Gum Chewing Speeds Postop Ileus Resolution

BY TIMOTHY F. KIRN
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San Francisco — A pack of chewing gum can save laparoscopic abdominal surgery patients over $500 in hospitalization costs?

That's what a randomized study of postoperative ileus and "sham feeding" found.

Estimates are that half of inpatient abdominal and pelvic surgery patients do not have a return of bowel function for 4 days, and 25% have not had a return by 6 days. The cost of postoperative ileus nationally is estimated to be $750 million to $1 billion a year.

A number of investigators have begun to explore the use of sham feeding—that is, chewing without swallowing food—to see whether it can cause cholinergic stimulation of the gut and speed the return to normal bowel function following abdominal surgery.

This study took that concept to the next level, James T. McCormick, D.O., said at the annual clinical congress of the American College of Surgeons. It found that laparoscopic colectomy patients randomized to chewing four sticks of gum a day had their first defecation and were discharged from the hospital almost a day earlier than other patients.

The study, which enrolled 102 patients undergoing elective colectomy, included both open colectomy and laparoscopic colectomy patients. However, the benefits were seen only in the patients who had a laparoscopic procedure, said Dr. McCormick of the Western Pennsylvania Hospital, Pittsburgh.

In the laparoscopic patients, the 42 patients who chewed gum had an average time to first bowel movement of 2.9 days, compared with an average of 3.5 days in the 20-patient, clear-liquid control group, and were released from the hospital in 4.4 days, compared with 5.2 days.

Patients in the study began to receive solid food when it was deemed that they could tolerate it, and there was no difference between the groups in hunger or vomiting. The patients who chewed gum were given the gum at mealtimes and one time in the evening to simulate a snack. By protocol, they chewed for 15 minutes.

"Is more chewing better? I don't know," Dr. McCormick said. ■

Get Consent for The Unexpected

St. Louis — Physicians need to obtain comprehensive patient consent before surgery to help guide their approach to unexpected findings during the procedure, according to Ira Horowitz, M.D.

In a presentation at the 15th International Pelvic Reconstructive and Vaginal Surgery Conference, Dr. Horowitz looked at several hypothetical cases. "It is imperative that we discuss various scenarios with the patient prior to surgery," said Dr. Horowitz, the Willaford Ransom Leach Professor and vice chairman and director of the division of gynecologic oncology in the department of gynecology and obstetrics at Emory University, Atlanta.

In one hypothetical case, a malpractice lawyer with a mucinous cystadenoma had signed a consent form to remove only the mass. The physician is permitted to remove the uterus and contralateral ovary if a carcinoma is present. "You have a suspicion of cancer. What do you do?" Dr. Horowitz asked.

"The answer might be to do nothing, because the patient has limited your ability to act independently with the consent signed," he said.

Pelvic surgeons would be wise to have a gynecologic oncologist available if cancer is suspected. A seasoned pathologist also should be present to perform a frozen section. "There is an increased survival rate when a gynecologic oncologist assists in staging and debulking of the patient with ovarian carcinoma," he said.

"A mucinous borderline tumor is frequently reread as invasive carcinoma," Dr. Horowitz said. "The challenge to the gynecologists and the gynecologic oncologist is when to do staging without a definite diagnosis of cancer. This is why it is so important to discuss these options and possibilities with the patient prior to surgery. If you discuss this before the patient is put to sleep, you won't allow yourself to be put in this position," he said.

—Robin Seaton Jefferson