Normal food at will and nil-by-mouth enteral feeding after major upper GI surgery did not differ for mortality or morbidity

**QUESTION**
Does allowing normal food at will increase morbidity compared with “nil-by-mouth” enteral tube feeding (ETF) after major upper gastrointestinal (GI) surgery?

**METHODS**

**Design:** randomised controlled trial (RCT).

**Allocation:** concealed.

**Blinding:** (unblinded).*

**Follow-up period:** 8 weeks.

**Setting:** 5 referral centres in Norway.

**Patients:** 453 patients (mean age 64 y, 59% men, based on 447 patients) who had major upper GI surgery. Exclusion criteria included severe extra-abdominal disease or trauma, life expectancy <3 months, or indications for parenteral nutrition.

**Interventions:** normal food at will (n = 220) or ETF by needle-catheter jejunostomy (n = 227) after surgery. ETF consisted of nutrition, 20 ml/h on day 1, increasing by 20 ml/h/d (if tolerated) up to 80 ml/h; after 5 days, patients were allowed food at will.

**Outcomes:** mortality, major complications (including bacteraemia, sepsis, pneumonia, wound rupture, and pancreateatitis). Secondary outcomes included minor complications (atelectasis, wound infection, and incisional hernia) and adverse events, bowel function, postoperative weight loss, and length of hospital stay.

**CONCLUSION**

Allowing normal food at will and nil-by-mouth enteral feeding after major upper gastrointestinal surgery did not differ for mortality and morbidity.

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**COMMENTARY**

The approach to feeding after major upper GI surgery varies, with reports indicating a trend toward a more conservative strategy of nil by mouth compared with early oral feedings at will.1 The reluctance to initiate oral feedings stems from concerns about the integrity of the anastomosis as well as gastric dysmotility. A systematic review by Lewis et al identified 11 RCTs and found that feeding at will after major upper or lower GI surgery reduced infection and length of hospital stay, and increased vomiting.2 Insufficient detail in reporting and poor methodological quality of the included trials limits generalisability.

The well-designed RCT by Lassen et al showed no differences in the primary end point of mortality or in complication rates. The food-at-will group showed improvement in time to first flatus, an accepted indicator that bowel function has returned, although this did not translate to a significant difference in time to first bowel movement. Groups did not differ in the need for nasogastric decompression. At follow-up, more patients in the ETF group had wound infections and complications after discharge.

The study by Lassen et al provides additional support that food at will is well tolerated. Nil by mouth, often associated with routine nasogastric decompression and jejunostomy placement, may pose unnecessary discomfort and risk without providing additional benefits. The authors acknowledged heterogeneity of groups as many different procedures were represented. However, about 70% of procedures in both groups comprised 5 types of procedures. Although some clinicians may hesitate in moving toward feeding at will, it should be considered: patients have shorter hospital stays and there is little difference in clinical outcomes for major general surgical procedures.

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