ENTEROCUTANEOUS FISTULA

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- An abnormal connection between the small intestine and the skin can occur as a result of CD, radiotherapy or abdominal trauma, but the condition most commonly follows a surgical - complication – either a leak from an anastomosis or an inadver - coeliac tent enterotomy . At least 50% of small bowel enterocutaneous fistulae develop after surgery in which no small bowel has been resected as a result of injury to the intestine during division of adhesions. The frequency of this complica tion has been shown to increase with the number of previous laparotomies. Management of patients with an enterocutaneous fistula can be very challenging, especially when the fistula output Figure is high (defined as >500 /uni00A0 mL of e ffl uent/day). The majority of low-output fistulae can be expected to heal spontaneously , - provided there is no distal obstruction or disease at the fistula site. Reasons for failure of spontaneous healing also include epithelial continuity between the gut and the skin and an associated complex abscess. The management of fistulae is based on well-established principles (‘SNAP’; see Summary box 74.7). An early return - to theatre to try to treat the problem definitively (i.e. by ished patient is doomed to failure. Summary box 74.7 Principles of management of enterocutaneous fistulae (SNAP) /uni25CF /uni25CF /uni25CF /uni25CF Infected collections are best identified at CT (Figure 74.10 and can be drained percutaneously . Skin protection is import ant as small bowel e ffl uent is caustic. Nutritional support must include fluid and electrolytes, which can be lost in high quan tities from a proximal fistula, as w ell as carbohydrates, protein, fat and vitamins. Judgements have to be made between enteral and parenteral feeding: enteral feeding has advantages, but if the fistula is proximal or high output total parenteral nutrition will be requir ed. Defining fistula anatomy is best done after careful discussion with the radiologist; a sequence of contrast studies (follow-through, fistulogram and enema) may well be required to define bowel length and plan a surgical strategy . Surgery can be extremely technically demanding and an anastomosis should be avoided in the presence of continuing intra-abdominal sepsis or when the patient is hypoalbuminae mic (<32 /uni00A0 g/dL).

S, elimination of Sepsis and skin protection N, Nutrition – a period of parenteral nutrition may well be required A, Anatomical assessment P , de /f_i nitive Planned surgery

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