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Nutrition in HPB Surgery

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1. Patients undergoing HPB cancer surgery should undergo nutrition screening and evaluation since malnutrition is associated with poor prognosis and independent risk factor for mortality.
2. The reasons for decrease in mortality rate after pancreaticoduodenectomy is advances in critical care, wide spectrum antibiotics, high volume hospitals, improved interventional radiology, better patient selection and multidisciplinary nutrition management.
3. Any patient who cannot receive normal diet in perioperative period for 5 days or who are unable to maintain oral intake above 50% of energy target for 7 days should receive perioperative nutritional therapy.
4. Enteral access like nasojejunal tube or feeding jejunostomy should be considered only in patients at risk since they might be associated with complications like tube dislodgement, discomfort or leakage.
5. A meta-analysis of 5 RCTs with 690 patients showed that enteral nutrition is associated with shorter length of stay after Pancreaticoduodenectomy with no difference in fistula rate, infectious complications and delayed gastric emptying.
6. Small meals 5-6 times a day along with pancreatic enzyme supplementation is recommended method of re-alimentation during early phase of recovery after surgery.
7. Enteral nutrition does not result in anastomotic leak but patients with anastomotic leak will not tolerate oral nutrition.
8. GI dysmotility after pancreaticoduodenectomy is common and is caused by splanchnic hypoperfusion, paralytic ileus or intra-abdominal collections.
9. Nutritional treatment is a major component of management of post-pancreaticoduodenectomy complications like pancreatic fistula or delayed gastric emptying, who require trophic enteral nutrition with energy target of 30Kcal/kg and protein target of 1.3-1.5gm/kg.
10. A multicentre RCT of 9 centres in France comprising 204 patients showed that naso-jejunal early Enteral nutrition after pancreaticoduodenectomy may not be safe in all patients since post-operative complications like pancreatic fistula are more common with early NJ nutrition group.
11. Some patients may require supplemental or total PN if at least 60% of energy target cannot be reached with enteral nutrition.
12. No evidence for routine use of peri-operative immuno-nutrition and selected malnourished cancer patients may benefit from perioperative immuno-nutrition for 5-7 days.
13. Oral nutritional support therapy should be continued post operatively as long as the problem persists and should be followed up closely.

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