __________________________

*STATE/PROVINCE: __________________________ *ZIP: __________________________

*COUNTRY: __________________________

*PHONE: __________________________

FAX: __________________________

*EMAIL ADDRESS: __________________________

Special Needs: ☐ Hearing Impaired ☐ Sight Impaired ☐ Other: __________________________
☐ Dietary (Please Specify)

REGISTRATION FEES  Course materials, 1 cocktail events, 3 lunches & 3 continental breakfasts

<table>
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<td>ASER Physician Member Registration</td>
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*Non-member fee includes 1 year of membership.

SUB TOTAL: __________________________

PAYMENT MUST ACCOMPANY REGISTRATION

TOTAL DUE: __________________________

METHOD OF PAYMENT
The following methods of payment are acceptable for the registration fee:

1. Check: Made payable to ASER. There is a $25 returned check fee.
   ☐ Check Included

2. Credit Card Payments: ☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX
   NAME ON CARD: __________________________
   CARD #: __________________________
   SECURITY CODE: __________________________
   EXP. DATE: __/____
   SIGNATURE: __________________________

PAYMENT MUST ACCOMPANY REGISTRATION

TOTAL DUE: __________________________

REGISTRATION CANCELLATION
All cancellations must be in writing and sent via U.S. mail, email or fax. Fee for cancellations postmarked or date stamped before April 14, 2017 will be completely refunded with an administrative fee of $25. NO REFUNDS WILL BE MADE AFTER APRIL 14, 2017.

Questions? Contact Us:
American Society for Enhanced Recovery
6737 W. Washington St.
Suite 4210
Milwaukee, WI 53214
info@aserhq.org
OFFICE: 414-389-8610
FAX: 414-276-7704

PLEASE NOTE: Registration is not complete until you receive a confirmation email for your registration. If you do not receive this email within 5-7 days of registration, please contact us at 414-389-8610.

It is recommended to bring your confirmation of registration with you to the conference.