

EARLY MOBILIZATION IN POSTOPERATIVE GASTROINTESTINAL PATIENTS AT THE GENERAL SURGERY DEPARTMENT – HA NOI MEDICAL UNIVERSITY HOSPITAL

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ABSTRACT

Early mobilization is a key element of an enhanced recovery after surgery (ERAS) program. To describe the current status of early mobilization in postoperative gastrointestinal patients at the General Surgery Department, Hanoi Medical University Hospital. The cross-sectional study was conducted on 258 patients who underwent scheduled gastrointestinal surgery from May to August 2024, tracking their mobilization process. The rate of patients starting to mobilize within 24 hours was 99.2%, with an average of mobilization duration of 41.3 ± 12.4 minutes. The most regular exercise was in-bed limb exercise, presenting for 98.1% with an average duration of 12.7 ± 5.4 minutes. At day 6 postoperatively, 1.2% of patients had still not practiced walking in the corridor; the average mobilization duration in the group with postoperative wound drainage was less than in the non-drainage group, which was 73.6 ± 17.5 minutes and 79.9 ± 22.3 minutes, respectively ($p < 0.05$). The cause for refusal of early mobilization was fear of pain (77.5%); followed by fear of the incision podium (72.1%). Although the initiation rate of early mobilization was high, duration remained far below ERAS targets. Some supportive strategies should be implemented to close the gap and translate initiation into clinically meaningful exposure.

Key words: *early mobilization, ERAS, post-operative, gastrointestinal, Hanoi Medical University Hospital.*

I. INTRODUCTION

Early mobilization is one of the key principles in the Enhanced Recovery After Surgery (ERAS) program, which can include sitting upright, transferring from bed to chair, rising from a

chair, exercising in or out of bed, walking in the room or hallway, and exercising limbs in bed. Early mobilization at the hospital is thought to reduce postoperative complications after major abdominal cancer surgery (1),(2). Aprisandi's literature review identifies 11 (eleven) benefits of early mobilization, including reduced length of stay, minimized postoperative complications, lower pain, enhanced walking ability, improved quality of life, reduced readmission and mortality rates, reduced overall hospitalization costs, more physical therapy sessions prior to discharge, increased satisfaction, and no fracture displacement or implant failure (3). It has been observed that early mobilization lowers the risk of deep vein thrombosis and postoperative pulmonary and cardiovascular issues (4). Ambulating offers patients more comfort and greater benefits than standing still for a prolonged period. It promotes blood flow, stimulates circulation, and may help prevent the formation of blood clots that can lead to stroke. Gastrointestinal, urinary, and pulmonary functions are all improved with ambulation, in addition to increasing muscle tone and strength, particularly in abdominal and lower limb muscles. It also enhances coordination, posture, and balance in the elderly. Furthermore, ambulating supports joint flexibility, especially in the knees, hips, and ankles. A systematic review of Greer N.L. indicated that adhering to ERAS helped to reduce postoperative complications by half and reduce hospitalized time by 2.5 days in the colon surgery group, leading to reduced treatment costs (5). The latest ERAS guideline for colon surgery recommended that patients should be out of bed within 2 hours on the day of surgery (at least sitting upright in a chair). The goal is to spend at least 6 hours per day out of bed until discharge(2,6). However, many studies have indicated that early mobilization is the

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component with the lowest adherence in the ERAS program. Grass F. et al. indicated that 58% of 1170 patients didn't target the 360-minute goal of being out of bed within the first day after surgery (7). It was reported that mobilizing patients as early as the day of surgery still became an uncommon practice (8). While early mobilization offers clear benefits, it is not without risks, including increased fall risk and discomfort, and must be implemented cautiously (9). Hanoi Medical University Hospital started to practice the ERAS in a multidisciplinary way. We conducted this study to describe the status of early mobilization in postoperative patients with gastrointestinal diseases at the General Surgery Department, Hanoi Medical University Hospital.

II. MATERIALS AND METHODS

Participants

Postoperative patients with gastrointestinal diseases at the General Surgery Departments, Hanoi Medical University Hospital.

• **Inclusion criteria:** Patients 18 years and older, after scheduled gastrointestinal surgery, agreed to participate in the study. (Surgery for gastrointestinal diseases according to the program, includes surgeries related to the esophagus, stomach, duodenum, small intestine, colon, liver, bile and biliary tract, pancreas, rectum, hemorrhoids, anal fistula, and inguinal hernia). Patients have a health classification according to the American Society of Anesthesiologists (ASA) standards before surgery from I to III. Patients agree to participate in the study and sign a patient consent form 24 hours before surgery.

• **Exclusion criteria:**

- Patient with indication of emergent surgery.
- Transferred to the Intensive Care Unit or have a temporary immobilization indication for the first 24 hours after surgery.
- Have a motor deficit or a history of hemiparesis or paralysis after the stroke.
- Pregnant.
- Psychiatric disorders and unconsciousness.
- Incomplete medical records according to the study medical record sample.

Methods

- The cross-sectional study from May 2024 to August 2024, at the General Surgery Department, Hanoi Medical University Hospital.

- Sampling and sample size: Convenience sampling was employed, whereby all patients who received inpatient treatment at the department during the study period and met the inclusion criteria were selected for participation. A total of 258 patients were enrolled in the study.

- Variables: Participant characteristics included age, gender, medical history, type of organ involved in surgery, surgical method, incision drainage status... Postoperative mobilization data included the time of first mobilization, type of mobilization, duration (in minutes), and reasons for reluctance or refusal to engage in early mobilization.

- Data collection: Following the collection of patient characteristics, we monitored and evaluated the patients' early mobilization activities and duration across a 6-day postoperative period, beginning from the moment they were moved to the General Surgery Department. Daily interviews with the patient and family members were paired with nursing records when nurses were present during mobilization activities to record exercise time. Using a pre-printed tracking sheet, the patient or nurse could record the patient's time periods of mobilization throughout the day, including how many times they got out of bed and how long they spent doing so.

- The early mobilization protocol after surgery included the following steps:

(1) During the first 6 hours postoperatively, the patient lay with the head of the bed elevated at a 30-degree angle and may use a thin pillow. The patient was positioned in the left or right lateral Fowler position, depending on the type of surgery performed.

(2) After 6 hours, patients started to practice sitting up gradually by adjusting the head of the bed from a low to a higher position. Since dizziness could occur during postural changes, these movements were carried out slowly and with assistance. Bed rails were raised to prevent the risk of falls.

(3) While on bed rest, patients were encouraged to perform active limb exercises independently.

(4) After 24 hours, patients began practicing standing and walking around the bed with the assistance and guidance of medical staff.

(5) According to the most recent recommendations from the third updated ERAS guidelines published since 2013, the specific mobilization time targets were 2 cumulative hours out of bed on the day of surgery and 6 hours from the first postoperative day (POD).

Data analysis

The statistical analysis of data is presented as the mean $\pm$ standard error of the mean. Percentages were used to display the qualitative variables. The means, standard deviation (SD), and 95% confidence intervals were used to express the quantitative variables. The data were analysed using SPSS version 14.0 (SPSS Inc). We used the *t*-test to compare the difference between duration time of mobilization by surgery

characteristics. A *p*-value <0.05 was considered statistically significant.

Ethnic issues

The study was conducted following the approval of the Scientific Committee of Hanoi Medical University Hospital. With graduation recognition decision number 8251/QD-DHYHN on December 6, 2024, the Hanoi Medical University bachelor of nursing graduation assignment board approved the study's results. All collected data were used solely for research purposes. The confidentiality of participants' personal information was strictly maintained.

III. RESULTS

Characteristics of early postoperative mobilization time and type of mobilization in the first 24 hours are presented in Tables I and II. After 3 hours transferred to the department, almost all of the patients started to exercise early within the first 24 hours. The total duration of mobilization increased from POD-1 to POD-2. (Table I).

Table 1. The time of early mobilization postoperatively (n=258)

The time of first mobilization	Number (n)	Frequency (%)
Median (hours)	3.0 (Q1-Q3: 2.0 - 4.0)	
Within 24 hours	256	99.2
After 24 hours	2	0.8
Total duration of mobilization	$\bar{X} \pm SD$	
POD-1*	41.3 $\pm$ 12.4	
POD-6**	77.7 $\pm$ 20.9	

*POD-1: Postoperative day 1; **POD-6: Postoperative day 6; SD: standard deviation.

Within the first 24 hours postoperatively, nearly all patients performed in-bed limb exercises, whereas only about half of were able to sit upright or ambulate away from the bed. However, ambulation was maintained for a longer average duration (13.2 $\pm$ 5.3 minutes) than other activities. Only 2 patients did not exercise in the first day. (Table II).

Table 2. The type of mobilization within the first 24 hours postoperatively

Type of mobilization	Number (n)	Frequency (%)	Mean time (minutes) ($\bar{X} \pm SD$)
Sitting upright in bed	134	51.9	11.8 $\pm$ 7.3
Sitting upright at the edge of the bed (both legs dangling off the side)	10	3.9	6.5 $\pm$ 3.4
In-bed limb exercises	253	98.1	12.7 $\pm$ 5.4
Standing at the bedside	38	14.7	7.5 $\pm$ 3.6
Ambulating away from the bed	155	60.1	13.2 $\pm$ 5.3
Immobilization	2	0.8	0

SD: standard deviation.

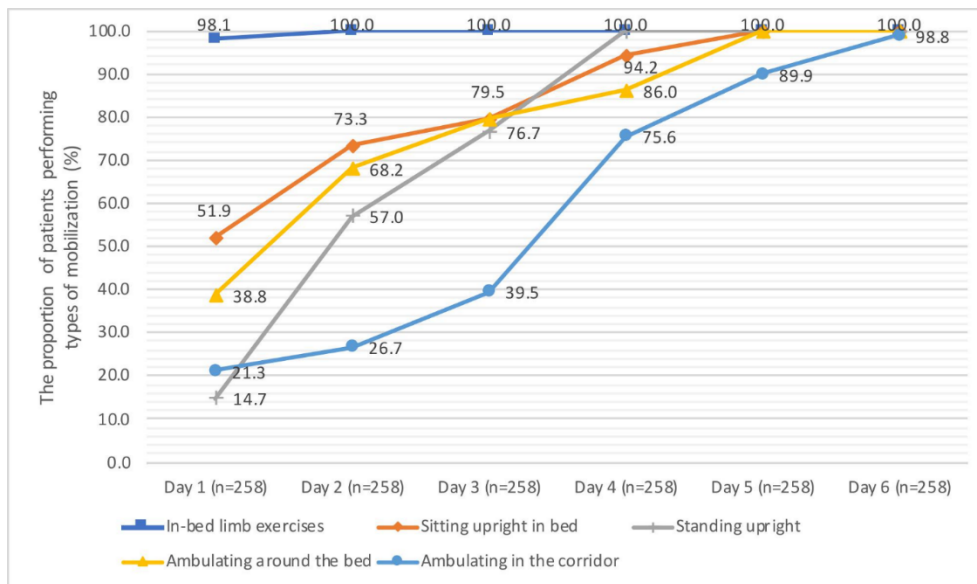


Figure 1. All types of mobilization observed in the study progressively increased during the first six postoperative days.

While in-bed limb exercises were almost demonstrated the most rapid increase, whereas universal from day 1, other activities such as ambulation in the corridor was the slowest to siting upright, standing, and ambulating reach full participation. gradually increased. Standing upright

Table 3. The average duration of mobilization by surgical characteristics

Characteristic	Number (n)	Day 1 (n=258) X̄± SD (minutes)	Day 6 (n=258) X̄± SD (minutes)	p ^a
Surgical method				
Open surgery	41	38.1 ± 11.1	73.5 ± 16.7	<0.0001*
Laparoscopic surgery	217	45.3 ± 22.5	78.6 ± 21.6	<0.0001*
p ^b		0.04*	0.15	
Postoperative wound drainage				
Yes	88	42.4 ± 16.8	73.6 ± 17.5	<0.0001*
No	170	45.6 ± 23.2	79.9 ± 22.3	<0.0001*
p ^c		0.25	0.02*	

*t-test; p^a: compare Day 1 to Day 6; p^b: comparision open surgery to laparoscopic surgery; p^c: comparison drainage incision and non-drainage incision; p<0.05: consider statistically significant.

Table III shows that the duration of mobilization gradually increased from postoperative day 1 to day 6 across all surgical

methods, regardless of the presence of wound drainage (p<0.0001). However, a significant difference between open and laparoscopic surgery was observed on POD-1 (p=0.04), whereas this difference between the drainage and non-drainage groups was showed on POD-6 (p=0.02).

Table 4. The reason for refusal of early mobilization

Reason	Number (n)	Frequency (%)
Fear of pain	200	77.5
Fear of wound dehiscence	186	72.1
Feeling fatigue	169	65.5
Fear of bleeding	98	38.0
Fear of drain dislodgement	57	22.1

The most common reason for refusal of early mobilization was fear of pain (77.5%), followed

by fear of wound dehiscence (72.1%) and feeling fatigue (65.5%) (Table IV).

IV. DISCUSSION

The study showed that 256 out of 258 patients (99.2%) initiated mobilization within the first postoperative day (POD), starting 3 hours after being transferred to the General Surgery Department. This result was similar to the result of Fagevik's study with 96% of the patients being mobilized within 24h (11).

According to the target and definition of early mobilization, patients should mobilize as soon as possible – ideally within 24 hours postoperatively. Almost all of the patients in our department practiced early mobilization postoperatively, such as sitting upright in bed, transferring from bed to chair, standing from chair, and in-bed limb exercises. In our study the total mobilization time within the first 24 hours after surgery was 41.3 ± 12.4 minutes. This duration on POD-1 was relatively short, it was much lower than that reported by Grass et al. (4.7 ± 2.6 h on POD-1 and 5.5 ± 2.5 h on POD-2 in 1170 colorectal cases) (7). In our study, 34.4% of the patients achieved the 120-minute mobilization goal within the first 24 hours postoperatively, compared with 42% of 1170 patients reaching the 6-hour target in Grass's study. (7). Objective accelerometer data from Höpfner's pilot study revealed a median of 135 min of mobilization on day 1, with only 16.7 % of ERAS patients meeting the 360-min target and substantial under-reporting in patient diaries (10). A 1492-patient Swedish multicentre survey showed that, just 52 % reached the edge of the bed within 6 hours, highlighting that early initiation does not guarantee adequate duration (11).

There are several investigations have explored early postoperative mobilization following gastrointestinal surgery. One of them is the study of Zhang L. in 470 patients undergoing digestive surgery, over 50% ambulated within the inpatient room or corridor during the first 24 postoperative hours, though 46.4% delayed mobilization until POD-2 or later (12). Nevertheless, corridor walking was delayed, and three patients were still unable to leave their rooms by POD-6. In a similar vein, 60.1% of the 258 patients in our group were ambulating from bed within 24 hours. The average standing time (7.5 ± 3.6 min) was much less than walking (13.2 ± 5.3 min), highlighting the superior benefits of dynamic mobility, even when standing and bedside ambulation reached 100% by POD 4 and 5, respectively. The retrospective

study by Nishijima et al. (n=718) found that delayed ambulation beyond POD-2 was associated with increased infectious complications and prolonged hospitalization. In contrast, a randomized controlled trial by Ni et al. involving 120 hepatic surgery patients demonstrated that early mobilization led to faster gastrointestinal recovery and shorter hospital stays. A feasibility study conducted by Rosowicz et al. in patients after colorectal surgery shown that commencing mobilization within 24 hours postoperatively decreased the incidence of severe complications (13–15). However, according to the Willner et al. study, only a small percentage of patients achieved the ERAS goal of 360 minutes each day, despite a median improvement in mobilization time throughout the first three postoperative days after gastrointestinal surgery (16). These findings support the positive impact of early mobilization on postoperative outcomes, while also emphasizing the ongoing challenges in achieving mobilization goals and the need for individualized strategies to improve patient adherence.

In our study, mobilization duration in non-drainage group was longer than that of others on POD-6. The appearance of medical devices (e.g., urinary catheters, intravenous lines, and surgical drains) could negatively impact the patients' physical exercise activities after surgeries. According to the ERAS guidelines, the use of urinary catheters and abdominal drains should be minimized and, if necessary, removed as early as possible to promote postoperative recovery. Specifically, for patients undergoing elective colonic or upper rectal resections, urinary catheters are recommended to be removed within 24 hours postoperatively, regardless of thoracic epidural analgesia use. For mid to lower rectal resections, removal within 24 to 48 hours is advised (17). Early removal of these devices is associated with reduced risks of catheter-associated urinary tract infections and facilitates early mobilization, which is a core component of ERAS protocols. Patients can feel discomfort, pain, or a sense of insecurity due to the risk of accidentally dislodging or removing medical tubes during movement. These concerns often make them reluctant to mobilize, which affects their physical activities. Additionally, providing patients with appropriate mobility aids, such as wheeled walking frames, can alleviate discomfort

and enhance their sense of security, thereby promoting independent movement and adherence to mobilization protocols.

Our study showed that fear of pain and fear of wound dehiscence were considered as reasons affecting early mobilization, with percentages of over 70%. In the study of Zhang L., the factors that delayed mobilization were feelings of weakness, fatigue, nervousness, or fear of dislodgement (12). Additionally, gender and age were independent predictors of early mobilization ability, which were associated with the physiological differences between males and females. Compared to women, men usually tend to have a more developed and robust physique. Women also face more psychological problems, such as a sense of nervousness, depression, and stress after surgery. Pain relievers are also important factors affecting early mobilization. A qualitative study showed that patients believed pain control before mobilization was less effective than after mobilization. Hence, effective pain control would help patients to feel more confident when performing activities as guided by healthcare professionals (18).

Although early initiation of mobilization was achieved in nearly all patients, the overall duration of activity during the first postoperative day remained limited. Several factors, including pain, fatigue, and the presence of drainage catheters, may have contributed to reduced mobility.

To enhance postoperative mobilization, practical strategies such as the use of portable walkers, early removal of urinary and wound drainage catheters, and introduction of digital activity monitoring systems may be beneficial. Postoperative psychological counseling is recommended to enhance patients' attitude and motivation for early mobilization, conducted by nurses or clinical psychologists. These approaches could help patients gain confidence, reduce fear of movement, and support adherence to mobilization protocols. Future studies should evaluate the effectiveness and feasibility of these interventions in different surgical populations.

V. LIMITATIONS

There were several limitations to our study. First, the sample size was relatively small, and all

data were collected from a single department; therefore, the findings may not fully represent the mobilization status in other settings. Future studies with larger, multi-departmental samples are needed to validate these results. Second, the study included patients with various diseases and surgical procedures, which may have introduced confounding factors affecting mobilization outcomes. Third, potential confounders such as age, body mass index, and comorbidities were not adjusted for the analysis, which could have influenced the observed mobilization patterns on the operative day and subsequent days. Mobilization time was recorded subjectively (patient/family diaries and manual nursing logs) without wearable devices, introducing measurement bias.

VI. CONCLUSION

Although the initiation rate of early mobilization was high, the duration remained far below ERAS targets. Individualized, procedure-aware protocols, stronger multimodal analgesia, early removal of drains/catheters/lines when safe, mobility aids, and objective digital activity monitoring are required to close the gap and translate initiation into clinically meaningful exposure.

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AVAILABILITY OF DATA AND MATERIALS

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

AUTHOR CONTRIBUTIONS

All authors contributed to the conception and design of the study. The first draft of the manuscript was written by M.A.T and D.H.N, and

all authors commented on previous versions of the manuscript. P.A.P and T.T.N. confirm the authenticity of all the raw data. All authors have read and approved the final version of the manuscript.

ETHICS APPROVAL AND CONSENT TO PARTICIPATE

The study was conducted following the approval of the Scientific Committee of Hanoi Medical University Hospital. With graduation recognition decision number 8251/QD-DHYHN on December 6, 2024, the Hanoi Medical University bachelor of nursing graduation assignment board approved the study's results. Written informed was obtained from all the patients prior to enrollment.

PATIENT CONSENT FOR PUBLICATION

Written informed was obtained from the patients for publication of the data. A copy of the written consent is available for review by the Editor-in-Chief of this journal on request.

COMPETING INTERESTS

The authors declare that they have no competing interests.

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