

Are we starving our cesarean patients too much postoperatively?

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Abstract

Cesarean section is a common operation in obstetric care. Delayed initiation of oral fluids and food may be uncomfortable for women in the postoperative period. Early feeding should be initiated without any fear of side effects. Patients have early postoperative recovery; it is cost effective and results in higher patient satisfaction. Early oral intake post cesarean section regardless of objective signs of the return of bowel functions was demonstrated to be safe and effective, with added patient comfort as the primary benefit.

Keywords: Cesarean section, Early feeding, Early recovery.

Case Study

Cesarean section is a common operation in obstetric care. Practices to withhold fluids and/or food after cesarean section vary considerably and are not evidence based. So, as a pilot study we telephonically interviewed ten practicing obstetricians in Mumbai regarding their standard practice of feeding post cesarean section. All of them fed their patients after return of bowel sounds which was almost never done before 24 hours of cesarean section. Delayed initiation of oral fluids and food may be uncomfortable for women in the postoperative period. Early feeding post cesarean section is an established practice in our institute. After institutional Surgical and Anesthesia consent were obtained 100 women who received spinal anesthesia for cesarean section (elective and emergency) were included in our study. Each of the 100 women included in the study were given clear liquids like water, juice within two hours and soft diet within six hours of spinal that is within four hours after surgery was completed. None of the patients had nausea, vomiting or any other gastrointestinal complications even after 36 hours of cesarean section. We extrapolated our results from gastrointestinal surgeries.

After colorectal operations, traditional care regimens have usually included restricted oral intake to prevent signs of postoperative ileus and to protect the surgical anastomoses. However, several gastrointestinal physiologic studies that examined the contractile activity of the intestine noticed that postoperative dysmotility predominantly affects the stomach. The small bowel recovers normal function 4–8 hours after laparotomy. The concept of postoperative ileus as a paralysis of the entire bowel with the complete absence of any functional contractile activity is misleading [1-2]. The other rationale for withholding food is to allow anastomoses time to heal before being stressed by food. However, the stomach and pancreas secrete one to two liters of fluid daily, which is readily absorbed in the small intestine. Therefore, patients without a nasogastric tube postoperatively are in fact tolerating high volumes of fluid. In addition, starvation changes the body's metabolism within 24 hours by increasing insulin resistance and reducing muscle function. Optimal nutritional status and maintenance of bowel function contribute significantly to wound healing [3]. Early oral intake reduces sepsis risk by decreasing bacterial

colonization and decreased translocation through defects on the bowel mucosa into the blood circulation. In a study in 2012 by Abell et al. as per Early Recovery After Surgery (ERAS) protocol, drinking in the recovery room was encouraged and patients were fed and mobilized early. As a result, length of stay decreased and re-admission rate reduced[4]. In another study done in 2017 it was found that there is no justification to withholding oral feeds as is traditionally done. Early feeding should be initiated without any fear of side effects. Patients have early postoperative recovery; it is cost effective and results in higher patient satisfaction[5]. Hence, based on available evidence and our observations, our practice of early oral intake post cesarean section regardless of objective signs of the return of bowel functions was demonstrated to be safe and effective, with added patient comfort as the primary benefit.

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