



LETTER TO THE EDITOR

Medical and surgical management of patients with enterocutaneous fistula and intestinal failure: The case for specialised functional units[☆]



Necesidad de formar unidades funcionales especializadas en el manejo médico-quirúrgico de pacientes con fístulas enterocutáneas y fracaso intestinal

Dear Editor,

The term intestinal failure was defined for the first time a few decades ago, but recently, following a thorough review of the literature, the European Society of Clinical Nutrition and Metabolism (ESPEN) has defined and classified this clinical situation as follows¹:

- Intestinal failure is defined as the reduction of gut function below the minimum necessary for the absorption of macronutrients and/or water and electrolytes, such that intravenous supplementation is required to maintain health and/or growth. Intestinal failure is often associated with the presence of a high output intestinal fistula, defined as an output greater than 500 ml/24 h, and/or a high output stoma, in which output exceeds 1500 ml/24 h.¹

This rare clinical condition, commonly associated with intestinal ischaemia or inflammatory bowel disease (Crohn's disease), has a very high mortality, usually around 10% but it can sometimes exceed 25%.² In Spain, to the best of my knowledge, there are no national statistics on the morbidity and mortality associated with intestinal failure, except for several case studies, mainly in children, or experience in home parenteral nutrition.^{3,4}

More recently, the European Society of Coloproctology (ESCP) also published a consensus document using Delphi methodology to define the best surgical treatment for these patients.⁵ The document is full of extremely useful and practical information on the management of intestinal failure, and is recommended for all specialist surgeons and gastroenterologists.

In it, the authors highlight the importance of creating multidisciplinary intestinal failure units to improve the morbidity and mortality associated with this condition.⁶ Evidence has shown that these new teams can achieve a 95% success rate in managing complex intestinal fistulas.^{7–9} Multidisciplinary intestinal failure units have been in operation since the 1970s in the UK and some other European countries. They should be mainly formed by a gastroenterologist with specialist training in nutrition, and if possible, with interest in inflammatory bowel disease, a surgeon with experience and training in this type of surgery, usually a specialist in colorectal surgery, an interventional radiologist, an anaesthesiologist with expertise in complex abdominal surgery, a stoma or wound care nurse and a nurse with expertise in the administration of parental nutrition, a dietician and, ideally, a specialist in hospital pharmacy. In some cases other specialists may be needed, such as a plastic surgeon, urologist, microbiologist, etc.

The document also defines the quality metrics for these units: overall and 30-day in-hospital mortality, unplanned reoperation for complications, recurrent intestinal fistulation after failed surgical treatment, re-admission to hospital, and percentage of patients who are able to discontinue parenteral support 2 years after reconstructive surgery.⁵ More importantly, the document defines the criteria for referral to a specialist unit from other centres.^{2,5}

In Spain, these patients are usually treated in hospitals that lack the necessary experience or resources. Fortunately, guidelines published by different scientific societies can help us create such specialist units and thus provide the standard of care these patients need. This new approach, however, will place a considerable economic burden on hospitals providing intestinal failure units. With this letter, I would like to throw open the challenge of organising these functional units in Spanish hospitals, following recommendations contained in consensus documents.

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