change any part of their care pathway. The results we reported were over a longer period of time going back to 1994 and finishing in 2001. Many things have changed during this time, and between 2000 and 2004 our unit carried out 90 oesophageal resections with a mortality of 2.2%.

The point of our paper was not to focus on peri-operative mortality but more on the actual benefit one might expect from postoperative ventilation. As mentioned in the paper, there are other studies that have questioned the need for postoperative ventilation and, providing patients are kept in a high dependency unit with full monitoring and critical care support, we do not feel that prolonged postoperative ventilation for 18 h, as suggested by Forshaw and colleagues, provides any advantage to the patient. Forshaw and colleagues suggest that these patients are kept in the recovery area until the following morning, although in many hospitals postoperative ventilation would necessitate the patient being admitted to the intensive care unit. We identify in our paper that this might well result in a significant number of patients having their oesophagectomy cancelled for lack of an intensive care bed when this was not necessary. The results from our initial study, and these have been supported by our more recent data (as shown above), demonstrate that there appears to be no benefit from prolonged ventilation providing all physiological parameters are closely monitored in a critical care environment. Although the mortality in the early part of our own series was higher than later years, we did not identify any problems that were directly related to early postoperative extubation.

COMMENT ON

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PM Murphy, P Modi, J Rahamim, T Wheatley, SJ Lewis. An investigation into the current peri-operative nutritional management of oesophageal carcinoma patients in major centres in England. *Ann R Coll Surg Engl* 2006; **88**: 358–62)

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Managing patients after oesophagectomy

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We wish to commend the authors for high-lighting an extremely important aspect in managing patients after oesophagectomy.

However, no indication was given regarding the type of resection performed in the centres surveyed. In Exeter, we currently offer minimally invasive oesophagectomy (MIO) to all patients suitable for resection and, this procedure has specific diet-related issues which are important to high-light:

1. In the absence of significant postoperative discomfort and morbidity following MIO, patients were inadvertently taking large portions of hospital food when commenced on oral intake after the fifth postoperative day. This resulted in excessive gastric distension, and subsequent anastomotic leak in two patients. As a consequence, we have now introduced an enforced, structured postoperative diet with no further problems.
2. The authors do not mention the route of postoperative jejunal feeding used. We use fine bore nasojejunal feeding tubes placed endoscopically during surgery. These are well tolerated, and rapidly weaned after the commencement of oral intake on postoperative day 5/6 by virtue of the rapid restoration of gastrointestinal function after MIO. This avoids the inherent morbidity associated with percutaneous jejunostomy tubes.¹

Reference

1. Pearce CB, Duncan HD. Enteral feeding. Nasogastric, nasojejunal, percutaneous endoscopic gastrostomy, or jejunostomy: its indications and limitations. *Postgrad Med J* 2002; **78**: 198–204.

AUTHOR'S RESPONSE

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First, can I explain that the purpose of the study was to survey current practice in England for the management of patients undergoing gastrointestinal surgery as it was suspected that the nutritional management of these patients may not be uniform. It was beyond the scope of our review to explore the rationale for specific dietary interventions for different surgical techniques. We appreciate that surgical technique varies and thus the route of nutritional support.

From a nutritional point of view, patients undergoing upper gastrointestinal surgery are vulnerable to malnutrition and benefit from specialised dietetic input. The use of nasojejunal tubes and a structured dietetic programme may well be sensible. However, a proportion of patients will benefit from nutritional supplementation after discharge from