Is DrEaMing (drinking, eating and mobilising) the dream?

The idea of patients drinking, eating and mobilising (DrEaMing) at 24 hours postoperatively is being used as a marker of functional recovery. This marker of recovery and quality is explored in this article.

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The traditional model of postoperative recovery has been characterised by intravenous fluids, catheters, bed rest and immobility for patients, in turn leading to prolonged hospital stays and associated adverse events, such as venous thromboembolism.

Enhanced recovery after surgery is a multidisciplinary, multimodal approach to the perioperative care of patients. When first described in 1995, it reduced the length of stay after major colonic surgery from 5 days to between 2 and 3 days (Bardram et al, 1995). Over the last 26 years enhanced recovery after surgery pathways have been adopted for a multitude of different surgical procedures, generally resulting in reduced length of stay, reduced postoperative complications and a lower cost of delivery of care (Kehlet, 2020). However, these programmes tend to focus on surgical outcomes such as length of stay rather than recovery from the patient's own point of view. In part, this has led to the focus on postoperative drinking, eating and mobilising (DrEaMing) as a measure of functional recovery.

What is the DrEaM?

The idea of DrEaMing was first introduced by an international initiative as part of 'The CHEERS-DREAM' campaign with the aim of restoring a fluid and nutritional state to assist in a functional recovery (Levy et al, 2016). If a patient is drinking, eating and mobilising after major surgery it means that they are likely to have adequate analgesia, hydration and cardiorespiratory function, thereby they are on the road to functional recovery.

DrEaMing is a patient-centred measure of outcome, which has led to its adoption as a marker of quality by the American Society for Enhanced Recovery and Perioperative Quality Initiative (Moonesinghe et al, 2017). Furthermore in the UK, the Perioperative Quality Improvement Programme (2018) had patients DrEaMing at 24 hours postoperatively as one of its top five improvement opportunities. The Perioperative Quality Improvement Programme found that, in 2018, 53% of the patients enrolled in the programme were DrEaMing (Perioperative Quality Improvement Programme, 2018) at 24 hours. This improved in 2019 within all recruiting surgical specialties except head and neck surgery (Perioperative Quality Improvement Programme, 2019).

When does DrEaMing not work?

Despite DrEaMing appearing to be a good marker of quality, there are still some important points which should be taken into consideration. First, DrEaMing does not fully indicate functional recovery; for example it does not necessarily indicate recovery of neurocognitive function. Postoperative cognitive decline is associated with increased morbidity and mortality (White et al, 2019). Second, DrEaMing at 24 hours postoperatively is not always feasible after certain surgical procedures, such as oesophagectomies. In patients undergoing major upper gastrointestinal surgery the Perioperative Quality Improvement Programme (2019) found that less than 20% of those recruited were DrEaMing at 24 hours. Third, there is the hypothesis that patients DrEaMing at postoperative hour 24 is a good marker of quality and good enhanced recovery (Moonesinghe et al, 2017). However, the result of studies examining if early DrEaMing is beneficial are yet to be published. If it is the case that

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early (operative procedure-specific) DrEaMing is beneficial perioperative care pathways will need to change to encourage early DrEaMing.

Conclusions

DrEaMing is currently being used as a patient-centred marker of quality in the perioperative period, on the presumption that the ability to drink, eat and mobilise is an indicator of functional recovery. However DrEaMing at postoperative hour 24 has not yet been validated as either a marker of quality or recovery. As such it is not currently able to replace other validated systems.

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