

Principles for the nutritional management of enterocutaneous fistulae

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1. In the initial stage (no more than a few days) the patient needs to be nil by mouth to establish the fistula output (high output traditionally defined as > 500ml / 24 hrs). If the output is < 500ml / 24 hrs consider whether the patient can be managed on oral / enteral nutrition alone without parenteral nutrition.
2. Establish central venous access for the administration of parenteral nutrition if required. If possible use a PICC. Avoid the use of jugular lines as these are uncomfortable for the patient and are the most susceptible to catheter related sepsis.
3. Check U+E, glucose, LFT, Ca, Mg, PO4, FBC prior to commencing parenteral nutrition.
4. Parenteral nutrition should be established by the Nutrition Support Team (avoid commencing at the weekend; nutritional support is rarely an emergency) initially at a slow rate to avoid Refeeding Syndrome.
5. Consider the use of oral/enteral nutrition in addition to parenteral nutritional support. There should be very few instances where the patient should not have oral nutrition. Parenteral nutrition may increase the speed of fistula closure, but does not affect the proportion of fistulae that close. There is no good evidence to support bowel rest and some evidence to support gut utilization.
6. Basis of oral nutrition

Low fibre.
Restrict non-electrolyte drinks to < 1L / day.
Avoid drinking fluids 30 mins before and after meals.
7. Medication

Loperamide – 30 mins prior to meal and at night.

PPI

Octreotide – give a 3 day trial to see if reduces output. Only continue its use if a good reduction in fistula output is seen (since it reduces intestinal blood flow and nutrient absorption which could be detrimental).