



# Enteral Nutrition Following Esophagectomy

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## Editorial

The weight loss is a common clinical condition occurred in patients with esophageal cancer and it was present in 57% of patients at the time of diagnosis [1]. This weight loss is related to malignancy and insufficient oral intake secondary to dysphagia, and it can be increased by neoadjuvant therapies. The weight loss can persist at least 3 years after surgery [1]. Therefore, surgical patient candidate for esophageal surgery should be nutritionally evaluated before the time of surgery to detect malnutrition. Malnourished patients are considered as high risk patients to develop high postoperative morbidity and mortality rates, and 40% of malnourished patients experienced postoperative complications [2,3]. Moreover, the oncologic results were influenced by malnutrition and overall survival was less good in malnourished patients [4]. Esophagectomy is a complex surgical procedure with the need to use an abdominal digestive graft to establish the gastrointestinal continuity and it is a high risk procedure with high rates of associated complications. Best perioperative nutritional condition is essential for a successful esophageal surgery, and so, adequate nutrition is important to achieve perioperative nutritional optimization. Enteral Nutrition (EN) is the preferred nutritional support and parenteral nutrition should be used when EN is inaccessible or contraindicated. Enteral feeding can be administrated through multiple routes, including oral intake, jejunostomy-tube and nasoduodenal or nasojejunal tube. Early enteral nutrition *via* jejunostomy tubes has become a common practice in esophageal surgery [5]. Jejunostomy tube route has been the most used route for enteral feeding following major gastrointestinal surgical procedures. The well documented benefits of early enteral feeding on functional and nutritional outcomes, including complications and mortality after major gastrointestinal surgery have been clearly demonstrated by published reports [6]. Also, early enteral nutrition was associated with shorter hospital stay length, improved quality of life and overall survival [7,8].

Recently, the early oral feeding has been evaluated in major gastrointestinal surgery and the published reports have revealed the great benefits on postoperative outcomes that were similar to those of artificial enteral nutrition showed by previous reports [9,10]. The published reports on the ERAS programs implemented in different surgical specialties have once again proved the benefits of enteral nutritional through oral route on the postoperative outcomes [11]. Despite the safety and various advantages of early oral enteral nutrition in many major gastrointestinal surgical procedures, such as colorectal and gastric surgery [12]. The hesitance of some surgeons to initiate early oral feeding following esophagectomy is not evidence based attitude but instead based on fears regarding anastomotic leak, pneumonia secondary to aspiration and insufficient nutritional intake with oral feeding. This hesitance in initiating early oral feeding after esophagectomy has led to limitation of studies on this topic. Early oral feeding is an important component of the ERAS program protocols. The recent implementation of the ERAS program in esophageal surgery has resulted in publishing some reports. A meta-analysis regrouping thirteen studies evaluating ERAS protocols following esophagectomy showed a reduced length stay and decreased pulmonary complications without significant increase in readmissions [13]. Also, early oral feeding was associated with significant cost-saving [12]. Overall, the recent evidence, including ERAS program reports clearly demonstrates that early oral feeding is safe associated with cost saving, shorter length of hospital stay, faster return of bowel function, and improved quality of life and survival. Additionally, early oral feeding is not associated with a significant increase in anastomotic leak and non surgical complications.

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