



COMPARATIVE STUDY BETWEEN EARLY ENTERAL FEEDING VERSUS CONVENTIONAL ENTERAL FEEDING AFTER ENTERIC ANASTOMOSIS SURGERY

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ABSTRACT

Background: The safety and effectiveness of early oral feeding after bowel anastomosis surgery has not been determined. We performed a comparative study to evaluate early oral feeding compared with conventional feeding method in patients undergoing bowel anastomosis surgery. **Methodology:** A total number of n=60 patients were enrolled of the study. 30 patients in early feeding group and 30 in conventional study group. In early group (n=30) and n=30 in conventional feeding group. Patient of early feeding group was started on oral fluid on postoperative day 1 while those in conventional feeding group were started feeding after resolution of ileus. Patients' characteristics, surgical procedure, time of passage of first faeces, any complication, length of hospital stay were assessed and compared between the two groups. **RESULTS:** The two groups [Early feeding group (EFG) and Conventional feeding group (CFG)] were similar in demographic and baseline data, the number of days to first faeces (p=0.066) along with any complications. However, length of hospital stay (p=0.03) was significantly shorter in early feeding group. Anastomotic leak, wound infection, vomiting, abdominal distension were less in EFG. but were not statistically significant. **Conclusion:** Early feeding after bowel anastomosis is safer and can improve the condition of the patient without increasing any postoperative complications. There is significant shorter hospital stay in early feeding group thus reducing the financial burden on patient and institution.

KEYWORDS :

INTRODUCTION

Observing the low incidence of complications following early feeding in patients undergoing intestinal anastomosis, the need for delayed feeding is frequently being questioned. The early enteral feeding after intestinal anastomosis can be safely started.

The concept of delayed oral feeding following gut surgery only after passage of flatus or stool has been adopted over the years with the notion that restriction of oral feeding offers the GIT longer time to heal and recover and reduces stress on anastomosis site and prevent leakage thus reducing post-operative complications.¹ But even if we do not give oral feeding, about 2-2.5 L of gastrointestinal and pancreatic secretions enters the small bowel and transit from the anastomosis site. It was antecedently assumed that the fasting would defend the anastomosis from any complication like abdominal distention, vomiting, ileus, anastomotic dehiscence or leaks, wound infection and would allow a hermetic closure of the anastomosis before the beginning of enteral feeding.^{2,4}

It is clearly demonstrated that the mucosal epithelium of the bowel is perfectly sealed after the first 24 hours of the post-operative period. According to Davila-Perez et al.⁵, it is not necessary to keep the 5-day fasting in order to prevent post-operative complications and should not be used routinely. ESPEN guidelines suggested early initiation of enteral feeding within twenty-four hours after gastrointestinal surgery should be initiated, however conjointly stated that it has to be adapted in keeping pace with the individual tolerance and type of surgery.⁶

Initiation of feeding ought to be progressive and a 24-hr liquid diet should be maintained before starting a bland diet just in case of complications ought to arise. Gulsen Ekigen et al. reported in their study that early small-volume feed tends to be tolerated and are valuable despite the kind of abdominal surgery and in different study the time for reaching a complete diet were significantly earlier in the early feeding group, also hospital stay decreased.⁷

Studies have shown improved wound healing⁸, and reduced infectious complications with early nutrition. The first randomised study to show jejunal feeding was tolerated within 24 hours of surgery was published in 1979 and showed a reduced length of hospital stay (LoS) in patients fed early. Subsequently, there have been further studies which have explored the safety and benefits of early postoperative feeding^{9,10} with mixed results in terms of benefits in relation to LoS and postoperative complications such as pneumonia, anastomotic dehiscence, abdominal abscess and wound infection. Early postoperative feeding has now been incorporated into the UK ERAS (Enhanced Recovery After Surgery) programme. However, the extent to which early postoperative feeding is implemented clinically is unclear, and it is a care practice that is not always carried out.

Ahmed and colleagues¹¹ conducted a systematic review of 11 studies in a variety of countries reporting compliance to individual ERAS elements in a clinical setting in colorectal surgical patients. In the nine studies which reported relevant data, compliance with early postoperative feeding ranged from 13% to 100%. Another study showed that of the 861 colorectal surgical patients enrolled in an ERAS programme, 65% had 'normal food' but this was on postoperative day two.¹²

Post operative dysmotility mainly affects stomach and colon but small intestine recovers within 4-8 hours after surgery.¹⁶ Hence feeding within first 24 hours after surgery is very well tolerated.^{17,18} Contrary to widespread opinion, evidence from clinical studies and animal experiments suggests that initiating feeding early is advantageous. In animals, starvation reduces the collagen content in anastomotic scar tissue^{19,20} and diminishes the quality of healing,^{21,22} whereas feeding reverses mucosal atrophy induced by starvation²³ and increases anastomotic collagen deposition and strength.²⁴ Experimental data in both animals and humans suggest that early enteral nutrition is associated with an improvement in wound healing.²⁵ Finally, early enteral feeding may reduce septic morbidity. Based on these findings present study was designed.

AIMS AND OBJECTIVES

1. To assess whether early postoperative oral feeding is safe in patients undergoing elective intestinal surgery.
2. To assess whether early postoperative oral feeding
 - a. Hastens the resolution of ileus.
 - b. Lead to earlier acceptance of regular diet.
 - c. Results in increased/decreased post operative complications.
 - d. Shortens the duration of postoperative hospital stay.

MATERIAL AND METHODS

This prospective and comparative randomized control study was done at **Department of General Surgery, G.R. Medical College, Gwalior** from November 2020 to October 2022 after taking validation from institutional ethical committee.

Inclusion Criteria

All fit patients above 15 years and less than 70 years who gave consent for study and underwent intestinal resection and anastomotic surgery electively after being admitted in surgery department at J.A. Group of hospitals, G.R. Medical College, Gwalior in the said period.

Exclusion Criteria

- Patients with organ failure
- Patients requiring emergency surgery
- Active intra abdominal infection
- Patients with a positive history of carcinoma, chemotherapy or radiotherapy, suffering from HIV(immunocompromised patients)
- Patients who did not give consent to be included in the study.

METHODS

Informed consent was taken after explaining every aspect of surgery (pre op bowel preparation and Ryle's Tube removal) along with prognosis in detail in patient's language.

Randomization was done by lottery method. Postoperatively, patients were kept in surgical ICU for atleast 48 hrs with constant monitoring of vital parameters.

A total number of 60 patients-42 males and 18 females were enrolled for the study. They were divided into 2 groups of 30 patients each into early feeding group (EFG) and conventional feeding group (CFG).

Patients of early feeding group was supplemented with early enteral feeding in form of 100-150 ml fluid thrice daily on first postoperative day after clamping Ryle's Tube, while in the CFG, feeding was started after resolution of ileus and once the bowel sounds started appearing.

A detailed history, clinical examination and required preoperative investigation were carried out in every case. In both groups, every patients required similar antibiotic prophylaxis of Injection Ceftriaxone 1 gm and Injection

Metrogl 500mg with insertion of Ryle's tube, IV access and urinary catheterization. All the patients were operated under general anesthesia with similar operating guidelines (for eg. similar operating technique of 4 layers anastomosis, suture selection and placement of intra abdominal drain)

In post operative period, 100-150 ml fluid thrice daily (at 8 hr interval) was started within 24 hrs of operation in EFG with clamping of Ryle's tube. When the patient started accepting the fluid diet, Ryle's tube was removed and the semisolid and oral diet were subsequently started to reach the nutritional requirement as per weight as soon as possible.

If the patient could not tolerate the oral feed, the subsequent feed was omitted and then restarted the liquid feed, once the patient started accepting the oral liquid feed.

In CFG group, the Ryle's tube was removed once the output was less than 50ml/day and the bowel sounds appeared. The patient was allowed liquid diet and then shifted to semisolid diet and then to solid diet. In case, the patient did not tolerate the feed, the patient was managed in above described manner.

Proper and regular monitoring of all patients were done with recording of all vital parameters and any untoward incidence along with any complication.

All parameters like time of appearance of bowel sounds, incidence of vomiting, abdominal distention, time of passage of first flatus and faeces, duration of hospital stay along with development of complications like anastomotic leak, wound infection, wound dehiscence, respiratory tract infection, urinary tract infection and mortality were recorded. The anastomotic leak was established by clinical examination, abdominal distention, tachycardia, drain output and radiological investigations (USG, CT-scan).

This study was performed after taking ethical clearance from our Institutional Ethical Committee. All the gathered data was tabulated into a master chart and was then statistically analyzed using Chi Square Test and Student's "t" test while using SPSS software.

OBSERVATION AND RESULTS

In our prospectively conducted comparative study, 60 patients who qualified the inclusion criteria were randomized into 2 groups of 30 patients each. Group A was early feeding group (EFG) in which oral feeding was started on first post operative day (within 24 hours after anastomosis) while Group B was conventional feeding group (CFG) in which feeding was started after resolution of post operative ileus and return of bowel sounds.

These patients were followed in post operative period for their drain output, any nausea and vomiting, any abdominal distention, anastomotic leakage, wound complications, pulmonary complications, urinary tract infections and hospital stay duration.

Table 2 : Correlation between sex distribution & 2 groups

Sex	Early feeding group		Conventional feeding group		Chi square	P value
	No. of patients	%	No. of patients	%		
M	22	73.3	20	66.7	0.34	0.55
F	8	26.7	10	33.3		
Total	30	100	30	100		

There were 22 (73.3%) males in EFG and 20 (66.7%) males in CFG. There were 8 (26.7%) females in EFG and 10 (33.3%) females in CFG. So, statistically both the groups were comparable in respect to gender distribution (p value = 0.55).

Table 4 : Correlation between Age Group Distribution in 2 groups

Age group	Early feeding group		Conventional feeding group		Chi square	p value
	N	%	N	%		
Upto 19	2	6.7	2	6.7	4.8	0.84
20-39	10	33.3	10	33.3		
40-59	15	50	14	46.7		
60 & above	3	10	4	13.3		
Mean Age (years)	40.50		42.96			

Out of the 60 patients, the youngest patient was of 15 years and the eldest of them was of 68 years age. Majority of patients in both groups i.e. 15 (50%) patients in EFG and 14 patients (46.7%) in the CFG group belonged to 40 – 59 year age group. Also in the other age groups, the distribution of the patients were comparable, statistically both the groups were also comparable as p value was 0.84 and was insignificant.

Table 5 : Diagnosis comparisons in Two Groups

Diagnosis	Early enteral feeding		Conventional method of feeding	
	N	%	N	%
Colostomy in situ	2	6.7	2	6.7
Appendicular lump	3	10.0	3	10
Ileal stricture	3	10.0	2	6.7
Ileostomy insitu	17	56.7	14	46.7
Jejunal diverticulum	1	3.3	1	3.3
Jejunal polyp	1	3.3	1	3.3
Kochs abdomen	3	10.0	3	10
Ileal band	0	0	2	6.7
Jejunal mass	0	0	2	6.7
Total	30	100	30	100

Most of the patients enrolled in the study in both the groups were of ileostomy in situ, 17 (56.7%) in EEG and 14 (46.7%) in CFG. Other most common diagnosis with which patients were admitted were ileal stricture, appendicular lump, Koch's Abdomen and colostomy in situ. Both the groups were almost similar in having patient's with similar diagnosis & their corresponding number of patients.

Table 6 : Group comparisons (Early enteral feeding vs Conventional method of feeding) for surgical procedure

Operation	Early enteral feeding		Conventional method of feeding	
	N	%	N	%
Colostomy closure	2	6.7	2	6.7
Ileo ileal anastomosis	2	6.7	4	13.3
Jejuno jejunal anastomosis	2	6.7	4	13.3
Right hemicolectomy	7	23.2	6	20.0
Stoma closure	17	56.7	14	46.7
Total	30	100	30	100

Maximum number of procedures done in both groups was ileostomy closure for ileostomy – 17 patients (51%) in EFG and 14 patients (42%) in CFG. Also, other procedures done were colostomy closure [2 (6.7%) each in both the groups], ileo-ileal anastomosis [2 (6.7%) in EFG vs 4 (13.3%) in CFG], jejun-jejunal anastomosis [2 (6.7%) patients each in EFG and 4 (13.3%) in CFG]. 7 (23.3%) right hemicolectomies were done in EFG and 6 (20%) right hemicolectomies were done in CFG. Hence, both the groups were comparable in the surgical procedures performed.

Table 7 : Correlation between vomiting in 2 groups

Vomiting	Early feeding group		Conventional feeding group		Chi square	P value
	N	%	N	%		
+	3	10%	01	3.3%	0.115	0.7
-	27	90%	29	96.7%		

Only 3 (10%) out of the 30 patients suffered from vomiting in

EFG while 1(3.3%) out of 30 patients suffered from vomiting in CFG. Feeding was stopped for the next 8 hours (i.e. subsequent feed was omitted) in patients with vomiting and resumed after 8 hours. Patients tolerated feeding well after 16 hours.

Although the incidence of vomiting is comparatively high in EFG in comparison to the CFG, but it was statistically insignificant (p value = 0.7).

Table 8 : Correlation between abdominal distension in EFG & CFG

Abdominal distension	Early feeding group		Conventional feeding group		Chi square	P value
	N	%	N	%		
+	3	10	00	0	3.158	0.237
-	27	90	30	100		
Total	30	100	30	100		

Only 3 (10%) out of 30 patients developed abdominal distension in EFG while no patients developed distention of abdomen in CFG. All those patients who had vomiting developed mild distention but were managed conservatively without putting Ryle's Tube.

Statistically both groups were comparable and the p value was insignificant. (p = 0.237).

Table 9 : Correlation between resolution of ileus (first passage of faeces) in EFG & CFG

Resolution of ileus (first passage of faeces) (POD)	Early feeding group		Conventional feeding group		Chi square	P value
	n	%	N	%		
2	16	53.3	4	13.4	0.19	0.66
3	10	33.3	18	60	2.5	0.11
4	4	13.4	8	26.4	0.15	0.9

In our study when we compared resolution of paralytic ileus between two groups, we observed that maximum participants (n=16; 53.3%) had passed their first faeces on post operative day 2 in early feeding group while in conventional feeding group paralytic ileus resolved in maximum (n=18; 60%) patients on post operative period 3. In early feeding group 10 participants (33.3%) had passed their first feces on post operative day 3 while only 4 participants (13.4%) passed on post operative day 4.

In conventional feeding group, ileus had resolved in only 4 participants (13.4%) on post operative day 2 & in 8 participants (26.6%) on post operative day 4.

On statistically analyzing, both the groups were comparable in respect to resolution of the ileus and first passage of faeces and there was no statistical significance noted (p value > 0.05) suggesting delaying of feeding does not help in early resolution of the paralytic ileus.

Table 10 : Correlation between anastomotic leakage in 2 groups

Anastomotic leakage	Early feeding group		Conventional feeding group	
	N	%	N	%
Yes	0	0	1	3.3
No	30	100	29	96.7
Total	30	100	30	100

Out of 30 patients of EFG, there was no anastomotic leak noted, while in CFG, out of 30 patients 1 (3.3%) patient suffered from anastomotic leak. So, the anastomotic leak rate was 0% in EFG and a bit higher 3.3% in CFG, but was statistically insignificant. The leak was treated conservatively by maintaining electrolyte and nutritional balance, controlling the sepsis with the use of antibiotics and enemas (as and when required). It was a low output leak.

Table 11 : Comparison of mean postoperative hospital stay between 2 groups

Hospital stay	Early feeding group	Conventional feeding group	Mean difference	P value
	Mean ± SD	Mean ± SD		
	10.1 ± 2.7	13.9 ± 2.5	3.8 ± 0.2	0.03

When we compared mean postoperative hospital stay between early feeding group & conventional feeding group, it had been observed that mean hospital stay for participants given early enteral feeds was lower (i.e. 10.1±2.7 days) while who were given conventional enteral feeds was longer (i.e. 13.9±2.5 days).

This gives mean difference of 3.8±0.2 days with a p value of 0.03.

Hence the difference was highly statistically significant. (p value = 0.03).

Table 12 : Comparison of the complication rate of both groups

Complication	Early feeding Group	Conventional feeding Group	'p' value
Wound infection	2 (6.7%)	5 (16.7%)	0.54
Pulmonary complication	1 (3.3%)	2 (6.7%)	0.73
Urinary Tract Infection	3 (10%)	5 (16.7%)	0.78
Death/Mortality	0	0	1

In our study, 2 cases (6.7%) in the early feeding group and 5 cases (16.7%) in the conventional feeding group suffered from wound infections. The CFG group had higher wound infection rate, though statistically insignificant (p value = 0.54)

Similarly, 3 cases (10%) in the early feeding group and 5 cases (16.7%) in the conventional feeding group suffered from urinary tract infections. The CFG group had higher rate of Urinary Tract Infections, though statistically insignificant (p value = 0.78)

1 case (3.3%) had pulmonary complication in the early feeding group and 2 cases (6.7%) had pulmonary complications in the conventional feeding group. The CFG group had higher pulmonary complications, though statistically insignificant (p value = 0.73)

There was no death in our study in both groups hence, the death/mortality is 0 for the EFG and CFG groups. (p value = 1).

DISCUSSION

Traditionally, the post-operative management of patients who underwent intestinal resection and anastomotic surgery involved restraining of oral intake of fluids/nutrients until the resolution of post-operative paralytic ileus. Ileus is a predominant determinant of post surgical convalescence and affects it negatively.²⁶ Withholding the oral feeds in post operative period until the return of intestinal peristaltic sounds leads to deprivation of the intestinal mucosa from surface nutrients as well as prolongs parenteral fluid therapy, thereby depriving the patients of adequate nutrition and hence nutritional depletion of the patients body storage. Also prolonged nil by mouth approach keeps the patient bound to bed with its consequent complications along with prolonged hospital stay and increased cost of therapy.

Lately, the approach of perpetuating nil per oral approach and starting early oral feeds has been increasingly debated and rigorous efforts have been made to collect related clinical affirmation.^{27,28} Studies have shown that early enteral feeding has better outcome lowering rates of complications and shortening the hospital stay. Early feeding reduces the

incidence of infections, improves wound healing and anastomotic dehiscence.

Dag et al inferred that early feeding is useful with reference to post operative complications and duration of hospital stay. In his study, the early enteral group feeding patients resumed oral feeding on the day after operation without conformation of bowel motility, and most of these patients successfully put up with it, he extrapolated that feeding in 85.9% of the early feeding group was uneventful.¹⁰

In our study, majority of the patients were within the age group range of 15 to 70 years. Mean age group in early feeding group was 40.50 yrs and in the conventional feeding group was 42.96 yrs and was comparable. In EFG and CFG group, the age difference was statistically insignificant (p=0.84).

With respect to sex, in the EFG there was 22 (73.3%) males and 8(26.7%) females while in the CFG, there was 20(66.7%) males and 10(33.3%) females. The sex of the patient in both the groups did not have any significance (as the p value=0.55) in respect of male to female ratio.

In our study, majority of the patients were of ileostomy in situ and thus the most common procedure done was stoma (ileostomy) closure. All the other operations namely colostomy closure, ileo-ileal anastomosis, jejunio-jejunal anastomosis and right hemicolectomy were done under general anesthesia following similar operative guidelines in both the groups.

Only 3 patients (10%) in EFG and 1 patient (3.33%) in CFG complained of vomiting. Feeding was stopped for next feeding time (8hrs) in patients who complained of vomiting and was resumed after next omitted feed time. Then patients well tolerated the feeding after 8 hrs. Though the incidence of vomiting was slightly higher in incidence in EFG and compared to CFG, when it was statistically insignificant (p=0.73). Different studies on early enteral feeding, where feeding was started within 48 - 72 hours, had showed that patients could tolerate the early oral feeding^{3,29}. Our study also extrapolated the same view.

Those patients who had vomiting in EFG suffered from mild distention, which resolved as skipping the next feed and did not require any special measures like reinsertion of Ryle's tube. No patient in CFG developed any post operative distention. On statistically comparing both groups, they were found comparable with p value=0.237.

In this study, 2 patients of EFG and 5 patients of CFG developed wound infection. The rates of wound infection in EFG and CFG was 6.7% and 16.7% respectively. The rate of wound infection is higher in CFG than that of EFG, but the difference in rate of wound infection in both groups is not statistically significant (p=0.54).

The wound infection were managed by proper toileting along with suitable antibiotic therapy and regular dressing.

1 patient of EFG and 2 patient of CFG suffered from pulmonary complication. The rates of pulmonary infection was 3.3% in EFG and little bit higher 6.7% in CFG. 3 patient of EFG and 5 patient of CFG suffered from urinary tract infection. The rates of UTI in EFG and CFG are 10% and 16.7% respectively. Hence, the rate of UTI is higher in CFG than EFG. But the difference in rates of pulmonary infection and urinary tract infection is not statistically significant (p value=0.54 and 0.73 respectively).

There was no death recorded in our study in any group.

Out of 30 patients of EFG, there was no anastomotic leak noted, while in CFG, out of 30 patients 1 patient suffered from

anastomotic leak. So, the anastomotic leak rate was 0% in EFG and a bit higher 3.3% in CFG. This leak developed into a low output leak and did not require any re exploration. The patient was managed successfully by maintaining nutritional and electrolyte balance, intravenous fluids and antibiotics and use of enemas as and when required. On the comparison of anastomotic leak rate between 2 groups, it was statistically not significant. In 2 studies conducted by Fanaie et al.³⁰ and Ekingen³¹, they had concluded that the better anastomotic healing without any increase in anastomotic leakage and dehiscence in early oral fed group. The result of our study is also of the similar view to that of the above mentioned studies. The mean duration of post – operative stay (in days) in EFG and CFG was 10.1 days (SD – 2.7) and 13.9 days (SD – 2.5) respectively. The mean difference between the two groups was 3.8 days (SD – 0.2), higher in CFG group. This difference in mean duration of postoperative hospital stay between the two groups was found statistically significant ($p = 0.03$).

In our study, maximum patients 27 out of 30 i.e. 90% could tolerate the early oral feeding. Due to persistence of the residual effects of anaesthetic drugs within 4-6 hours of the surgery, the tolerance to early enteral feeding was only 65% of the cases in Stewart et. al. study which was quiet less in comparison to our study. Oral Feeding can be initiated even within 24 hours of operation, once the effect of anaesthetic drugs is over by that time.³²

Also the incidence of vomiting in our study in EFG and CFG was 10% and 3.3% respectively which on comparison was statistically insignificant. The incidence of nausea and vomiting in our study is comparable to that of previous studies.^{3,29}

Ileus resolved in 53.3% of patients on 2nd post-operative day in EFG while only 13.4% of patients of CFG, ileus was resolved till post op day 2. Hence there was early return of bowel functions in EFG in comparison to CFG. This was in conjunction with studies done by Kamie. et. al.²⁹ and VELEZ et. al.³³ which showed faster recovery of the bowel functions and hence shorter duration of the hospital stay. In our study we also had significantly shorter stay duration in hospital in EFG group than in CFG group.

In our study, 2 cases (6.7%) in EFG and 5 cases (16.7%) in CFG developed wound infections. The CFG group had higher wound infection rate, though statistically insignificant. It was similar to meta-analysis study conducted by Lewis et. al. who also showed lower incidence of wound infections in early fed group.³⁴

In the meta – analysis as well as in our study, there was no statistical difference between the incidences of wound infection in both the groups. There was few cases of post – operative pulmonary complications (EFG – 3.3%, CFG – 6.7%) & urinary tract infections (EFG – 10%, CFG – 16.7%). Both the groups and were found statistically insignificant on comparison ($p > 0.05$). This was similar to result inferred by meta – analysis conducted by Lewis et. al.³⁴, though the incidence rate was remarkably less in EFG.

In our study, the mean duration of post – operative hospital stay was mean 10.1 days (SD – 2.7 days) of EFG in comparison to mean 13.9 days (S.D. – 2.5 days) of CFG, which was significantly shorter (p – value = 0.01). The result of our study is comparable with that of previous studies^{35,33} in respect to the duration of hospital stay.

Hence Early Enteral Feeding helps in return of early bowel movements, faster recovery with less post – operative complications resulting in early discharge from the hospital shortening the post – operative hospital stay and saving significant financial burden of both patient and hospital.

CONCLUSION

Following conclusions can be drawn from our study :-

- There was early resolution of ileus and early passage of first stools in the early feeding group.
- Early enteral feeding was well tolerated in the group.
- Though there was slight higher incidence of vomiting and abdominal distention in the post – operative course of early feeding group, but it was mild and statistically insignificant.
- Mean duration of the post – operative hospital stay is significantly shorter in early feeding group.
- The rate of infective complications (urinary tract infections, Pulmonary infection and wound infection) is lower in the early feeding group.
- The rate of anastomotic leak is also lower in early feeding group

After observing the above findings, we can safely and firmly conclude that the traditional and conventional wisdom of not starting enteral feeds early till resolution of ileus and appearance of bowel peristaltic sounds might not stand the test of time and early enteral feeding should be started once anaesthetic drug effects are over.

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