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CORRESPONDENCE

Reply to the Letter to the Editor by Schwenk on the 28th of July 2022 concerning: Roulin D. and Demartines N.: Principles of enhanced recovery in gastrointestinal surgery. Langenbeck's Archives of Surgery. Online ahead of print 2022 doi: 10.1007/s00423-022–02,602-9

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Dear Editor,

The letter by Dr. Schwenk was a little surprising for us, as he represents a commercial company and makes several statements that need to be challenged.

First, his interpretation that fast track and ERAS are not different is not based on data and needs to be reappraised in the context. Fast track recovery was first used in 1994 by Engelman in cardiac surgery [1] and then developed by Kehlet in general surgery, based on surgical pathophysiology and focused on length of stay reduction. His group observed that with a fix short length of stay for sigmoid resection, unplanned readmission was as high as 20% [2]. Fast track was in fact the ancestor of Enhanced Recovery After Surgery (ERAS), which further developed the basic concept, together with Kehlet as senior author [3]. ERAS offers a systematization for both implementation and quality control, with several precise guidelines (free access on www.erassociety.org) that did not exist with fast track. The goal is not to claim that one is better than the other is, even if they are different, but simply to explain the filiation. As proof, on PubMed as accessed on the 17th August 2022, the number of publication with "Enhanced Recovery After Surgery" was exponentially growing in 2021 with 1267 articles, while papers on "fast track surgery" remained on a plateau phase with 293 publications in 2021. Data on outcome are here the key.

Second, the statement about ERAS trademark is rather funny: the goal was to protect the high quality standard requested to implement a full ERAS program with systematic applications of validated items. The ERAS® Society is an academic non-for profit society and there is neither ground, nor reason to open a polemic about that.

The type and name of perioperative protocols used is finally not the main point in assessing perioperative medicine, provided a protocol is really used with controlled compliance. "*Are you really doing what you think you do? Then show the data!*" Ideally, perioperative protocols as ERAS have to be whenever possible validated with data, and applied systematically with quality control, in favor of the patients.

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Declarations

Competing interests ND is a member of the executive committee of the ERAS® Society

Conflict of interest ND is member of the executive committee of the ERAS® Society.

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