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EDITORIAL

Enhanced recovery after surgery or in surgery? The difference is not only about semantics

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Perioperative medicine is constantly evolving. It encompasses a set of measures designed to mitigate surgical aggression. Its successive names — fast-track surgery, accelerated recovery, rapid rehabilitation, enhanced recovery after surgery — reflect an evolution in the paradigm of perioperative medicine. From being a simple care pathway, it has become an optimised approach integrating care based on the best scientific evidence and applied to surgery patients in a prospective clinical pathway. The care pathway incorporating enhanced rehabilitation is arguably the quintessence of perioperative medicine. We owe the concept of perioperative medicine to our anaesthetist colleagues, who defined it at the *États généraux de l'anesthésie-réanimation* (EGAR) in 2010 [1]. But these meetings have somewhat neglected the surgeon's role in perioperative medicine, which is also essential. It is true that the surgeon's main area of competence is ''surgical technique''. However, we must reach beyond the technical problems of surgery and open up to the overall care of the patient. If we take the example of colorectal surgery, of the 22 perioperative measures, only two (premedication and type of anaesthetic drugs) lie outside the surgeon's remit. The surgeon is thus involved in some 20 measures in the care pathway. These include not only the minimally invasive approach and the absence of drainage, but also the type of analgesia, the duration of fasting (pre- and postoperative), and early re-feeding.

Evolution of the concept of perioperative care

Henrik Kehlet (together with his team) is considered the pioneer of a new model of perioperative care, which he called ''fast-track surgery'' in the 1990s. The original publication included a short series of 16 patients with a median hospital stay of 2 days [2]. But a few years and scientific studies later, a new paradigm emerged: rather than considering ''fast'' postoperative recovery as the main feature of this care pathway, the northern European teams preferred to emphasise enhanced recovery after surgery. The care pathway with the predominantly evidence-based perioperative measures has favourable effects on postoperative recovery. Fig. 1 illustrates this recovery with a faster return home. Thus the term

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Figure 1. Enhanced recovery allows a better postoperative course and an early return home.

''Enhanced Recovery After Surgery'' (ERAS) was chosen by North European experts and pioneers in the early 2000s [3]. Quality of postoperative recovery thus took precedence over length of hospital stay (which became a simple marker). In 2010, the ERAS Society was founded, and ERAS became a registered trademark. The concept quickly spread beyond the Scandinavian and Anglo-Saxon spheres, reaching French-speaking countries in 2013. Its French translation was *réhabilitation* (some prefer *récupération*) *améliorée après chirurgie* (RAC). The name of the French-speaking group GRACE (Groupe francophone de réhabilitation améliorée après chirurgie [Francophone group for enhanced recovery after surgery]) incorporated the acronym RAC [4]. *Réhabilitation* was preferred to *récupération* for better international visibility. Unlike ERAS Society, GRACE did not opt to trademark RAC, taking the view that care is for everyone. A significant proportion of colleagues prefer the acronym RAAC, the second A standing for *après* [after], if only because ''RAC'' was already in use for ''Calcified Aortic Stenosis'' (Rétrécissement Aortique Calcifié in French), which might cause confusion. The acronym RAAC is used in congresses, scientific articles, brochures, by the French Haute Autorité de santé (HAS [higher health authority]), by the Agence technique de l'information sur l'hospitalisation (ATIH [technical agency for information on hospitalisation]), and by French Social Security.

So is it RAC or RAAC? (in other words: ERAS or ERIS?)

In recent years, a new concept associated with ERAS/RAC has been developed, namely prehabilitation, which consists in improving the physiological functions of patients who are to undergo major surgery [5]. This prehabilitation is essentially ''pre-operative rehabilitation''. It is multimodal management (like ERAS/RAC) that includes the treatment of possible co-morbidities, anaemia, malnutrition, cardio-respiratory physical exercise, and psychological support. The consensus is that prehabilitation is especially indicated for elderly or frail patients who are to undergo major surgery including for cancer [6]. Forecasts (at least in France) point to an inevitable ageing of the population at least until 2050 [7]. This growing cohort of frail patients will most likely be eligible for prehabilitation. The improvement expected from this management is both preoperative and postoperative. All this argues for replacing ''enhanced recovery AFTER surgery'' by ''enhanced recovery IN surgery''. Let us therefore revive the original acronym ''RAC'' in French to describe this recent evolution in our care practice.

Lastly, patient management is constantly evolving, and RAC and ambulatory surgery are no longer antinomic [8]. Both refer to an optimised care pathway that may, in the near future, come to bear another name and another acronym.

Disclosure of interest

Viatris.

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