Considerable attention has been paid to speedy resumption of oral nutrition after surgery. Evidence suggests that paralytic ileus after surgery is transient and has little clinical effect on the return to oral nutrition in the early postoperative phase. An important impetus for early return to oral nutrition is shorter hospital stay.

Charoenkwan et al conducted a comprehensive review of studies that assessed outcomes after early postoperative feeding in women having gynaecological surgery, only 3 trials met the inclusion criteria. The authors acknowledged the variability in the quality of the trials and the limited data available for individual outcomes. Data for some major morbidity outcomes (ie, nausea, postoperative ileus, nasogastric tube placement, and febrile morbidity) were provided by only 1 study each. Outcomes related to patient preference, cost, and physiological benefits of early postoperative feeding were lacking; these areas present a clear opportunity for future research. The schedule for early return to oral nutrition varied slightly among the included studies. One study offered patients a soft diet on the first postoperative day and a solid diet on the second day, whereas the other 2 studies offered clear fluids on the first postoperative day, advancing to a solid diet as tolerated. Although oral nutrition can be initiated safely in patients having major gynaecological surgery, nausea is often a discomforting factor. Therefore, decisions about early feeding should be made jointly by nurses, physicians, and patients and should reflect the patient’s ability and desire to ingest nutrition.

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**Outcomes:** symptoms of postoperative ileus (nausea, vomiting, and abdominal distension); time to presence of bowel sounds, passage of flatus, passage of stool, and start of solid diet; and length of hospital stay.

**MAIN RESULTS**
Early feeding increased risk of nausea, but groups did not differ for vomiting, abdominal distension, or ileus (table). Early feeding reduced time to bowel sounds by 0.5 day (95% CI 0.2 to 0.8; 1 RCT, n = 195) and time to solid diet by 1.5 days (CI 0.7 to 2.3; 2 RCTs, n = 301). Groups did not differ for time to passage of flatus or stool, or length of hospital stay.

**CONCLUSIONS**
In women having major abdominal gynaecological surgery, early initiation of oral intake of food and fluids increases risk of nausea but not other postoperative complications. Early feeding results in faster resumption of some aspects of bowel function and earlier return to a solid diet.

**ABSTRACTED FROM**

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**Clinical impact ratings:** Genitourinary surgery 5/7; Perioperative 6/7

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Number of trials (n)</th>
<th>Early feeding</th>
<th>Delayed feeding</th>
<th>RRI (95% CI)</th>
<th>NNH (CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>1 (195)</td>
<td>43%</td>
<td>24%</td>
<td>79% (19 to 171)</td>
<td>6 (4 to 17)</td>
</tr>
<tr>
<td>Abdominal distension</td>
<td>2 (301)</td>
<td>34%</td>
<td>31%</td>
<td>7% (~23 to 47)</td>
<td>Not significant</td>
</tr>
<tr>
<td>Vomiting</td>
<td>2 (301)</td>
<td>6.1%</td>
<td>7.1%</td>
<td>14% (~100 to 63)</td>
<td>Not significant</td>
</tr>
<tr>
<td>Ileus</td>
<td>1 (96)</td>
<td>8.5%</td>
<td>14%</td>
<td>40% (~90 to 81)</td>
<td>Not significant</td>
</tr>
</tbody>
</table>

*Abbreviations defined in glossary: RRI, RRR, NNH, NNT, and CI calculated from data in article using a fixed-effects model.*