Title: Guidelines for Perioperative Care for Liver Surgery: Enhanced Recovery After Surgery (ERAS) Society Recommendations.

Authors: Melloul E, Hübner M, Scott M, Snowden C, Prentis J, Dejong CH, Garden OJ, Farges O, Kokudo N, Vauthey JN, Clavien PA, Demartines N

Journal: World journal of surgery

Year: 2016 Oct

Issue: 40

Volume: 10

Pages: 2425-40

DOI: 10.1007/s00268-016-3700-1

Guidelines for perioperative care for liver surgery:

Enhanced Recovery After Surgery Society (ERAS) Recommendations

Emmanuel Melloul, MD, Martin Hübner, MD, Michael Scott, MD,
Chris Snowden, MD, James Prentis, MD, Cornelis H.C. Dejong, MD, PhD
O. James Garden, MD, Olivier Farges, MD, PhD, Norihiro Kokudo, MD, PhD
Jean-Nicolas Vauthey, MD, Pierre-Alain Clavien, MD, PhD,
Nicolas Demartines, MD

Correspondence to:

Nicolas Demartines, MD, FACS, FRCS

Department of Visceral surgery

University hospital Lausanne, CHUV

Rue du Bugnon 46

1011 Lausanne

Switzerland

demartines@chuv.ch

Authors conflict of interest:

EM no conflicts of interest

MH no conflicts of interest

MS Grants, consulting and travel: Merck, Deltex, Baxter, LIDCO, not related to present work

CS no conflicts of interest

JP no conflicts of interest
CHCD no conflicts of interest

OJG Educational grant: Ethicon (Johnson and Johnson), not related to present work

OF no conflicts of interest

NK Research grants from Dainihon Sumitomo, Bristol Mayers, and Taiho Yakuhin, not related to present work

JNV no conflicts of interest

PAC no conflicts of interest

ND Grants and consulting: Nestlé Scientific, MSD, Covidien, Johnson and Johnson, not related to present work

Authors' contributions:

EM performed the systematic review, wrote and edited the manuscript

MH performed the systematic review, wrote one part of the manuscript and edited the manuscript

MS performed the systematic review, wrote one part of the manuscript and edited the manuscript

CS performed the systematic review, wrote one part of the manuscript

JP performed the systematic review, wrote one part of the manuscript

CHCD revised critically and edited the manuscript

OJG revised critically and edited the manuscript

OF revised critically and edited the manuscript

NK revised critically and edited the manuscript

JNV revised critically and edited the manuscript

PAC revised critically and edited the manuscript

ND supervised the strategy, revised critically and edited the manuscript

Abstract

Background: Enhanced Recovery After Surgery (ERAS) is a multimodal pathway developed to overcome the deleterious effect of perioperative stress after major surgery. In colorectal surgery, ERAS pathways reduced perioperative morbidity, hospital stay and costs. Similar concept should be applied for liver surgery. This study presents the specific ERAS Society recommendations for liver surgery based on the best available evidence and on expert consensus.

Methods: A systematic review was performed on ERAS for liver surgery by searching EMBASE and Medline. Five independent reviewers selected relevant articles. Quality of randomized trials was assessed according to the Jadad score and CONSORT statement. The level of evidence for each item was determined using the GRADE system. The Delphi method was used to validate the final recommendations.

Results: A total of 157 full texts were screened. Thirty-seven articles were included in the systematic review and 16 of the 23 standard ERAS items were studied specifically for liver surgery. Consensus was reached among experts after 3 rounds. Prophylactic nasogastric intubation and prophylactic abdominal drainage should be omitted. The use of postoperative oral laxatives and minimally invasive surgery results in a quicker bowel recovery and shorter hospital stay. Goal directed fluid therapy with maintenance of a low intraoperative central venous pressure induces faster recovery. Early oral intake and mobilization is recommended. There is no evidence to prefer epidural to other types of analgesia.

Conclusions: The current ERAS recommendations were elaborated based on the best available evidence and endorsed by the Delphi method. Nevertheless, prospective studies need to confirm the clinical use of the suggested protocol.

Enhanced Recovery After Surgery (ERAS) is a multimodal pathway developed to improve recovery after major surgery. The ERAS strategy has been validated in colorectal surgery and is applied in other specialties including urology, thoracic, vascular, and orthopedic surgery [1-3]. In colorectal surgery, ERAS pathways allow significant reduction in postoperative complications, faster functional recovery, shorter hospital stays and reduced costs, even in elderly patients [4-6]. Patients within ERAS pathways mainly benefit from reduced medical complications while surgical morbidity remains generally unchanged [5].

Liver surgery is a major and challenging procedure for both anesthesiologists and surgeons, and for the patient. Major morbidity ranges from 17% in benign to 27% in malignant disease, with a mortality risk of up to 5% [7]. In particular, pulmonary complications may reach 30% with increased risk of thromboembolic events of 5% [7-10]. In addition, about 50% of patients experience nausea and adverse digestive events [11]**.** Perioperative stress is increased during major liver surgery and all measures implemented to reduce the metabolic stress response could potentially reduce medical complications [5]. A recent meta-analysis demonstrated that enhanced recovery pathways for liver surgery was associated with a significant decrease in postoperative complications and length of hospital stay compared to standard care [12]. However, the majority of studies including ERAS protocols in liver surgery were performed in patients with normal liver parenchyma while data in cirrhotic and obstructive jaundiced patients remained scarce. Unfortunately, published protocols vary widely and actual application of the intended protocol (compliance) was provided in one single study only [13]. Furthermore, hepatic and colorectal surgeries differ in terms of underlying disease, co-morbidities, metabolic stress response and organ-specific complications**.** It is currently unclear whether the ERAS elements validated for colorectal surgery can be extrapolated and applied for liver surgery.

The present systematic review elaborates specific ERAS Society guidelines for enhanced recovery care after liver surgery by systematic review of the literature and expert consensus with the Delphi method.

Methods

1.1 Literature search and data selection

According to the PRISMA statements [14], Embase and Medline (through Pubmed) were searched systematically using the medical subject headings (MeSH) “Hepatectomy AND the 23 pre-, intra-, and postoperative validated ERAS items”. Only full text articles in English were analyzed. Eligible articles included meta-analyses, randomized controlled trials (RCTs) or prospective cohort studies with control group published between January 1997 (1st landmark published study on ERAS [15]) and 1st December 2015. Retrospective series were considered only if data of better quality could not be identified.

1.2 Inclusion and exclusion criteria

This systematic review focused on non-obstructive jaundiced patients without cirrhosis. All types of hepatectomy according to the Brisbane classification were included [16]. Major hepatectomy was defined as resection of 3 or more *Couinaud's* segments. Patients with choledocho-jejunostomy or vascular reconstruction were also included. All series including liver transplantation and patients with additional non-liver surgery (e.g. hepato-pancreaticoduodenectomy, colorectal associated resection) were excluded.

1.3 Data extraction and quality assessment

The first literature search was performed independently by 5 authors (EM, MH, MS, CS, and JP) in January 2015. The terms of interest were first identified in the title, secondly in the abstract or medical subject headings. All studies of interest were screened with thorough full text reading. The quality of RCTs included was assessed using the Jadad-score (range 0-5) and the Consolidated Standards of Reporting Trials (CONSORT) statement checklist [17, 18]. According to the published ERAS recommendations for pancreaticoduodenectomy [19], the level of evidence for each item was determined using the Grading of Recommendations Assessment Development and Evaluation (GRADE) system, in which the level of evidence was classified as high, moderate, low or very low [20]. The research team (EM, MH, ND) made a final decision on inclusion of a study or not, and was responsible for drafting the first manuscript.

1.4 Items analyzed

The classical 23 ERAS items validated for colorectal surgery were analyzed for liver surgery (**Table 1)**. When only evidence in colorectal surgery was found for an item, it was searched for any evidence or rationale that this item should not be used in liver surgery.

1.5 Modified Delphi method

A 3-round web-based Delphi approach was used in this consensus process [21]. Surgical program directors, chairmen of liver surgery departments, academic surgeons and anesthesiologists with publications involving ERAS and/or liver surgery were identified using PubMed database. They were deemed as “experts”. To ensure the international standpoint to this consensus, we aimed to recruit a panel of experts from America, Asia and Europe. A recruitment letter in English was sent via e-mail providing a brief outline of the project and its objectives. If invited experts did not respond to the invitation within 2 weeks, a reminder was sent out. Further experts were invited if no answer came in the next 2 weeks or the expert declined to participate in the study. A positive response to the recruitment letter served as informed consent.

In all 3 rounds, the manuscript was distributed by email via a secured web-link. As previously validated, a modified Delphi process was used [22]. Each expert was asked to comment and edit anonymously the recommendations for each ERAS item using the text editor track change system. The research team served in the role of facilitator, undertaking the synthesis between rounds. The process of synthesis included discussion among the research team, exploring all expert opinions, disagreements and suggestions for change, before synthesized recommendations were drafted for each subsequent round. Consensus was defined as agreement by ≥ 75% of raters [23].

Results

The electronic search yielded 1867 potential studies. The selection process according to PRISMA guidelines is displayed in **Figure 1**.

Overall 10 RCTs, 3 prospective case series, 5 retrospective case control series, 16 meta-analyses, 2 systematic reviews, and one expert opinion study were included in the analysis. The overall quality of RCTs was high (**Table 2**); 9 RCTs had a Jadad score ≥3. Among the 23 published ERAS items for colorectal surgery, 16 were studied specifically for liver surgery (perioperative oral nutrition, perioperative oral immunonutrition, treatment with carbohydrates, postoperative artificial nutrition, anti-thrombotic prophylaxis, antimicrobial prophylaxis and skin preparation, type of incision, no routine resection site drainage, minimally invasive approach, peri-operative steroid administration, postoperative glycaemic control, no prophylactic nasogastric intubation, prevention of delayed gastric emptying, laxatives use, multimodal analgesia, and stringent fluid management). Seven items were not studied in liver surgery patients and data were extrapolated from previous studies in colorectal surgery (preoperative counseling, no preoperative fasting, early mobilization, audit, early oral nutrition, prevention of postoperative nausea and vomiting (PONV) and prevention of postoperative ileus). The summary and grading of recommendations with their respective level of evidence are depicted in **Table 1** and the results of the liver specific studies used for the analysis summarized in **Table 2 (and suppl. Table 1)**.

Delphi process results

Seven experts agreed to participate to this consensus after the first invitation (1 from America, 1 from Japan, 1 from Netherlands, 2 from England, 1 from France, and 1 from Switzerland). After 3 rounds, all recommendations were agreed between the experts with a minimum of 75%. **Tables 3** summarize the items with <75% agreement in round 1 and 2.

ERAS Recommendations

1. Preoperative counseling

There are no studies evaluating the therapeutic effect of preoperative counseling and patient education before liver surgery. However, it is documented that patient decision aids such as printed documents and online information sources increase the involvement of patients in decision-making process and also increase the value of informed consent [24]. In addition, leaflets or multimedia information regarding the procedure and details of the patients' postoperative tasks improve results of perioperative feeding, mobilization and respiratory physiotherapy thereby reducing complications after major abdominal surgery [1, 19].

Recommendation: Patients should receive routine dedicated preoperative counseling and education before liver surgery.

Evidence level: moderate

Grade: strong

2. Perioperative nutrition

Malnutrition is an important modifiable risk factor for adverse outcomes after major surgery. Routine nutritional screening should be mandatory for all patients undergoing major surgery [25-27]. Several screening tools are available and their usefulness in clinical practice is demonstrated. The *Nutritional Risk Score* (NRS), the *Malnutrition Universal Screening Tool* and the *Subjective Global Assessment* (SGA) deserve particular mention [25, 28]. According to the ESPEN guidelines, delaying surgery to allow for preoperative enteral nutrition (for at least 2 weeks) is recommended in patients with at least one of the following criteria: weight loss >10-15% within 6 months, BMI<18.5 kg/m^2, and serum albumin<30 g/l (with no evidence of hepatic or renal dysfunction) [25, 28]. Current recommendations suggest 5-7 days of oral supplements before surgery in patients at risk of malnutrition [25, 28]. In severely undernourished patients who cannot be fed adequately orally or enterally, parenteral nutrition is recommended (Grade A) [29].

Recommendation: Patients at risk (weight loss >10-15% within 6 months, BMI<18.5 kg/m^2, and serum albumin<30 g/l in the absence of liver or renal dysfunction) should receive oral nutritional supplements for seven days prior to surgery. For severely malnourished patients (>10% WL), surgery should be postponed for at least 2 weeks to improve nutritional status and allow patients to gain weight.

Evidence level: high

Grade of recommendation: strong

3. Perioperative oral immunonutrition

Immunonutrition (IN) contains ω-3 fatty acids, arginine, and nucleic acids. So far, the only randomized study on nutrition and liver resection included 26 patients only [30], and no meaningful difference was reported. The ongoing PROPILS trial is likely to deliver a definitive answer: 200 IN patients will be compared to 200 patients receiving isocaloric isonitrogenous nutrition for seven days before liver resection with overall complications as primary endpoint [31].

Recommendation: There is limited evidence for the use of IN in liver surgery.

Evidence level: low

Grade of recommendation: weak

4. Preoperative fasting and pre-operative carbohydrate load

Preoperative fasting no more than 2 hours for liquids and 6 hours for solid food has proven to be safe and is recommended for digestive surgery [32]. A recent systematic review included 17 randomized trials with 1,445 surgical patients [33]. Patients receiving carbohydrates had less perioperative insulin resistance and fewer symptoms like malaise, hunger, thirst, nausea or anxiety. No difference in terms of complications was observed but one study demonstrated reduced hospital stay [33]. Carbohydrate loading is firmly established in colorectal guidelines [34, 35] and may be recommended in major liver surgery, since some data in the literature support the deleterious effect of insulin resistance on liver regeneration [36].

Recommendation: Preoperative fasting does not need to exceed 6 hours for solids and 2 hours for liquids. Carbohydrate loading is recommended the evening before liver surgery and 2 hours before induction of anesthesia.

Evidence level: No preoperative fasting more than 6 hours: moderate; Carbohydrate loading: low

Grade of recommendation: No preoperative fasting more than 6 hours: strong; Carbohydrate loading: weak

5. Oral bowel preparation

Mechanical bowel preparation (MBP) may lead to fluid and electrolyte imbalances [37]. There are neither studies nor evidences about MBP before liver surgery.

Recommendation: Oral MBP is not indicated before liver surgery.

Evidence level: low

Grade of recommendation: weak

6. Pre-anesthetic medication

A recent Cochrane review on premedication for day case surgery in adults suggested that patients receiving oral anxiolytics showed impairment of psychomotor function 4 hours post operatively, which reduced the patient's ability to mobilize, eat and drink [39]. This may also hold in patients with impaired liver function after resection and long-acting sedative premedication should be avoided. In selected cases, short acting anxiolytics may be administered, to facilitate regional anesthesia prior to general anesthesia induction.

> **Recommendations:** Long acting anxiolytic drugs should be avoided. Short acting anxiolytics may be used to perform regional analgesia prior to the induction of anesthesia.
>
> **Evidence level:** moderate
>
> **Grade of recommendation:** strong

7. Anti-thrombotic prophylaxis

Major hepatectomy in a normal liver parenchyma is an independent risk factor for postoperative PE [9]. In a large comparative cohort study (n=419), patients treated with postoperative thrombo-prophylaxis beginning at day 1 after major hepatectomy had lower post-operative symptomatic venous thromboembolism (VTE) [42]. LMWH or unfragmented heparin treatment should be initiated 2-12 hours before surgery and continued until patients are fully mobile [19]. Of note, possible interference with the use of epidural analgesia still needs to be assessed. The heparin should be administered 12 hours prior to insertion of epidural catheter. A Cochrane meta-analysis supports continued treatment for 4 weeks after hospital discharge particularly in oncologic patients [43]. In addition, the use of compressive stockings and intermittent pneumatic compression devices can further decrease this risk [35].

Recommendation: LMWH or unfragmented heparin reduces the risk of thromboembolic complications and should be started 2-12 hours before surgery, particularly in major hepatectomy. Intermittent pneumatic compression stockings should be added to further decrease this risk.

Evidence level: Use of heparin: moderate; Use of intermittent pneumatic compression devices: low

Grade of recommendation: Use of heparin: strong; Use of intermittent pneumatic compression devices: weak

8. Peri-operative steroid administration

According to a previous meta-analysis including 5 RCTs' (n=379 patients) comparing pre-operative steroid administration to placebo during liver resection, pre-operative steroid use was associated with a significant reduction in levels of bilirubin and interleukin 6 (IL-6) on postoperative day 1 [44]. In addition, steroid used was associated with a trend towards lower incidence of post-operative complications. A more recent meta-analysis by Li et al. showed contradictory results, with no impact on postoperative complications after liver resection [45]. Most studies used methylprednisolone at a dosage of 30mg/kg 30 minutes to 2 hours prior to surgery. The use of steroids in diabetics has not been studied and since the glycaemic control is impaired after hepatectomy it is best avoided in this group until further studies are available.

Recommendation: Steroids (methylprednisolone) may be used before hepatectomy in normal liver parenchyma, since it decreases liver injury and intraoperative stress, without increasing the risk of complications. Steroids should not be given in diabetic patients.

Evidence level: moderate

Grade of recommendation: weak

9. Antimicrobial prophylaxis and skin preparation

Liver surgery is classified as clean-contaminated surgery due to bile duct transsection. There is no clear evidence for systematic use of antimicrobial prophylaxis in liver surgery [46-48]. In addition, there is no evidence on the benefit of long- or short-term antibiotic therapy in patients with previous bile duct drainage (PBD). Up to 70% of PBD patients have positive bile cultures (4% with MRSA) and are associated in up to 30% of cases with surgical site infection (SSI), but without increased mortality or postoperative hospital stay compared to patients with negative bile cultures [49].

Based on the Advisory Statement from the National Surgical Infection Prevention Project, antibiotics should be administered before skin incision less than one hour before surgery [50]. In a recent Cochrane meta-analysis including 7 RCTs' (n=521 patients), no antimicrobial method (i.e. perioperative antibiotic therapy, pre- and probiotics through enteral feeding catheter) could improve outcomes after liver surgery [46]. Hirokawa et al. demonstrated that postoperative antibiotic therapy with flomoxef sodium (3rd generation Cephalosporin) every 12 hours for 3 days did not prevent postoperative infectious complications compared to single preoperative administration [47]. The administration of antibiotics for 2 or 5 days after hepatectomy without biliary reconstruction did not modify SSI and systemic infections [48].

Recommendation: Single dose intravenous antibiotics should be administered before skin incision and less than one hour before hepatectomy. Postoperative “prophylactic” antibiotics are not recommended.

Evidence level: moderate

Grade of recommendation: strong

Regarding skin preparation, one single RCT (n=100 patients) assessed the efficacy of chlorhexidine-gluconate for pre-hepatectomy skin cleansing [51]. According to this study, SSI (primary outcome measure) were not different compared to control with saline solution only. On the other hand, a recently published large RCT (n=849 patients) including abdominal (and liver surgery) and non-abdominal types of surgery demonstrated that preoperative cleansing with chlorhexidine-alcohol 2% was superior to povidone-iodine to prevent SSI [52].

Recommendation: Skin preparation with chlorhexidine 2% is superior to povidone-iodine solution.

Evidence level: moderate

Grade of recommendation: strong

10. Incision

There are 4 major types of incision: median incision, right transverse incision with vertical extension to the xiphoid (J-shaped), subcostal incision extending to the left, and bilateral transverse incision with vertical extension (Mercedes-type). According to the two largest retrospective cohort studies (n=1426 and 626 patients, respectively) including one or multiple control groups, Mercedes-type incision had the highest incisional hernia risk at one year [53, 54]. Of note, perioperative morbidity and pulmonary complications were similar whatever the shape of the incision. For a better exposure of the hepatocaval junction, the inverted “L incision” (modified Makuuchi) can also be used [55].

Recommendation: The choice of incision is at the surgeon’s discretion. It depends on the patient’s abdominal shape and location in the liver of the lesion to be resected. Mercedes-type incision should be avoided due to higher incisional hernia risk.

Evidence level: moderate

Grade of recommendation: strong

11. Minimally invasive approach

The Second International Consensus Conference on Laparoscopic Liver Resections in Morioka 2014 (Japan) concluded that minor laparoscopic liver resections (LLRs) had become standard practice while major still remain innovative procedures and deserved further investigations [56]. One single retrospective study assessed LLRs in patients within ERAS protocol and suggested its feasibility with acceptable risk and possible additional accelerate recovery with reduced length of stay [57]. The results of the on-going multicenter Orange-II trials assessing open versus laparoscopic left lateral hepatic sectionectomy within an enhanced recovery ERAS program may provide further evidence [58]. Twelve other systematic reviews were identified [59-70], 9 included meta-analysis comparing open versus laparoscopic liver surgery [61-63, 65-70]. These meta-analyses concluded that LLR was associated with lower intraoperative blood loss, blood transfusion, postoperative complications, and shorter hospital stay. In addition, LLR reduced the incidence of liver failure, and lowered postoperative ileus, while decreasing overall cost [63, 66, 71]. Moreover, it seems that patients with LLR had a faster oral intake and required less intravenous narcotic use [69]. LLR achieved similar short and long term oncologic outcomes for HCC or colorectal liver metastases (CLM) [62, 65, 72]. Finally, some authors advocated the systematic use of LLR for left lateral resection in benign liver lesions and in living donors for pediatric liver living donor transplantation [73, 74].

Recommendation: LLR can be performed by hepato-biliary surgeons experienced in laparoscopic surgery, in particular left lateral sectionectomy and resections of lesions located in anterior segments.

Evidence level: moderate

Grade of recommendation: strong

There were no studies assessing the safety of robotic liver surgery in patients within an ERAS protocol. Robotic liver resection seems to be feasible by hepato-biliary surgeons with advanced training, especially for lesions located in the postero-superior segments [75, 76]. However, according to a recent large series comparing robotic versus laparoscopic hepatectomy, significant benefits were not demonstrated yet [77].

Recommendation: There is currently no proven advantage of robotic liver resection in ERAS. Its use should be reserved for clinical trials.

Evidence level: low

Grade of recommendation: weak

12. Prophylactic Nasogastric intubation

Two recent Cochrane systematic reviews demonstrated that prophylactic nasogastric intubation after abdominal surgery should be abandoned in favor of selective use. Increased pulmonary complications and longer time to return of bowel function were observed in patients with routine nasogastric tube [78]. One RCT (including 200 patients) confirmed those results after hepatectomy [79].

Recommendation: Prophylactic nasogastric intubation increases the risk of pulmonary complications after hepatectomy. Its routine use is not indicated.

Evidence level: high

Grade of recommendation: strong

13. Prophylactic abdominal drainage

The strongest evidence to omit routine prophylactic drainage after major abdominal surgery arises from a meta-analysis published in 2004 [80]. This meta-analysis however, included 3 RCTs on liver resection only, with low sample size [81, 82]. Kyoden et al. assessed the value of prophylactic drainage in a retrospective cohort study including 1269 consecutive elective liver resections [83]. Prophylactic drainage reduced the frequency of subphrenic abcess and biliary fistula or bilioma formation.

Recommendation: The available evidence is non-conclusive and no recommendation can be given for the use of prophylactic drainage or against it after hepatectomy.

Evidence level: low

Grade of recommendation: weak

14. Preventing intraoperative hypothermia

Normothermia (>36º) during surgery is recommended to reduce postoperative cardiac and non-cardiac complications [84-89]. However, no study specific to liver surgery investigating this point could be found. According to one RCT and one recent meta-analysis, even mild hypothermia increased significantly the risk for blood loss and transfusion [85, 89]. One meta-analysis suggested that circulating water garments offer better temperature control than forced air warming systems [90].

Recommendation: Perioperative normothermia should be maintained during liver resection.

Evidence level: moderate

Grade of recommendation: strong

15. Postoperative nutrition and early oral intake

Lassen et al. conducted a multicenter randomized trial with 427 digestive surgery patients, who received either normal food from postoperative day 1 or a conservative regimen with *nil* by mouth and enteral tube feeding [91]. There was no difference in complications, reoperations or mortality, but resumption of bowel function was faster in the "early food" group. Sixty-six patients in this study had either liver resection or hepatico-jejunostomy, confirming safety and benefits of early oral intake. Hendry et al. demonstrated the benefits of the routine use of oral laxatives combined with oral nutritional supplements in liver surgery patients within enhanced recovery pathway [92]. Postoperative supplemental nutrition is only indicated in malnourished patients or in prolonged postoperative fasting (>5 days) such as when severe complications arise [25-27]. A systematic review confirmed that enteral nutrition should be preferred over parenteral nutrition after liver resections for better immune function and lower rates of infectious complications [93].

Recommendation: Most patients can eat normal food at day one after liver surgery. Postoperative enteral or parenteral feeding should be reserved for malnourished patients or those with prolonged fasting due to complications (e.g. ileus >5 days, delayed gastric emptying).

Evidence level: Early oral intake: moderate; Oral nutritional supplements: moderate; No routine postoperative artificial nutrition: high.

Grade of recommendation: Early oral intake: strong; Oral nutritional supplements: weak; No routine postoperative artificial nutrition: strong.

16. Postoperative glycaemic control

Perioperative hyperglycemia is frequently observed after major surgery [94, 95]. These changes result from a transient insulin resistance with a compromised peripheral insulin-dependent glucose uptake [96]. Hyperglycemia induced by surgical stress results in deregulation of liver metabolism and immune function, impairing postoperative recovery. In colorectal and pancreatic surgery, early postoperative hyperglycemia was associated with adverse outcomes [19, 97, 98]. Postoperative insulin sensitivity is significantly reduced in patients not treated with insulin during surgery [99]. In addition, there is a rapid change in glucose concentration during hepatectomy with Pringle maneuver, reflecting glycogen breakdown within hepatocytes because of hypoxia [100]. According to one RCT (n=88) patients who received insulin therapy using a closed-loop glycemic control system (i.e. an artificial pancreas) during hepatectomy had reduced total hospital costs and SSI [101]. There is evidence that preoperative oral supplementation with carbohydrate and branched-chain amino acid-enriched nutrient decreased insulin resistance in patients undergoing hepatectomy [102]. A raised blood lactate after liver surgery, which correlates with postoperative morbidity [103], can be related to insulin resistance or to a mix between insulin resistance and ischemia-reperfusion injury. Therefore insulin therapy should be initiated early.

Recommendation: Insulin therapy to maintain normoglycaemia is recommended.

Evidence level: moderate

Grade of recommendation: strong

17. Prevention of delayed gastric emptying

Left-sided liver resection may be associated with a higher risk of DGE due to disruption of normal gastrointestinal movement at the point of contact between the stomach and the cut liver surface. According to 2 RCTs, the use of omentum flap to cover the liver cut surface after left-sided hepatectomy reduced the incidence of DGE [104, 105].

Recommendation: An omentum flap to cover the cut surface of the liver reduces the risk of DGE after left-sided hepatectomy.

Evidence level: high

Grade of recommendation: strong

18. Stimulation of bowel movement

According to 2 recent meta-analyses, the use of ERAS protocol significantly shortened the time to first flatus, hence reducing the postoperative ileus period [12, 106]. In the study by Hendry et al., the routine use of postoperative laxatives resulted in an earlier first passage of stool but the overall rate of recovery was unaltered in liver surgery patients [92]. The use of chewing gum (CG) after surgery has been addressed in a large Cochrane review [107]. This meta-analysis showed no clear benefit of CG in ERAS patients and included few patients with liver surgery. The use of laparoscopic surgery and aiming for a neutral fluid balance by avoiding salt and fluid overload in the postoperative period have been shown to reduce the risk of postoperative ileus [12, 66].

Recommendation: Stimulation of bowel movement after liver surgery is not indicated.

Evidence level: high

Grade of recommendation: strong

19. Early mobilization

Bed rest is associated with multiple documented deleterious effects [108, 109]. Bed rest favors diffuse muscle atrophy, thromboembolic disease, and insulin resistance [110]. There was no evidence that early mobilization is deleterious after liver surgery. Further studies are needed to determine the frequency and the number of hours required to improved patients outcome.

Recommendation: Early mobilization after hepatectomy should be encouraged from the morning after the operation until hospital discharge.

Evidence level: low

Grade of recommendation: weak

20. Analgesia

In one RCT using Thoracic Epidural Analgesia (TEA) a short length of stays of 4 days after major liver resection was achieved with low complication rate [13]. A concern using TEA is the possible prolongation of prothrombin time after hepatectomy, which may delays epidural catheter removal and increases administration of corrective blood products [111]. A recent RCT showed that epidural analgesia in open liver resection might be a risk factor for postoperative kidney failure due to hypotension [112]. Several studies have suggested that intrathecal opiates are a suitable alternative to epidural analgesia and traditional morphine PCA [113, 114]. One recent RCT compared the role of local anesthetic wound infusion catheter plus patient-controlled opiate analgesia to standard epidural analgesia after open liver resection within an ERAS protocol [115]. Wound infusion reduced the length of time required to fulfill criteria for hospital discharge, however epidural analgesia conferred better analgesia control. A meta-analysis of 4 studies (n=705) with open liver resections has shown lower pain scores on day 1 post operatively with epidural, but similar outcome compared to local anesthetic infiltration via wound catheters [116]. There was no difference in hospital length of stay and the overall complication rate was higher in the epidural group.

Recommendations: Routine TEA cannot be recommended in open liver surgery for ERAS patients. Wound infusion catheter or intrathecal opiates can be good alternatives when combined with multimodal analgesia.

Evidence level: moderate

Grade of recommendation: strong

21. Postoperative nausea and vomiting

Postoperative nausea and vomiting (PONV) is common after major surgery, but the multimodal approach within ERAS pathway enables most patients after liver resection to eat on postoperative day 1 [13]. Risk factors are assessed preoperatively and include: previous PONV, female gender, younger age, non-smoker, and use of volatile anesthetic agents and opioids [117]. 5HT3 antagonists remain the first line therapy due to their good side effect profile. Low dose dexamethasone improves liver regeneration (with no additional benefit at higher doses) [118]. As dexamethasone can worsen glycemic control, it should be used with caution in diabetics. Other secondary drugs are antihistamines, butyrophenones and phenothiazines [118].

Recommendations: A multimodal approach to PONV should be used. Patients should receive PONV prophylaxis with 2 antiemetic drugs.

Evidence level: moderate

Recommendation Grade: strong

22. Fluid management

The reduction of hepatic venous congestion by careful control of central venous pressure (CVP) during hepatic resection is associated with a reduction in intraoperative blood loss [119-121]. A Cochrane review evidenced that a lower CVP reduced blood loss, but there was no difference in red cell transfusion requirements, intraoperative morbidity or long-term survival benefits [122]. Those results were confirmed in a recent meta-analysis by Hughes et al. [123]. Although the measure of stroke volume variation (SVV) has been proposed as appropriate replacement for CVP monitoring [124], it is more likely that a synergistic combination of CVP monitoring and SVV methods will become the standard form of hemodynamic monitoring in liver surgery.

One recent study has demonstrated that goal directed fluid therapy at the end of hepatic resection and during the first 6 hours enabled a faster restoration of circulating volume with reduction of complications [13]. The use of balanced crystalloid solution rather than 0.9% normal saline to maintain intravascular volume is recommended to avoid hyperchloremic acidosis and other causes of postoperative morbidity [125, 126]. The role of colloids remains controversial and the use of hetastarches increases the risk of renal dysfunction when a SIRS response and sepsis is presents, and should be avoided in liver resection [127].

Recommendations: The maintenance of low CVP (below 5 cmH2O) with close monitoring during hepatic surgery is advocated. Balanced crystalloid should be preferred over 0.9% saline or colloids to maintain intravascular volume and avoid hyperchloraemic acidosis or renal dysfunction, respectively.

Evidence level: moderate

Recommendation Grade: strong

21. Audit

The effectiveness of audit in improving healthcare has been demonstrated in a recent Cochrane systematic review [128]. Feedback was more efficient when baseline performance was low, when the source was a supervisor or a colleague, and when it was provided more than once, delivered in verbal and written formats, and when it included both explicit targets and action plan. Since strict adherence to the protocol is paramount for the success of ERAS implementation, auditing compliance has become *per se* a key element [34].

Recommendation: Systematic audit improves compliance and clinical outcome in healthcare practice

Evidence level: moderate

Grade of recommendation: strong

Conclusions

This systematic review highlights that the current available data on enhanced recovery pathways in liver surgery is scarce and lacks standardization. Although 16 out of the 23 standard items of ERAS were studied for liver surgery, the quality and level of evidence of the studies remain low. The highest level of evidence (level 1 or 2) was available for only 5 items. Though the value of enhanced recovery pathways has now been demonstrated in colorectal surgery, with a significant reduction in morbidity, cost and hospital stay, there is a need to perform high quality studies to confirm the benefit of ERAS pathways in liver surgery. In conclusion, the proposed ERAS pathway for liver surgery is based on the best available evidence, but it needs to be further investigated. In addition, a very important aspect of ERAS pathways is the assessment of adherence to the protocol (compliance). Compliance with the new proposed liver ERAS protocol should be documented as part of further trial to allow benchmarking.

References

1. Cerantola Y, Valerio M, Persson B et al. Guidelines for perioperative care after radical cystectomy for bladder cancer: Enhanced Recovery After Surgery (ERAS((R))) society recommendations. Clin Nutr 2013; 32: 879-887.
2. Varadhan KK, Neal KR, Dejong CH et al. The enhanced recovery after surgery (ERAS) pathway for patients undergoing major elective open colorectal surgery: a meta-analysis of randomized controlled trials. Clin Nutr 2010; 29: 434-440.
3. Ansari D, Gianotti L, Schroder J, Andersson R. Fast-track surgery: procedure-specific aspects and future direction. Langenbecks Arch Surg 2013; 398: 29-37.
4. Muller S, Zalunardo MP, Hubner M et al. A fast-track program reduces complications and length of hospital stay after open colonic surgery. Gastroenterology 2009; 136: 842-847.
5. Greco M, Capretti G, Beretta L et al. Enhanced recovery program in colorectal surgery: a meta-analysis of randomized controlled trials. World J Surg 2014; 38: 1531-1541.
6. Roulin D, Donadini A, Gander S et al. Cost-effectiveness of the implementation of an enhanced recovery protocol for colorectal surgery. Br J Surg 2013; 100: 1108-1114.
7. Dokmak S, Fteriche FS, Borscheid R et al. 2012 Liver resections in the 21st century: we are far from zero mortality. HPB (Oxford) 2013; 15: 908-915.
8. Dondero F, Taille C, Mal H et al. Respiratory complications: a major concern after right hepatectomy in living liver donors. Transplantation 2006; 81: 181-186.
9. Melloul E, Dondero F, Vilgrain V et al. Pulmonary embolism after elective liver resection: a prospective analysis of risk factors. J Hepatol 2012; 57: 1268-1275.
10. Farges O, Goutte N, Bendersky N et al. Incidence and risks of liver resection: an all-inclusive French nationwide study. Ann Surg 2012; 256: 697-704; discussion 704-695.
11. Verhoef C, Singla N, Moneta G et al. Fibrocaps for surgical hemostasis: two randomized, controlled phase II trials. J Surg Res 2015; 194: 679-687.
12. Hughes MJ, McNally S, Wigmore SJ. Enhanced recovery following liver surgery: a systematic review and meta-analysis. HPB (Oxford) 2014; 16: 699-706.
13. Jones C, Kelliher L, Dickinson M et al. Randomized clinical trial on enhanced recovery versus standard care following open liver resection. Br J Surg 2013; 100: 1015-1024.
14. Hutton B, Salanti G, Caldwell DM et al. The PRISMA Extension Statement for Reporting of Systematic Reviews Incorporating Network Meta-analyses of Health Care Interventions: Checklist and Explanations. Ann Intern Med 2015; 162: 777-784.
15. Kehlet H. Multimodal approach to control postoperative pathophysiology and rehabilitation. Br J Anaesth 1997; 78: 606-617.
16. Strasberg SM. Nomenclature of hepatic anatomy and resections: a review of the Brisbane 2000 system. J Hepatobiliary Pancreat Surg 2005; 12: 351-355.
17. Jadad AR, Moore RA, Carroll D et al. Assessing the quality of reports of randomized clinical trials: is blinding necessary? Control Clin Trials 1996; 17: 1-12.
18. Schulz KF, Altman DG, Moher D, Group C. CONSORT 2010 statement: updated guidelines for reporting parallel group randomized trials. Ann Intern Med 2010; 152: 726-732.
19. Lassen K, Coolsen MM, Slim K et al. Guidelines for perioperative care for pancreaticoduodenectomy: Enhanced Recovery After Surgery (ERAS(R)) Society recommendations. Clin Nutr 2012; 31: 817-830.
20. Guyatt GH, Oxman AD, Kunz R et al. Going from evidence to recommendations. BMJ 2008; 336: 1049-1051.
21. HSU CCaS, B. Delphi. 2007.

22. Pike I, Piedt S, Davison CM et al. Youth injury prevention in Canada: use of the Delphi method to develop recommendations. BMC Public Health 2015; 15: 1274.
23. Loblaw DA, Prestrud AA, Somerfield MR et al. American Society of Clinical Oncology Clinical Practice Guidelines: formal systematic review-based consensus methodology. J Clin Oncol 2012; 30: 3136-3140.
24. International patient decision aid standards collaboration. Background document. http://ipdas.ohri.ca/IPDAS_Background.pdf. Published February 17, 2005.
25. Weimann A, Braga M, Harsanyi L et al. ESPEN Guidelines on Enteral Nutrition: Surgery including organ transplantation. Clin Nutr 2006; 25: 224-244.
26. Guenter P, Robinson L, DiMaria-Ghalili RA et al. Development of Sustain: A.S.P.E.N.'s National Patient Registry for Nutrition Care. JPEN J Parenter Enteral Nutr 2012; 36: 399-406.
27. Weimann A, Breitenstein S, Breuer JP et al. [Clinical nutrition in surgery. Guidelines of the German Society for Nutritional Medicine]. Chirurg 2014; 85: 320-326.
28. Schindler K, Pernicka E, Laviano A et al. How nutritional risk is assessed and managed in European hospitals: a survey of 21,007 patients findings from the 2007-2008 cross-sectional nutritionDay survey. Clin Nutr 2010; 29: 552-559.
29. Braga M, Ljungqvist O, Soeters P et al. ESPEN Guidelines on Parenteral Nutrition: surgery. Clin Nutr 2009; 28: 378-386.
30. Mikagi K, Kawahara R, Kinoshita H, Aoyagi S. Effect of preoperative immunonutrition in patients undergoing hepatectomy; a randomized controlled trial. Kurume Med J 2011; 58: 1-8.
31. Ciacio O, Voron T, Pittau G et al. Interest of preoperative immunonutrition in liver resection for cancer: study protocol of the PROPILS trial, a multicenter randomized controlled phase IV trial. BMC Cancer 2014; 14: 980.
32. Gustafsson UO, Scott MJ, Schwenk W et al. Guidelines for perioperative care in elective colonic surgery: Enhanced Recovery After Surgery (ERAS((R))) Society recommendations. World J Surg 2013; 37: 259-284.
33. Bilku DK, Dennison AR, Hall TC et al. Role of preoperative carbohydrate loading: a systematic review. Ann R Coll Surg Engl 2014; 96: 15-22.
34. Gustafsson UO, Hausel J, Thorell A et al. Adherence to the enhanced recovery after surgery protocol and outcomes after colorectal cancer surgery. Arch Surg 2011; 146: 571-577.
35. Nygren J, Thacker J, Carli F et al. Guidelines for perioperative care in elective rectal/pelvic surgery: Enhanced Recovery After Surgery (ERAS((R))) Society recommendations. World J Surg 2013; 37: 285-305.
36. Beyer TA, Werner S. The cytoprotective Nrf2 transcription factor controls insulin receptor signaling in the regenerating liver. Cell Cycle 2008; 7: 874-878.
37. Holte K, Nielsen KG, Madsen JL, Kehlet H. Physiologic effects of bowel preparation. Dis Colon Rectum 2004; 47: 1397-1402.
38. Cao F, Li J, Li F. Mechanical bowel preparation for elective colorectal surgery: updated systematic review and meta-analysis. Int J Colorectal Dis 2012; 27: 803-810.
39. Walker KJ, Smith AF. Premedication for anxiety in adult day surgery. Cochrane Database Syst Rev 2009; CD002192.
40. Dahl JB, Moiniche S. Pre-emptive analgesia. Br Med Bull 2004; 71: 13-27.
41. Zhang J, Ho KY, Wang Y. Efficacy of pregabalin in acute postoperative pain: a meta-analysis. Br J Anaesth 2011; 106: 454-462.
42. Reddy SK, Turley RS, Barbas AS et al. Post-operative pharmacologic thromboprophylaxis after major hepatectomy: does peripheral venous thromboembolism prevention outweigh bleeding risks? J Gastrointest Surg 2011; 15: 1602-1610.

43. Rasmussen MS, Jorgensen LN, Wille-Jorgensen P. Prolonged thromboprophylaxis with low molecular weight heparin for abdominal or pelvic surgery. Cochrane Database Syst Rev 2009; CD004318.
44. Richardson AJ, Laurence JM, Lam VW. Use of pre-operative steroids in liver resection: a systematic review and meta-analysis. HPB (Oxford) 2014; 16: 12-19.
45. Li N, Gu WL, Weng JF et al. Short-term administration of steroids does not affect postoperative complications following liver resection: Evidence from a meta-analysis of randomized controlled trials. Hepatol Res 2015; 45: 201-209.
46. Gurusamy KS, Naik P, Davidson BR. Methods of decreasing infection to improve outcomes after liver resections. Cochrane Database Syst Rev 2011; CD006933.
47. Hirokawa F, Hayashi M, Miyamoto Y et al. Evaluation of postoperative antibiotic prophylaxis after liver resection: a randomized controlled trial. Am J Surg 2013; 206: 8-15.
48. Togo S, Tanaka K, Matsuo K et al. Duration of antimicrobial prophylaxis in patients undergoing hepatectomy: a prospective randomized controlled trial using flomoxef. J Antimicrob Chemother 2007; 59: 964-970.
49. Takara D, Sugawara G, Ebata T et al. Preoperative biliary MRSA infection in patients undergoing hepatobiliary resection with cholangiojejunostomy: incidence, antibiotic treatment, and surgical outcome. World J Surg 2011; 35: 850-857.
50. Bratzler DW, Houck PM, Surgical Infection Prevention Guidelines Writers W et al. Antimicrobial prophylaxis for surgery: an advisory statement from the National Surgical Infection Prevention Project. Clin Infect Dis 2004; 38: 1706-1715.
51. Hsieh CS, Cheng HC, Lin JS et al. Effect of 4% chlorhexidine gluconate predisinfection skin scrub prior to hepatectomy: a double-blinded, randomized control study. Int Surg 2014; 99: 787-794.
52. Darouiche RO, Wall MJ, Jr., Itani KM et al. Chlorhexidine-Alcohol versus Povidone-Iodine for Surgical-Site Antisepsis. N Engl J Med 2010; 362: 18-26.
53. D'Angelica M, Maddineni S, Fong Y et al. Optimal abdominal incision for partial hepatectomy: increased late complications with Mercedes-type incisions compared to extended right subcostal incisions. World J Surg 2006; 30: 410-418.
54. Togo S, Nagano Y, Masumoto C et al. Outcome of and risk factors for incisional hernia after partial hepatectomy. J Gastrointest Surg 2008; 12: 1115-1120.
55. Chang SB, Palavecino M, Wray CJ et al. Modified Makuuchi incision for foregut procedures. Arch Surg 2010; 145: 281-284.
56. Wakabayashi G, Cherqui D, Geller DA et al. Recommendations for laparoscopic liver resection: a report from the second international consensus conference held in Morioka. Ann Surg 2015; 261: 619-629.
57. Stoot JH, van Dam RM, Busch OR et al. The effect of a multimodal fast-track programme on outcomes in laparoscopic liver surgery: a multicentre pilot study. HPB (Oxford) 2009; 11: 140-144.
58. van Dam RM, Wong-Lun-Hing EM, van Breukelen GJ et al. Open versus laparoscopic left lateral hepatic sectionectomy within an enhanced recovery ERAS(R) programme (ORANGE II-trial): study protocol for a randomised controlled trial. Trials 2012; 13: 54.
59. Lin NC, Nitta H, Wakabayashi G. Laparoscopic major hepatectomy: a systematic literature review and comparison of 3 techniques. Ann Surg 2013; 257: 205-213.
60. Rao AM, Ahmed I. Laparoscopic versus open liver resection for benign and malignant hepatic lesions in adults. Cochrane Database Syst Rev 2013; 5: CD010162.
61. Parks KR, Kuo YH, Davis JM et al. Laparoscopic versus open liver resection: a meta-analysis of long-term outcome. HPB (Oxford) 2014; 16: 109-118.

62. Yin Z, Fan X, Ye H et al. Short- and long-term outcomes after laparoscopic and open hepatectomy for hepatocellular carcinoma: a global systematic review and meta-analysis. Ann Surg Oncol 2013; 20: 1203-1215.
63. Xiong JJ, Altaf K, Javed MA et al. Meta-analysis of laparoscopic vs open liver resection for hepatocellular carcinoma. World J Gastroenterol 2012; 18: 6657-6668.
64. Nguyen KT, Marsh JW, Tsung A et al. Comparative benefits of laparoscopic vs open hepatic resection: a critical appraisal. Arch Surg 2011; 146: 348-356.
65. Fancellu A, Rosman AS, Sanna V et al. Meta-analysis of trials comparing minimally-invasive and open liver resections for hepatocellular carcinoma. J Surg Res 2011; 171: e33-45.
66. Mirnezami R, Mirnezami AH, Chandrakumaran K et al. Short- and long-term outcomes after laparoscopic and open hepatic resection: systematic review and meta-analysis. HPB (Oxford) 2011; 13: 295-308.
67. Zhou YM, Shao WY, Zhao YF et al. Meta-analysis of laparoscopic versus open resection for hepatocellular carcinoma. Dig Dis Sci 2011; 56: 1937-1943.
68. Mizuguchi T, Kawamoto M, Meguro M et al. Laparoscopic hepatectomy: a systematic review, meta-analysis, and power analysis. Surg Today 2011; 41: 39-47.
69. Croome KP, Yamashita MH. Laparoscopic vs open hepatic resection for benign and malignant tumors: An updated meta-analysis. Arch Surg 2010; 145: 1109-1118.
70. Simillis C, Constantinides VA, Tekkis PP et al. Laparoscopic versus open hepatic resections for benign and malignant neoplasms--a meta-analysis. Surgery 2007; 141: 203-211.
71. Bhojani FD, Fox A, Pitzul K et al. Clinical and economic comparison of laparoscopic to open liver resections using a 2-to-1 matched pair analysis: an institutional experience. J Am Coll Surg 2012; 214: 184-195.
72. Montalti R, Berardi G, Laurent S et al. Laparoscopic liver resection compared to open approach in patients with colorectal liver metastases improves further resectability: Oncological outcomes of a case-control matched-pairs analysis. Eur J Surg Oncol 2014; 40: 536-544.
73. Dokmak S, Raut V, Aussilhou B et al. Laparoscopic left lateral resection is the gold standard for benign liver lesions: a case-control study. HPB (Oxford) 2014; 16: 183-187.
74. Scatton O, Katsanos G, Boillot O et al. Pure laparoscopic left lateral sectionectomy in living donors: from innovation to development in France. Ann Surg 2015; 261: 506-512.
75. Troisi RI, Patriti A, Montalti R, Casciola L. Robot assistance in liver surgery: a real advantage over a fully laparoscopic approach? Results of a comparative bi-institutional analysis. Int J Med Robot 2013; 9: 160-166.
76. Ho CM, Wakabayashi G, Nitta H et al. Systematic review of robotic liver resection. Surg Endosc 2013; 27: 732-739.
77. Tsung A, Geller DA, Sukato DC et al. Robotic versus laparoscopic hepatectomy: a matched comparison. Ann Surg 2014; 259: 549-555.
78. Nelson R, Edwards S, Tse B. Prophylactic nasogastric decompression after abdominal surgery. Cochrane Database Syst Rev 2007; CD004929.
79. Pessaux P, Regimbeau JM, Dondero F et al. Randomized clinical trial evaluating the need for routine nasogastric decompression after elective hepatic resection. Br J Surg 2007; 94: 297-303.
80. Petrowsky H, Demartines N, Rousson V, Clavien PA. Evidence-based value of prophylactic drainage in gastrointestinal surgery: a systematic review and meta-analyses. Ann Surg 2004; 240: 1074-1084; discussion 1084-1075.

81. Belghiti J, Kabbej M, Sauvanet A et al. Drainage after elective hepatic resection. A randomized trial. Ann Surg 1993; 218: 748-753.
82. Fong Y, Brennan MF, Brown K et al. Drainage is unnecessary after elective liver resection. Am J Surg 1996; 171: 158-162.
83. Kyoden Y, Imamura H, Sano K et al. Value of prophylactic abdominal drainage in 1269 consecutive cases of elective liver resection. J Hepatobiliary Pancreat Sci 2010; 17: 186-192.
84. Frank SM, Fleisher LA, Breslow MJ et al. Perioperative maintenance of normothermia reduces the incidence of morbid cardiac events. A randomized clinical trial. JAMA 1997; 277: 1127-1134.
85. Rajagopalan S, Mascha E, Na J, Sessler DI. The effects of mild perioperative hypothermia on blood loss and transfusion requirement. Anesthesiology 2008; 108: 71-77.
86. Scott EM, Buckland R. A systematic review of intraoperative warming to prevent postoperative complications. AORN J 2006; 83: 1090-1104, 1107-1013.
87. Lehtinen SJ, Onicescu G, Kuhn KM et al. Normothermia to prevent surgical site infections after gastrointestinal surgery: holy grail or false idol? Ann Surg 2010; 252: 696-704.
88. Melton GB, Vogel JD, Swenson BR et al. Continuous intraoperative temperature measurement and surgical site infection risk: analysis of anesthesia information system data in 1008 colorectal procedures. Ann Surg 2013; 258: 606-612; discussion 612-603.
89. Wong PF, Kumar S, Bohra A et al. Randomized clinical trial of perioperative systemic warming in major elective abdominal surgery. Br J Surg 2007; 94: 421-426.
90. Galvao CM, Liang Y, Clark AM. Effectiveness of cutaneous warming systems on temperature control: meta-analysis. J Adv Nurs 2010; 66: 1196-1206.
91. Lassen K, Kjaeve J, Fetveit T et al. Allowing normal food at will after major upper gastrointestinal surgery does not increase morbidity: a randomized multicenter trial. Ann Surg 2008; 247: 721-729.
92. Hendry PO, van Dam RM, Bukkems SF et al. Randomized clinical trial of laxatives and oral nutritional supplements within an enhanced recovery after surgery protocol following liver resection. Br J Surg 2010; 97: 1198-1206.
93. Richter B, Schmandra TC, Golling M, Bechstein WO. Nutritional support after open liver resection: a systematic review. Dig Surg 2006; 23: 139-145.
94. Frisch A, Chandra P, Smiley D et al. Prevalence and clinical outcome of hyperglycemia in the perioperative period in noncardiac surgery. Diabetes Care 2010; 33: 1783-1788.
95. King JT, Jr., Goulet JL, Perkal MF, Rosenthal RA. Glycemic control and infections in patients with diabetes undergoing noncardiac surgery. Ann Surg 2011; 253: 158-165.
96. Lipshutz AK, Gropper MA. Perioperative glycemic control: an evidence-based review. Anesthesiology 2009; 110: 408-421.
97. Eshuis WJ, Hermanides J, van Dalen JW et al. Early postoperative hyperglycemia is associated with postoperative complications after pancreatoduodenectomy. Ann Surg 2011; 253: 739-744.
98. Jackson RS, Amdur RL, White JC, Macsata RA. Hyperglycemia is associated with increased risk of morbidity and mortality after colectomy for cancer. J Am Coll Surg 2012; 214: 68-80.
99. Blixt C, Ahlstedt C, Ljungqvist O et al. The effect of perioperative glucose control on postoperative insulin resistance. Clin Nutr 2012; 31: 676-681.
100. Maeda H, Okabayashi T, Nishimori I et al. Hyperglycemia during hepatic resection: continuous monitoring of blood glucose concentration. Am J Surg 2010; 199: 8-13.

101. Okabayashi T, Nishimori I, Maeda H et al. Effect of intensive insulin therapy using a closed-loop glycemic control system in hepatic resection patients: a prospective randomized clinical trial. Diabetes Care 2009; 32: 1425-1427.
102. Okabayashi T, Nishimori I, Yamashita K et al. Preoperative oral supplementation with carbohydrate and branched-chain amino acid-enriched nutrient improves insulin resistance in patients undergoing a hepatectomy: a randomized clinical trial using an artificial pancreas. Amino Acids 2010; 38: 901-907.
103. Vibert E, Boleslawski E, Cosse C et al. Arterial Lactate Concentration at the End of an Elective Hepatectomy Is an Early Predictor of the Postoperative Course and a Potential Surrogate of Intraoperative Events. Ann Surg 2015; 262: 787-793.
104. Igami T, Nishio H, Ebata T et al. Using the greater omental flap to cover the cut surface of the liver for prevention of delayed gastric emptying after left-sided hepatobiliary resection: a prospective randomized controlled trial. J Hepatobiliary Pancreat Sci 2011; 18: 176-183.
105. Yoshida H, Mamada Y, Taniai N et al. Fixation of the greater omentum for prevention of delayed gastric emptying after left-sided hepatectomy: a randomized controlled trial. Hepatogastroenterology 2005; 52: 1334-1337.
106. Ni CY, Yang Y, Chang YQ et al. Fast-track surgery improves postoperative recovery in patients undergoing partial hepatectomy for primary liver cancer: A prospective randomized controlled trial. Eur J Surg Oncol 2013; 39: 542-547.
107. Short V, Herbert G, Perry R et al. Chewing gum for postoperative recovery of gastrointestinal function. Cochrane Database Syst Rev 2015; 2: CD006506.
108. Kehlet H, Wilmore DW. Multimodal strategies to improve surgical outcome. Am J Surg 2002; 183: 630-641.
109. Convertino VA. Cardiovascular consequences of bed rest: effect on maximal oxygen uptake. Med Sci Sports Exerc 1997; 29: 191-196.
110. Brower RG. Consequences of bed rest. Crit Care Med 2009; 37: S422-428.
111. Sakowska M, Docherty E, Linscott D, Connor S. A change in practice from epidural to intrathecal morphine analgesia for hepato-pancreato-biliary surgery. World J Surg 2009; 33: 1802-1808.
112. Kambakamba P, Slankamenac K, Tschuor C et al. Epidural analgesia and perioperative kidney function after major liver resection. Br J Surg 2015; 102: 805-812.
113. Roy JD, Massicotte L, Sassine MP et al. A comparison of intrathecal morphine/fentanyl and patient-controlled analgesia with patient-controlled analgesia alone for analgesia after liver resection. Anesth Analg 2006; 103: 990-994.
114. Kasivisvanathan R, Abbassi-Ghadi N, Prout J et al. A prospective cohort study of intrathecal versus epidural analgesia for patients undergoing hepatic resection. HPB (Oxford) 2014; 16: 768-775.
115. Revie EJ, McKeown DW, Wilson JA et al. Randomized clinical trial of local infiltration plus patient-controlled opiate analgesia vs. epidural analgesia following liver resection surgery. HPB (Oxford) 2012; 14: 611-618.
116. Bell R, Pandanaboyana S, Prasad KR. Epidural versus local anaesthetic infiltration via wound catheters in open liver resection: a meta-analysis. ANZ J Surg 2015; 85: 16-21.
117. Apfel CC, Heidrich FM, Jukar-Rao S et al. Evidence-based analysis of risk factors for postoperative nausea and vomiting. Br J Anaesth 2012; 109: 742-753.
118. Carlisle JB, Stevenson CA. Drugs for preventing postoperative nausea and vomiting. Cochrane Database Syst Rev 2006; CD004125.

119. Chen H, Merchant NB, Didolkar MS. Hepatic resection using intermittent vascular inflow occlusion and low central venous pressure anesthesia improves morbidity and mortality. J Gastrointest Surg 2000; 4: 162-167.
120. Jones RM, Moulton CE, Hardy KJ. Central venous pressure and its effect on blood loss during liver resection. Br J Surg 1998; 85: 1058-1060.
121. Li Z, Sun YM, Wu FX et al. Controlled low central venous pressure reduces blood loss and transfusion requirements in hepatectomy. World J Gastroenterol 2014; 20: 303-309.
122. Gurusamy KS, Li J, Sharma D, Davidson BR. Cardiopulmonary interventions to decrease blood loss and blood transfusion requirements for liver resection. Cochrane Database Syst Rev 2009; CD007338.
123. Hughes MJ, Ventham NT, Harrison EM, Wigmore SJ. Central venous pressure and liver resection: a systematic review and meta-analysis. HPB (Oxford) 2015; 17: 863-871.
124. Dunki-Jacobs EM, Philips P, Scoggins CR et al. Stroke volume variation in hepatic resection: a replacement for standard central venous pressure monitoring. Ann Surg Oncol 2014; 21: 473-478.
125. McCluskey SA, Karkouti K, Wijeysundera D et al. Hyperchloremia after noncardiac surgery is independently associated with increased morbidity and mortality: a propensity-matched cohort study. Anesth Analg 2013; 117: 412-421.
126. Shaw AD, Bagshaw SM, Goldstein SL et al. Major complications, mortality, and resource utilization after open abdominal surgery: 0.9% saline compared to Plasma-Lyte. Ann Surg 2012; 255: 821-829.
127. Perner A, Haase N, Guttormsen AB et al. Hydroxyethyl starch 130/0.42 versus Ringer's acetate in severe sepsis. N Engl J Med 2012; 367: 124-134.
128. Ivers N, Jamtvedt G, Flottorp S et al. Audit and feedback: effects on professional practice and healthcare outcomes. Cochrane Database Syst Rev 2012; 6: CD000259.

Figures Legend

Figure 1. PRISMA Flow diagram

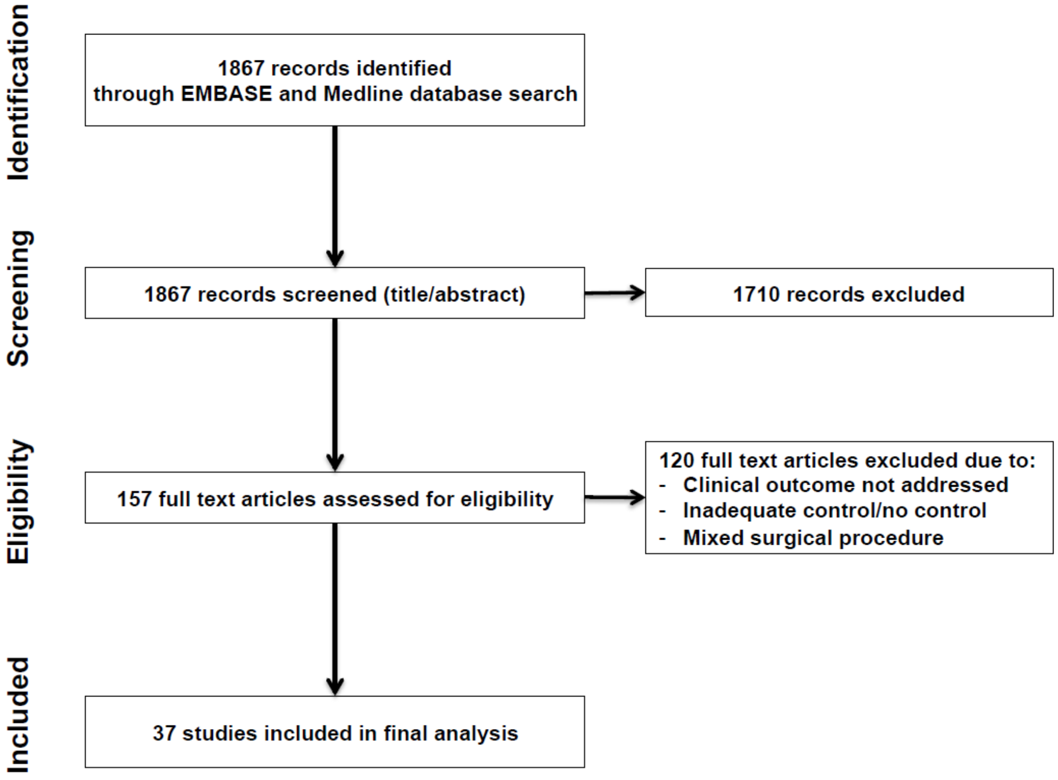

Table 1. Summary of ERAS recommendations for each item and the respective level of evidence

ERAS items	Summary	Evidence level	Grade of recommendation
1. Preoperative counselling	Patients should receive routine dedicated preoperative counseling and education before liver surgery.	Moderate	Strong
2. Perioperative nutrition	Patients at risk (weight loss >10-15% within 6 months, BMI<18.5 kg/m2, and serum albumin<30 g/l in the absence of liver or renal dysfunction) should receive oral nutritional supplements for seven days prior to surgery. For severely malnourished patients (>10% WL), surgery should be postponed for at least 2 weeks to improve nutritional status and allow patients to gain weight.	High	Strong
3. Perioperative oral immunonutrition	There is limited evidence for the use of IN in liver surgery.	Low	Weak
4. Preoperative fasting and preoperative carbohydrates load	Preoperative fasting does not need to exceed 6 hours for solids and 2 hours for liquids. Carbohydrate loading is recommended the evening before liver surgery and 2 hours before induction of anesthesia.	No preoperative fasting more than 6 hours: moderate Carbohydrate loading: low	No preoperative fasting more than 6 hours: strong Carbohydrate loading: weak
5. Oral bowel preparation	Oral MBP is not indicated before liver surgery.	Low	Weak

6. Pre-anesthetic medication	Long acting anxiolytic drugs should be avoided. Short acting anxiolytics may be used to perform regional analgesia prior to the induction of anesthesia.	Moderate	Strong
7. Anti-thrombotic prophylaxis	LMWH or unfragmented heparin reduces the risk of thromboembolic complications and should be started 2-12 hours before surgery, particularly in major hepatectomy. Intermittent pneumatic compression stockings should be added to further decrease this risk.	Use of heparin: moderate Use of intermittent pneumatic compression devices: low	Use of heparin: strong Use of intermittent pneumatic compression devices: weak
8. Peri-operative steroids administration	Steroids (methylprednisolone) may be used before hepatectomy in normal liver parenchyma, since it decreases liver injury and intraoperative stress, without increasing the risk of complications. Steroids should not be given in diabetic patients.	moderate	weak
9. Antimicrobial prophylaxis and skin preparation	Single dose Intravenous antibiotics should be administered before skin incision and less than one hour before hepatectomy. Postoperative “prophylactic” antibiotics are not recommended. Skin preparation with chlorhexidine 2% is superior to povidone-iodine solution.	Antimicrobial prophylaxis: moderate Skin preparation: moderate	Antimicrobial prophylaxis: strong Skin preparation: strong

10. Incision	The choice of incision is at the surgeon’s discretion. It depends on the patient’s abdominal shape and location in the liver of the lesion to be resected. Mercedes-type incision should be avoided due to higher incisional hernia risk.	Moderate	Strong
11. Minimally invasive approach	LLR can be performed by hepato-biliary surgeons experienced in laparoscopic surgery, in particular left lateral sectionectomy and resections of lesions located in anterior segments. There is currently no proven advantage of robotic liver resection in ERAS. Its use should be reserved for clinical trials.	Minimally invasive approach: moderate Robotic surgery: low	Minimally invasive approach: strong Robotic surgery: weak
12. Prophylactic Nasogastric intubation	Prophylactic nasogastric intubation increases the risk of pulmonary complications after hepatectomy. Its routine use is not indicated.	High	Strong
13. Prophylactic abdominal drainage	The available evidence is non-conclusive and no recommendation can be given for the use of prophylactic drainage or against it after hepatectomy.	Low	Weak
14. Preventing intraoperative hypothermia	Perioperative normothermia should be maintained during liver resection.	Moderate	Strong

15. Postoperative nutrition and early oral intake	Most patients can eat normal food at day one after liver surgery. Postoperative enteral or parenteral feeding should be reserved for malnourished patients or those with prolonged fasting due to complications (e.g. ileus >5 days, delayed gastric emptying).	Early oral intake: moderate Oral nutritional supplements: moderate No routine postoperative artificial nutrition: high	Early oral intake: strong Oral nutritional supplements: weak No routine postoperative artificial nutrition: strong
16. Postoperative glycaemic control	Insulin therapy to maintain normoglycaemia is recommended.	Moderate	Strong
17. Prevention of delayed gastric emptying (DGE)	An omentum flap to cover the cut surface of the liver reduces the risk of DGE after left-sided hepatectomy.	High	Strong
18. Stimulation of bowel movement	Stimulation of bowel movement after liver surgery is not indicated.	High	Strong
19. Early mobilization	Early mobilization after hepatectomy should be encouraged from the morning after the operation until hospital discharge.	Low	Weak
20. Analgesia	Routine TEA cannot be recommended in open liver surgery for ERAS patients. Wound infusion catheter or intrathecal opiates can be good alternatives combined with multimodal analgesia.	Moderate	Strong
21. Preventing postoperative nausea and vomiting (PONV)	Multimodal approach to PONV should be used. Patients should receive PONV prophylaxis with 2 antiemetic drugs.	Moderate	Strong

22. Fluid management	The maintenance of low CVP (below 5 cmH2O) with close monitoring during hepatic surgery is advocated. Balanced crystalloid should be preferred over 0.9% saline or colloids to maintain intravascular volume and avoid hyperchloraemic acidosis or renal dysfunction, respectively.	Moderate	Strong
23. Audit	Systematic audit improves compliance and clinical outcome in healthcare practice	Moderate	Strong

Table 2. RCTs dedicated to liver surgery selected in the systematic review with the level of evidence

Author	Year	Jadad score	Level evidence	Studied items	Morbidity	LOS
Lassen	2008	6	1	Postoperative artificial nutrition	No difference	No difference
Darouiche	2010	4	1	Skin preparation	Preoperative cleansing with chlorhexidine is superior to povidone iodine for preventing SSI	Not asssessed
Hayashi	2011	7	1	Peri-operative steroids administration	Positive impact on liver function. No difference in complications	No difference
Wong	2007	5	2	Preventing intraoperative hypothermia	Perioperative warming reduce blood loss and complications	No difference
Okabayashi	2009	3	2	Postoperative glycaemic control	Intensive insulin therapy using a closed loop system lower SSI	Decreased
Pessaux	2007	5	2	Prophylactic Nasogastric intubation (NGT)	NGT has no advantage. NGT increased the risk of pulmonary complications	No difference
Igami	2011	4	2	Prevention of delayed gastric emptying (DGE)	DGE reduced with omental flap on the cut surface after left sided hepatectomy	Not assessed
Yoshida	2005	3	2	Prevention of delayed gastric emptying (DGE)	DGE reduced with omental flap on the cut surface after left sided hepatectomy	Not assessed
Hendry	2010	2	2	Use of postoperative laxatives	Earlier passage of first stool, no change in morbidity	Decreased
Jones	2013	7	1	Goal directed fluid therapy	Decreased	Decreased

Table 3. Items with <75% expert agreement in rounds 1 and 2 of the Delphi process

Item	Round of disagreement	% of agreement
Perioperative oral immunonutrition	1	42
Perioperative steroids administration	1/2	42/71
Epidural analgesia	1	42
Minimally invasive surgery	1	71
Robotic surgery	1	57
Fluid management	1/2	29/71
Prophylactic abdominal drainage	1	71