

ICU Management & Practice, Volume 17 - Issue 3, 2017

The role of physiotherapy in Enhanced Recovery after Surgery in the intensive care unit

Enhanced recovery after surgery (ERAS) is an evidence-based, multimodal approach to optimising patient outcomes following surgery. The role of physiotherapy within ERAS and intensive care units (ICU) is important. Patients admitted to an ICU following elective major surgery may suffer from physical, psychological and cognitive problems, which can impact their return to function and quality of life. ICU physiotherapists can enable patients to achieve ERAS programme aims throughout their stay in an ICU and this may accelerate the achievement of discharge criteria and subsequent return to function. Functional limitations and persistent weakness may exist long after discharge, and therefore there is a need to increase the awareness and involvement of physiotherapists within the outpatient setting. Establishing a standardised rehabilitation programme, informed by key ERAS principles and delivered by specialist physiotherapists supported by a well-informed ICU team can have long term benefits to patients post-discharge.

Enhanced recovery after surgery (ERAS) is a combination of perioperative care components built upon a multimodal approach that integrates evidence-based interventions to reduce convalescences across multiple surgical procedures. Since ERAS was first implemented within hospitals over twenty years ago, post-surgical outcomes have improved for patients (Kehlet and Wilmore 2008). Length of stay has decreased, with no subsequent increase in readmission rates (Paton et al. 2014), with concurrent improvements in clinical outcomes whilst having a beneficial impact on healthcare resources. ERAS programmes are supported by evidence based preoperative, intraoperative and postoperative procedures to accelerate the achievement of discharge criteria. ERAS originated in elective colorectal surgery, but has spread to other surgical subspecialties, including, but not limited to, gastrointestinal, hepatobiliary, orthopaedic, cardiac, thoracic, head and neck, breast and gynaecologic surgery.

Physiotherapy and ERAS

The role of physiotherapy within ERAS pathways is important in both preoperative and postoperative routines. Implementing a preoperative strength programme has been shown to promote musculoskeletal improvements in preparation for a forthcoming physiological stressor (Carli et al. 2010), and is an emerging key component of ERAS. A literature review found preoperative exercise in patients scheduled for cardiovascular, thoracic, abdominal and major joint replacement surgery to be well tolerated and

effective (Hoogeboom et al. 2014). Postoperative exercise programmes are also recommended by ERAS guidelines, promoting muscle hypertrophy and the return to function after major surgery (ERAS Society 2017).

Early postoperative mobilisation is a fundamental principle of good physiotherapy practice and of ERAS programmes. It has been shown to reduce the rate of morbidity and length of stay following major surgery (Epstein 2014; Kehlet and Wilmore 2008), with immobilisation due to hospitalisation causing a decline in muscle strength, insulin adherence and functional ability. Early mobilisation can accelerate the achievement of discharge criteria, and has been evidenced to reduce the rate of postoperative pulmonary complications, venous thromboembolism and infection (Epstein 2014). Early mobilisation can only be achieved through adequate pain control; multimodal opioid-sparing regimes, which are central to ERAS programmes are essential. This is a fundamental principle within ERAS, in that each intervention, whether surgery and/or analgesic regimens, must consider its impact on rehabilitation goals and how to best support early postoperative mobilisation. There are many surgery-specific barriers to early mobilisation, highlighting the importance of a multidisciplinary care team approach.

Intensive care unit stay

A patient may be admitted to an intensive care unit (ICU) after elective major surgery if they require postoperative support either due to the complexity of surgery, or because of co-existing medical conditions. ICU admission is not always routine amongst all major surgeries that adopt ERAS principles, with orthopaedic procedures generally being the most well-tolerated by patients, and consequently rarely requiring ICU admission (AbdelSalam et al. 2012). ERAS guidelines highlight that gynaecologic, cardiac, pancreaticoduodenectomy, colorectal, hepatic and head and neck cancer patients may require transfer to an ICU, depending upon their condition following surgery. Admission to an ICU is patient- and surgery-specific, with many programmes using preoperative risk models in an attempt to predict need for and length of stay within intensive care. Standardising postoperative ICU management can lead to reductions in length of stay with no increase to postoperative complications (Agarwal et al. 2012). Programmes within ICUs should consist of a multidisciplinary team who utilise a model of perioperative care components of enhancing recovery.

Physiotherapy within intensive care units

The aim of physiotherapy treatment provided within ICUs can be broadly separated into two: improving respiratory function, and initiating the rehabilitation process. Patients in an ICU may require mechanical ventilation to help their breathing; however this can lead to pulmonary complications. Respiratory physiotherapy involves early mobilisation where possible, repositioning patients within bed to optimise

respiratory function, and utilising manual techniques or the manipulation of ventilator settings to clear lung secretions that build up within the lungs, when mobility and consequently deep breathing is limited. This helps to reduce the risk of pulmonary issues. Rehabilitation physiotherapy focuses initially on maintaining range of joint motion to prevent contractures, and on reducing the muscle loss that occurs due to immobility whilst a patient is in an ICU. Rehabilitation then focuses as soon as possible to sitting, standing and then walking, in order to facilitate their return to physical function. Patients can become weak quickly, and the use of exercises, electrical stimulation and ambulation practice can reduce muscle atrophy and joint stiffness that may occur.

The aforementioned roles of a physiotherapist within an ICU assimilate strongly with the key ERAS principles for accelerating the achievement of discharge criteria. To ensure a patient admitted to ICU continues to achieve functional recovery, the role of the physiotherapist is important. The impact of a perioperative ERAS programme has been shown to reduce the incidence of pulmonary complications with sustained improvement evident one year after implementation in patients admitted to an ICU following elective major surgery (Moore et al. 2017). Using an evidence-based physiotherapy protocol that addresses pulmonary dysfunction and promotes early mobility has been found to be safe and effective in comparison to nonspecialist care for patients on ICU (Hanekom et al. 2013). An appropriate level of clinical expertise should be required to safely work in a critical care environment, and creating an algorithm to guide non-specialist therapists can encourage best practice physiotherapy (Sommers et al. 2015) promoted within ERAS guidelines.

Early mobilisation of critically ill patients in an ICU is a safe and effective intervention that may lead to significant improvements to functional outcomes (Adler and Malone 2012). An admission to ICU should therefore not mean that a patient is removed from an ERAS pathway. In fact, it may be argued that it is the ICU-admitted patients that need ERAS the most. Mobilising a patient can include activities such as sitting, standing, ambulation and passive exercises performed by the physiotherapist. Functional exercise capacity, selfperceived functional status and muscle force have been reported to be greater at hospital discharge for patients receiving a passive or active exercise training session for 20 minutes a day (Burtin et al. 2009). Early mobilisation has also been linked to a decrease in mechanical ventilation duration when a multidisciplinary team with a recognised leader can implement change to the ICU culture and practice (Hashem et al. 2016).

Barber and colleagues (2015) found barriers to early mobilisation within ICUs to be a lack of resources and communication; highlighting the importance of educating and including the ICU team within the traditional ERAS team of anaesthetists, surgeons, and ward-based nurses and allied health professionals. Education should include the clinical aspects as well as combined working to ensure logistical factors are coordinated, such as the use of standard documentation. For example, ERAS patients are often managed on a specific ERAS pathway document; this needs to work seamlessly with ICU pathway documentation.

Rehabilitation post discharge

Following a critical illness or prolonged stay in an ICU, patients may suffer from physical, psychological and cognitive problems, which can negatively impact their health-related quality of life (Jones 2012). Intensive care unit-acquired weakness (ICUAW) is a clinical syndrome that occurs due to muscle atrophy and loss of muscle mass whilst a patient is intubated and mechanically ventilated. Recovery time increases with length of stay, and an effective rehabilitation programme is vital to ensure a patient can return as close as possible to their preoperative physical and mental health.

Functional limitations and persistent weakness may exist long after discharge, and therefore there is a need to increase the awareness and involvement of physiotherapists within the outpatient setting (Pawlik and Kress 2013). Physiotherapists are an essential component of the rehabilitation pathway, and can ensure that patients adopt ERAS principles, proven to facilitate recovery, once they are discharged from an ICU. The rehabilitation needs of a patient should be individualised, and assessments are important to determine which physiotherapy and counselling resources are required. Consequently, an adequate number of well-informed physiotherapists who are competent at managing critical care patients in an outpatient setting is needed.

There is limited evidence regarding the effectiveness of physiotherapy interventions following admission to an ICU, and ERAS guidelines for post-discharge rehabilitation are still evolving. Recent literature has suggested that high intensity rehabilitation could lead to greater improvements in functional outcomes in comparison to lower intensity programmes (Bandholm and Kehlet 2012). The use of progressive resistance training has been highlighted for augmenting a patient's hypertrophy, improving their strength, balance and muscular endurance (Borst 2004). Jones et al. (2003) found a self-help rehabilitation manual to be effective in aiding physical recovery and reducing depression; however, many patients still recalled delusional memories from ICU, prompting the need for further psychological care. A physiotherapy-led, outpatient rehabilitation programme, involving education sessions and circuit-based training has been proven to enhance exercise capacity along with significant psychological benefits following discharge from an ICU (McWilliams et al. 2009).

With this considered, a Cochrane review of exercise rehabilitation for recovery following discharge from an ICU was unable to determine an overall result for the effect of exercise training on recovery. Six studies were examined: three of the papers reported results in favour of post-discharge exercise training programmes and the remaining studies found no effect. Interventions included walking, strengthening exercises, education, arm and leg cycling exercises and self-help rehabilitation manuals (Connolly et al. 2015). Despite inconclusive results, the authors highlight the importance of physical rehabilitation for recovery after a critical illness.

Conclusion

The role of physiotherapy within ERAS and rehabilitation following intensive care is important and will be increasingly more so, as the development of ERAS programmes leads to a shift in outcome measures, from the current surrogate of length of stay, to functional and activity-based markers of recovery. There is limited research available that focuses on the effect of an ERAS programme on outcomes for patients discharged from an ICU following elective major surgery. This cohort may have the most to gain from a multimodal approach that integrates evidence-based interventions. Critical care physiotherapists adopt roles that assimilate strongly with key ERAS principles, and they can play a vital role in ensuring patients remain on track with their ERAS pathway whilst in an ICU. Providing a more intense, coordinated rehabilitation programme for patients following discharge from an ICU, delivered by a specialised physiotherapist and supported by a multidisciplinary team is hypothesised to improve recovery (Walsh et al. 2012).

Future research and investigation

Future research should focus on establishing a standardised rehabilitation programme, informed by ERAS principles, which can be delivered by specialist physiotherapists within an ICU and in an outpatient setting. Prospective studies are needed to determine the long-term effect of early mobilisation and exercise-based interventions. The ability to recover following discharge from an ICU can be more accurately measured when compared to values of baseline function, allowing clinicians to consider patients with pre-existing co-morbidities, who are less likely to respond to rehabilitation interventions. Thus, a safe and effective method for determining preoperative functional ability should be researched. Consideration of how to attain and importantly measure functional recovery should be the focus for physiotherapy research in the future, providing evidence for its inclusion in the ERAS programmes of tomorrow.

Abbreviations

ERAS enhanced recovery after surgery

ICU intensive care unit

ICUAW intensive care unit-acquired weakness

References:

- AbdelSalam H, Restrepo C, Tarity D et al. (2012) Predictors of intensive care unit admission after total joint arthroplasty. *J Arthroplasty*, 27(5): 720-725.
- Adler J, Malone D. (2012) Early Mobilization in the intensive care unit: A systematic review. *Cardiopulm Phys Ther J*. 23(1): 5-13.
- Agarwal HS, Saville BR, Slayton JM et al. (2012) Standardized postoperative handover process improves outcomes in the intensive care unit: A model for operational sustainability and improved team performance. *Crit Care Med*, 40(7): 2109-2115.
- Bandolm T, Kehlet H. (2012) Physiotherapy exercise after fast-Track total hip and knee arthroplasty: Time for reconsideration? *Arch Phys Med Rehabil*. 93(7). 1292-1294.
- Barber EA, Everard T, Holland AE et al. (2015) Barriers and facilitators to early mobilisation in intensive care: A qualitative study. *Australian Critical Care*, 28(4): 177-182.
- Borst SE. (2004) Systematic Review: Interventions for sarcopenia and muscle weakness in older people. *Age Ageing*, 33: 548-555.
- Burtin C, Clerckx B, Robbeets C et al. (2009). Early exercise in critically ill patients enhances short-term functional recovery. *Crit Care Med*, 37(9): 2499-2505.
- Carli F, Charlebois P, Stein B et al. (2010) Randomized clinical trial of prehabilitation in colorectal surgery. *Br J Surg*, 97(8): 1187-1197.
- Connolly B, Salisbury L, O'Neil B et al. (2015) Exercise rehabilitation following intensive care unit discharge for recovery from critical illness. *Cochrane Database Syst Rev*, 22(6): CD008632.
- Epstein NE. (2014) A review article on the benefits of early mobilization following spinal surgery and other medical/surgical procedures. *Surg Neurol Int*, 5(Suppl 3): S66-S73.
- ERAS Society (2017). ERAS Society Guidelines. Available from: <http://erassociety.org/guidelines/list-of-guidelines/>. [Accessed August 7 2017].
- Hanekom S, Louw QA, Coetzee AR. (2013) Implementations of a protocol facilitates evidence-based physiotherapy practice in intensive care units. *Physiotherapy* 99(2): 139-145.
- Hashem MD, Nelliot A, Needman DM. (2016) Early mobilization and rehabilitation in the ICU: Moving back to the future. *Respiratory care*, 61(7): 971-979.
- Hoogeboom TJ, Donkers JJ, Hulzebos EH et al. (2014) Merits of exercise therapy before and after major surgery. *Curr Opin Anaesthesiol*, 27(2):161-166.
- Jones C, Skirrow P, Griffiths RD et al. (2003). Rehabilitation after critical illness: A randomized, controlled trial. *Crit. Care. Med*. 31(10): 2456-2461.
- Jones C. (2012) Surviving the intensive care: Residual physical, cognitive and emotional dysfunction. *Thorac Surg Clin*, 22(4): 509-516.
- Kehlet H, Wilmore D. (2008) Evidence-based surgical care and the evolution of fast-track surgery. *Annals of surgery*, 248(2): 189-198.

McWilliams DJ, Atkinson D, Carter A et al. 2009. Feasibility and impact of a structured, exercise-based rehabilitation programme for intensive care survivors. *Physiother Theory Practice*, 25(8):566-571.

Moore JA, Conway DH, Thomas N et al. (2017) Impact of a perioperative quality improvement programme on postoperative pulmonary complications. *Anaesthesia*, 72(3): 317-327.

Paton F, Chambers D, Wilson P et al. (2014) Effectiveness and implementation of enhanced recovery after surgery programmes: a rapid evidence synthesis. *BMJ Open*, 4(7): e005015.

Pawlik AJ, Kress JP. (2013) Issues affecting the delivery of physical therapy services for individuals with critical illness. *Phys Ther*, 93(2): 256-265.

Sommers J, Engelbet RHH, Dettling-Ihnenfedldt D et al. (2015) Physiotherapy in the intensive care unit: an evidence-based, expert driven practical statement and rehabilitation recommendations. *Clin Rehabil*. 29(11): 1051-1063.

Walsh TS, Salisbury LG, Boyd J et al. 2012. A randomised controlled trial evaluating a rehabilitation complex intervention for patients following intensive care discharge: the RECOVER study. *BMJ Open*, 2:e001475.