



The Authors Reply: In Relation to the Editorial: Sabate A, Koo M. Intravenous Fluids: Concepts and Rationality of Use. Cir Esp. 2016;94:369-371[☆]

Respuesta a la carta en relación con el editorial: Sabate A, Koo M. Intravenous fluids: Concepts and rationality of use. Cir Esp. 2016;94:369-371

First of all, we would like to thank the authors for their comments and their additional statements about fluid therapy. One especially interesting aspect is postoperative ileus, which, in addition to generating diagnostic doubt about the disruption of the anastomoses, can influence operative results. Ileus is directly related with intraoperative visceral manipulation, drugs used during the intervention, postoperative analgesia, and electrolytic alterations during the postoperative period (mainly alkalosis due to unnecessary or excessive correction of the base deficit, and hypokalemia).

Early mobilization and the reestablishment of oral feeding facilitate peristalsis and therefore reduce the paralyzing effects that occur, especially in invasive surgery and the administration of opiates.

Fluid therapy can play an important role in enhanced recovery after surgery (ERAS) programs, where it is suggested that the baseline administration of fluids in the intraoperative period should be $<2 \text{ mL/kg/h}$.¹ However, it seems to be more important to comply with the program as a whole than the strict administration of fluids, all the while avoiding postoperative electrolyte dysfunction.²

Nonetheless, the role of postoperative analgesia in the ERAS protocol has not been completely defined. Although it presents limitations, epidural analgesia with local anesthesia would be the technique of choice in major abdominal procedures, especially in high-risk patients (age >70 and/or associated cardiorespiratory comorbidity). In minimally invasive surgery, epidural analgesia can be obviated, while abdominal wall analgesia is reinforced by administering local anesthetics directly to the surgical wound or using interfascial block of the transverse and oblique muscles. In our experience in colorectal surgery,³ the continuous infusion of ropivacaine in the surgical incision provided for the early initiation of oral intake versus the control group.

We fully agree with the authors in that the quantification of individual measures in the ERAS protocol is complex, and efforts should therefore be made toward the generalized implementation of the protocol.

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