


I read with great interest the excellent paper from Goh et al. [1] on the relationship between preoperative serum albumin levels and postoperative complications in patients undergoing oesophagectomy for oesophageal malignancies. This is a sensitive group in which malnutrition is caused not only by the metabolic perturbations from the neoplastic disease, but also from dysphagia and alimentary tract dysfunction, further aggravating the situation. Indeed, it has been demonstrated that up to 32% of oesophageal cancer patients being considered for oesophagectomy present with severe weight loss, underlining the fact that they are prone to malnutrition [2]. Given the well-established association between malnutrition and poor surgical outcomes, it seems reasonable that patients scheduled for major surgery, such as oesophagectomy, should undergo formal nutritional assessment, and if necessary nutritional support. Among the various indices used for the evaluation of the nutritional status, hypoalbuminaemia defined as serum albumin level < 3.0 g/dl, has been identified as the most valuable predictor of adverse postoperative outcomes, while to date, the only validated assessment method for surgical patients is the NRS-2002, which is based on weight loss, reduced intake and disease severity [3]. It is important to note that nutritional assessment of the surgical patient is not used to “clear” him for surgery, but rather to optimize surgical outcomes in high-risk groups.

When the oesophagectomy candidate is found to be malnourished, the options to proceed with nutritional support include oral supplements, parenteral nutrition (PN) and enteral tube feeding. The potential benefits of the first option are frequently unattainable due to gastrointestinal intolerance, anorexia and non-compliance, while the major drawbacks to preoperative initiation of PN include gastric emptying, central line complications and the risk of infection. Nevertheless, PN has been found particularly useful for patients undergoing upper gastrointestinal surgery, given that it can be provided for at least 7 days during the preoperative period [3]. A meta-analysis of various nutritional support methods in patients undergoing gastrointestinal surgery demonstrated that enteral nutrition (EN) is advantageous over PN in terms of infectious complications, anastomotic leaks and duration of hospital stay. Moreover, EN is especially beneficial for patients with malnutrition or malignancy [4]. Feeding jejunostomy tubes (JT) inserted percutaneously, endoscopically or laparoscopically can provide the desired route for EN before oesophagectomy or neoadjuvant therapy, although their routine use has been associated with the development of major complications, including reoperation, bowel ischemia and even death [5]. However, in the malnourished patient undergoing oesophageal resection apart from preoperative support, JT will also provide the postoperative nutritional bridge to oral intake.

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References


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I read with interest the excellent paper from Goh et al. [1] It comprehensively addressed the question of whether serum albumin acts as a predictor of complications in the postoesophagectomy patient. The authors took into account the important fact that low serum albumin may occur secondary to a number of other possible confounding factors. They also briefly address the fact that little is known about the role of preoperative nutritional support in these patients. This paper leads to a number of further questions that should be asked. Firstly, is there a difference in the predictive value of albumin if it is low in the preoperative setting, but restored using nutritional support to a normal level postoperatively, compared to the patient with a normal preoperative albumin which becomes low in the postoperative setting? Secondly, is there an ideal time and rate at which to improve a patient’s albumin level in order to reduce the chances of further complications? Finally, is there a difference in outcomes between patients who have their albumin restored using parenteral nutrition versus those patients who have this done using enteral nutrition?

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