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Original Research Article

Effect of oral feeding following elective caesarean section on paralytic ileus among participants in a tertiary institution in Southern Nigeria

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ABSTRACT

Background: Studies suggest that early initiation of oral feeding after caesarean delivery is well-tolerated by patients, but it is not yet practiced in most institutions. Traditionally, patients are kept on nil per oral until bowel functions return. This practice is associated with complications including paralytic ileus. However, the time for commencing oral feeding after elective caesarean delivery is still controversial. The aim of this study was to compare the effect of 2-hour (early) and 24-hour (delayed) post-operative oral feeding on the outcome of elective caesarean delivery in Rivers State University Teaching Hospital Port Harcourt.
Methods: This was a randomised controlled trial done in Rivers State University Teaching Hospital, Port Harcourt, between May 2023 and September 2023. 166 participants were selected consecutively during the period of study and randomised into two groups with 83 participants in each group. Using a structured questionnaire, data were collected and analysed with SPSS version 25 software.
Results: The proportion of post-operative ileus symptoms was 6.0% vs. 3.6% in the early and delayed groups showing no statistical difference ($\chi 2=0.52$; p–0.473). The time interval for return of bowel function (3.7±0.7 hours vs. 13.6±2.7 hours), passage of flatus (6.1±1.3 hours vs. 20.4±3.8 hours) and bowel movement (32.9±15.1 hour vs. 64.7±14.6 hours) were significantly higher ($p<0.05$) in the delayed group than the early group.
Conclusions: Early initiation of oral feeding after elective caesarean section is safe and is associated with earlier return of normal bowel function without fear of gastrointestinal symptoms or paralytic ileus.

Keywords: Bowel function, Early oral feeding, Elective caesarean section, Delayed oral feeding, Paralytic ileus

INTRODUCTION

Caesarean section is one of the frequently performed surgical procedures in current obstetrics.[1,2] Caesarean section has become extremely safe over the years; this has been possible due to transverse lower uterine segment and abdominal incisions, safe and better anaesthetic techniques, strict adherence to asepsis, antibiotics, blood and blood products availability, and high-quality suture material.[3] Though Caesarean section is a major abdominal surgery, it is different from other abdominal surgeries.[4] Most caesarean sections are performed for obstetrical indications rather than medical indications, and patients are well prepared preoperatively, especially in elective cases. These patients are young, in good health and well nourished. It is a relatively short operation, without much bowel manipulation and usually not infected.[4]

In the past, caesarean section was equated with other major abdominal surgeries hence, ambulation was delayed; oral feeding was started only after the bowel sounds were heard and patient had passed flatus.[5]

The rationale for this traditional approach to initiation of oral feeding after caesarean delivery was based on the assumption that if oral feeds were started earlier, the patient may develop postoperative ileus. However, available evidence has not supported such assumption. On the contrary, available reports suggest that early postoperative feeding may be associated with reduced distressing symptoms of thirst and hunger, decreased protein store depletion, better wound healing, faster recovery, improve mental-state, early ambulation and consequent earlier discharge from the hospital at reduced cost. As a result, the emphasis has shifted toward early initiation of oral feeding after caesarean section.[6, 7,8]

Enhanced recovery (ER) is also known as 'fast track', 'rapid' or 'accelerated recovery'. Enhanced recovery after surgery (ERAS) caesarean delivery pathway provides evidenced based recommendations for the surgical pathway that is related to caesarean delivery with, primarily, a maternal focus.[9] ERAS has been shown to result in both clinical benefits (reductions in length of stay, complications, and readmissions) and health system benefits (reduction in cost). According to ERAS, early feeding is defined variably as feeding as early as 30 minutes and up to 8 hours after caesarean delivery. The recommendation of ERAS is a regular diet within the 2 hours after caesarean delivery.[10,11,]

Studies revealed that early oral feeding improved recovery of bowel function, early ambulation, reduction of hospital stay and increased patients satisfaction without significant Gastrointestinal complication.[10,11] Furthermore, in Nigeria, there is paucity of literature and no study was found in the South-south region. Findings will serve as a source of secondary data for future research on similar study. Therefore, we determined the effect of 2-hours (early) and 24-hours (delayed) post elective caesarean section oral feeding on the incidence of paralytic ileus among parturients in RSUTH, Port Harcourt. We also determined the effect of 2-hour (early) and 24-hour (delayed) post elective caesarean section oral feeding on return of bowel function among parturients in RSUTH, Port Harcourt.

METHODS

This was a randomised controlled trial done in Rivers State University Teaching Hospital, Port Harcourt, between May 2023 and September 2023.The inclusion criteria were all pregnant women who were scheduled to undergo elective caesarean section for various indications and pregnant women who gave an informed consent for the study. The exclusion criteria were women with severe medical conditions such as diabetes mellitus that may require patient's intensive care after the caesarean section, women with a history of bowel surgery, women who had extensive adhesiolysis during the caesarean section, women who had primary post-partum haemorrhage and women who had the caesarean section done under general anaesthesia.

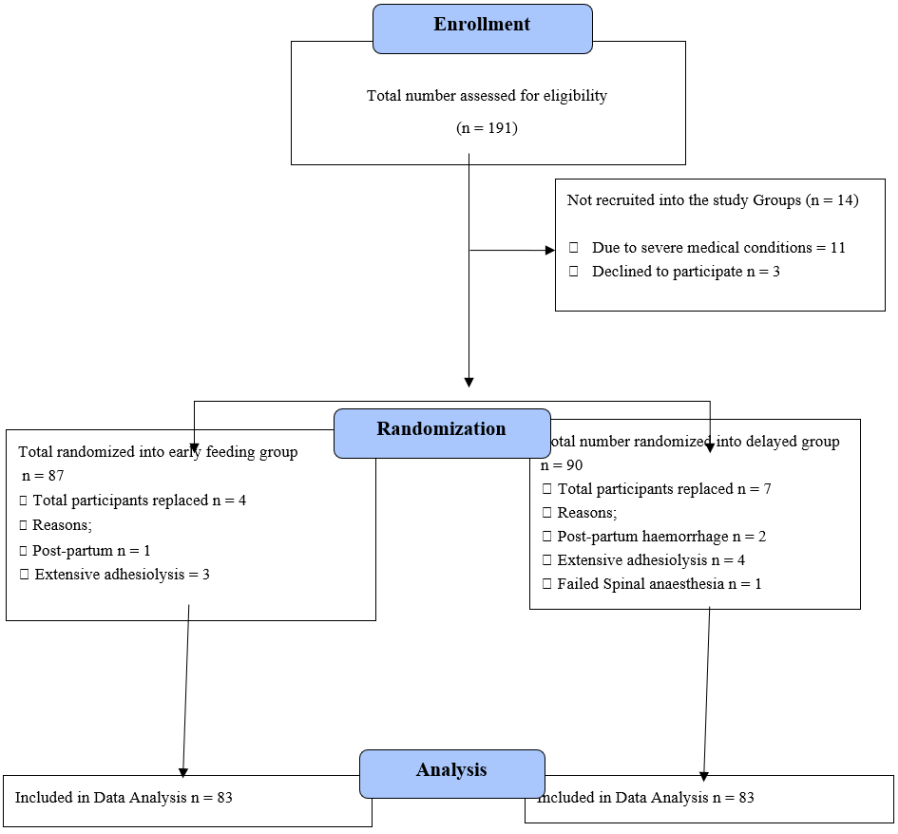

Figure 1: Research flow chart.

Primary outcome measure for this study was the development of paralytic ileus symptoms such as nausea, vomiting, inability to tolerate oral diet over 24 hours after commencing oral feeding, absence of flatus over 24 hours after surgery and abdominal distension. Secondary outcome measure included time interval to return of bowel function.

The sample size was determined using the sample size calculation formula for randomized controlled trial (dichotomous non-inferiority design).[12]

$$N = \frac{2(Z_\alpha + Z_\beta)^2 PQ}{d^2}$$

The sampling method that was used for this study was purposive sampling. All pregnant women who were admitted into the antenatal ward for elective caesarean deliveries in Rivers State University Teaching Hospital, Port Harcourt within the study period were consecutively recruited for the study. Eligible women were randomized into two groups with 83 participants in group A (early oral feeding) and 83 participants in group B (delayed oral feeding). Randomization was done at the Theater red line and women in the early feeding group had sips of oral fluid 2 hours post-operatively while those in the delayed feeding group had sips of oral fluid 24 hours post-operatively.

Using a structured study proforma data concerning the sociodemographic characteristic, obstetric features, delivery and post-operative period were collected.

Statistical analysis

Data obtained were entered into a spread sheet and analysed using statistical product and service solutions (SPSS) version 25, SPSS Inc., Chicago, IL, USA. Frequencies and percentages were used to summarize categorical variables; while continuous variable was summarized using mean and standard deviation. The difference in categorical variables between the two study groups were determined using chi-square test of proportion; while the difference in mean of continuous variable was investigated using the student's t test. Results were presented in tables and charts. The p-value was set at 0.05 to determine the statistical significance of findings from the study.

RESULTS

The age distribution and other sociodemographic characteristics show no significant difference between the two groups.

There was no statistically significant difference between the two groups with respect to booking status, parity and antenatal admission of the participants.

Table 1: Sociodemographic characteristics and anthropometric measurement of parturients who had early and delayed feeding in RSUTH, Port Harcourt.

Characteristics	Feeding time			Statistical test (P value)
	Total n=166 (%)	Early (2-hour) n=83 (%)	Delayed (24-hour) n=83 (%)	
Age group (years)				
18-24	18 (10.8)	11 (13.3)	7 (8.4)	3.29[a] (0.511)
25-29	29 (17.5)	13 (15.7)	16 (19.3)	
30-34	43 (25.9)	23 (27.7)	20 (24.1)	
35-39	47 (28.3)	25 (30.1)	22 (26.5)	
>40	29 (17.5)	11 (13.3)	18 (21.7)	
Age in years – Mean ± SD	33.3 ± 6.5	32.7 ± 6.4	33.8 ± 6.7	1.08[b] (0.281)
Marital status				
Single	7 (4.2)	5 (6.0)	2 (2.4)	1.34[c] (0.247)
Married	159 (95.8)	78 (94.0)	81 (97.6)	
Religion				
Christian	158 (95.2)	78 (94.0)	80 (96.4)	0.53[c] (0.469)
Islam	8 (4.8)	5 (6.0)	3 (3.6)	
Tribe				
Igbo	70 (42.2)	34 (41.0)	36 (43.4)	6.73[c] (0.242)
Ikwerre/Ogoni	40 (24.1)	22 (26.5)	18 (21.7)	
Ijaw	27 (16.3)	12 (14.5)	15 (18.1)	
Yoruba	12 (7.2)	3 (3.6)	9 (10.8)	
Hausa	6 (3.6)	4 (4.8)	2 (2.4)	
Others	11 (6.6)	8 (9.6)	3 (3.6)	
Educational level				
Primary	6 (3.6)	4 (4.8)	2 (2.4)	0.71[c] (0.849)

Continued.

Characteristics	Feeding time			Statistical test (P value)
	Total n=166 (%)	Early (2-hour) n=83 (%)	Delayed (24-hour) n=83 (%)	
Secondary	81 (48.8)	40 (48.2)	41 (49.4)	
Tertiary	79 (47.6)	39 (47.0)	40 (48.2)	
Occupation				
Employed	122 (73.5)	63 (75.9)	59 (71.1)	0.50[a] (0.482)
Unemployed	44 (26.5)	20 (24.1)	24 (28.9)	
Height in metres – Mean ± SD	1.58±0.06	1.57±0.06	1.58±0.06	0.32[b] (0.753)
Weight in Kg – Mean ± SD	94.8±10.0	94.3±10.1	95.3±9.9	0.68[b] (0.499)
Body mass index in kg/m^2 – Mean ± SD	38.3±4.8	38.2±5.0	38.5±4.8	0.33[b] (0.742)

[a]Chi-square test; [b]Student's t-test; [c]Fisher's exact test; SD – Standard deviation; Kg – Kilogram

Table 2: Obstetric features among parturients who had early and delayed feeding in RSUTH, Port Harcourt.

Characteristics	Feeding time			Statistical test (P value)
	Total n=166 (%)	2-hour n=83 (%)	24-hour n=83 (%)	
Booking status				
Booked	161 (97.0)	80 (96.4)	81 (97.6)	0.20[a] (0.652)
Unbooked	5 (3.0)	3 (3.6)	2 (2.4)	
Parity				
Nulliparous	46 (27.7)	27 (32.5)	19 (22.9)	6.93[a] (0.074)
Primiparous	26 (15.7)	15 (18.1)	11 (13.3)	
Multiparous	86 (51.8)	40 (48.2)	46 (55.4)	
Grand multiparous	8 (4.8)	1 (1.2)	7 (8.4)	
Parity – Median (Range)	2 (0 – 6)	1 (0 – 6)	2 (0 – 6)	2877.0[b] (0.096)
Antenatal admission				
Yes	11 (6.6)	5 (6.0)	6 (7.2)	0.10[c] (0.755)
No	155 (93.4)	78 (94.0)	77 (92.8)	
Antenatal complication				
Yes	9 (5.4)	3 (3.6)	6 (7.2)	1.06[a] (0.304)
No	157 (94.6)	80 (96.4)	77 (92.8)	
GA at antenatal complication in weeks – Mean ± SD	30.9±8.3	32.0±8.0	30.0±9.3	0.34[d] (0.743)

[a]Fisher's exact; [b]Mann-Whitney-U test; [c]Chi-square test; [d]Student's t-test; GA – gestational age

Table 3: Features of caesarean section among parturients who had early and delayed feeding in RSUTH, Port Harcourt.

Characteristics	Feeding time			Statistical test (P value)
	Total n=166 (%)	2-hour n=83 (%)	24-hour n=83 (%)	
Type of caesarean section (CS)				
First elective CS	88 (53.0)	45 (54.2)	43 (51.8)	0.10[a] (0.756)
Repeat elective CS	78 (47.0)	38 (45.8)	40 (48.2)	
EGA at delivery	37.9±0.8	38.0±0.9	37.8±0.8	1.05[b] (0.295)
Additional surgery (BTL)				
Yes	18 (10.8)	6 (7.2)	12 (14.5)	2.24[a] (0.134)
No	148 (89.2)	77 (92.8)	71 (85.5)	
Pre-operative PCV	33.8±2.1	33.9±2.2	33.7±2.0	0.47[b] (0.636)
Duration of surgery minutes	54.8±11.1	53.9±11.0	55.7±11.1	1.05[b] (0.295)
Blood loss in ml	456.6±109.0	458.6±105.1	454.7±113.4	0.23[b] (0.821)
Post-operative PCV	30.6±2.0	30.8±2.2	30.5±2.0	1.04[b] (0.299)

EGA – Estimated gestational age; BTL – Bilateral tubal ligation; PCV – Packed cell volume; [a]Chi-square test; [b]Student's t-test

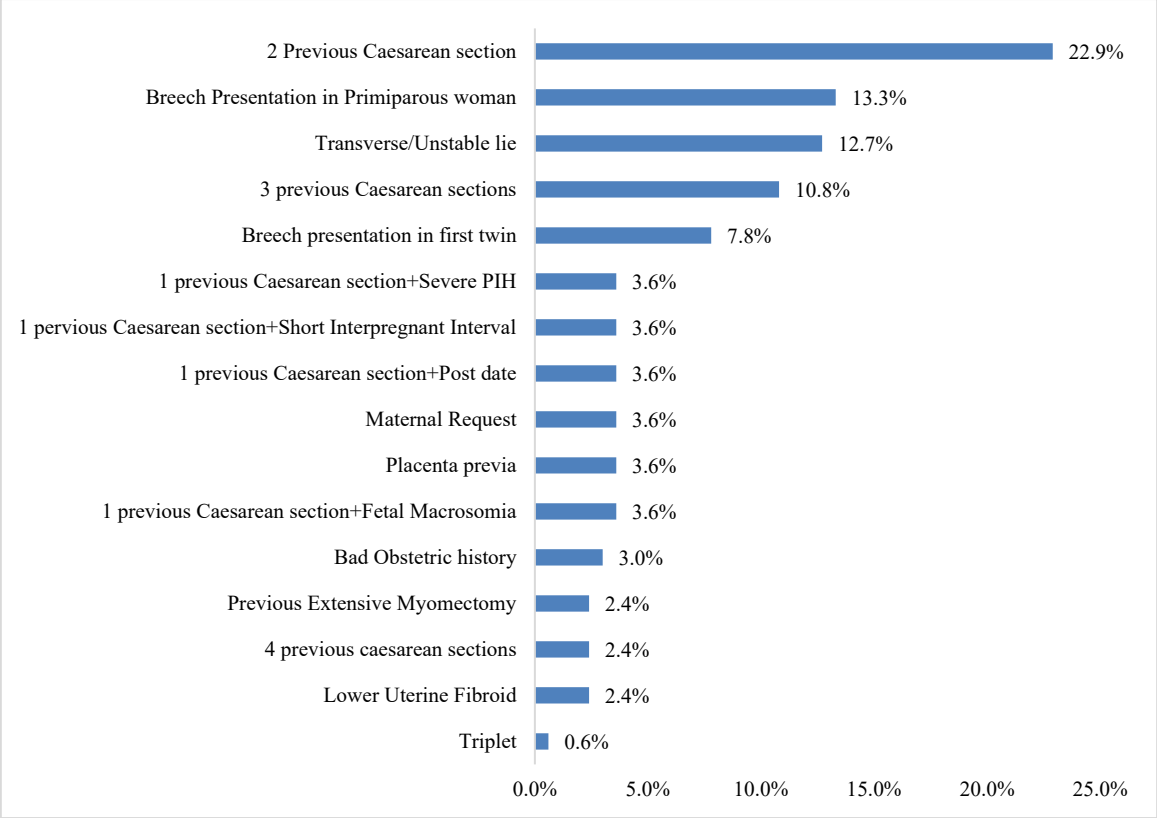

Figure 1: Indications for caesarean section among parturients who had early and delayed feeding in RSUTH, Port Harcourt n=166.

Table 4: Symptoms of paralytic ileus following caesarean section among parturients who had early and delayed feeding in RSUTH, Port Harcourt.

Characteristics	Feeding Time			Fisher's exact (P value)
	Total n=166 (%)	2-hour n=83 (%)	24-hour n=83 (%)	
Presence of paralytic ileus symptoms				
Yes	8 (4.8)	5 (6.0)	3 (3.6)	0.52 (0.473)
No	158 (95.2)	78 (94.0)	80 (96.4)	
Number of paralytic ileus symptoms				
No symptoms of paralytic ileus	158 (95.2)	78 (94.0)	80 (96.4)	0.69 (0.708)
One symptom of paralytic ileus	6 (3.6)	4 (4.8)	2 (2.4)	
Two symptoms of paralytic ileus	2 (1.2)	1 (1.2)	1 (1.2)	
Vomiting				
Yes	3 (1.8)	2 (2.4)	1 (1.2)	0.33 (0.568)
No	163 (98.2)	81 (97.6)	82 (98.8)	
Nausea				
Yes	7 (4.2)	4 (4.8)	3 (3.6)	0.15 (0.700)
No	159 (95.8)	79 (95.2)	80 (96.4)	

Among the indications for elective CS, two previous CS accounted for the highest while Triplet gestation the lowest.

There was no statistical difference in the type of CS done in the early and the delayed groups. Among the parturients in the both groups that had Bilateral Tubal Ligation there were no significant difference statistically. The mean pre-operative packed cell volume (PCV) and post-operative PCV were similar between the two group.

There was no case of abdominal distention or constipation in both groups.

With respect to number of symptoms of paralytic ileus, there was no significant difference between the 2 groups. The distribution of symptoms of paralytic ileus which include nausea and vomiting were not significantly different between women in the early and delayed groups.

Table 5: Return of bowel function following caesarean section among parturients who had early and delayed feeding in RSUTH, Port Harcourt.

Variables	Mean ± SD	Mean difference (95% CI)	t-test (P value)
Time interval for the return of bowel sound in hours			
Total sample	8.7±5.4		
2-hour feeding	3.7±0.7	9.9 (9.3-10.6)	31.89 (0.001*)
24-hour feeding	13.6±2.7		
Time interval for the passage of flatus in hours			
Total sample	13.2±7.7		
2-hour feeding	6.1±1.3	14.2 (13.4-15.1)	32.11 (0.001*)
24-hour feeding	20.4±3.8		
Time interval for bowel movement in hours			
Total sample	48.8±21.8		
2-hour feeding	32.9±15.1	31.8 (27.2-36.4)	13.80 (0.001*)
24-hour feeding	64.7±14.6		

*Statistically significant

The indicators of return of bowel functions (return of bowel sound, passage of flatus and bowel movement) were significantly (p–0.001) longer in the 24-hour feeding group than the 2-hour feeding group.

DISCUSSION

Delayed maternal oral feeding up to twenty-four hours after uncomplicated caesarean section is currently being practice in Rivers State University Teaching Hospital (RSUTH) where this study was carried out. This is because of the assumption that early commencement of oral feeding increases the risk of post-operative paralytic ileus especially when bowel sounds had not returned.[5-8] The findings of this study negate this assumption as few participants that had mild gastrointestinal complications in the early oral feeding group (6.0%) were not significantly different from the delayed oral feeding group (3.6%). This is similar to findings from previous studies where safety of early initiation of oral feeding after uncomplicated caesarean section has been documented.[5-8,13-19] This finding is also supported with high level of evidence by the enhance recovery after surgery (ERAS) society recommendations (part 3).[11,20] Mba et al, in south east Nigeria reported no significant difference in the incidence of paralytic ileus symptoms between the early and delayed feeding groups.[8] Similarly, Adelekan et al, in southwest Nigeria reported no significant difference between the two groups.[17] Also, Guo et al reported no significant difference in the symptoms of paralytic ileus between both groups.[18] Furthermore, Saxena et al, reported no significant difference in incidence of paralytic ileus between early and delayed oral feeding.[19] In addition, both meta-analyses conducted by Huaping et al and Kim et al concluded that early commencement of oral feeding did not increase symptoms of paralytic ileus.[21,22] However, Hassan et al (<5 hours vs. 8 hours) reported that the incidence of paralytic ileus symptoms were significantly lesser in the early group than the late group.[23] This study suggests that early commencement of maternal oral feeding after uncomplicated caesarean delivery stimulate bowel functions, hence the shorter mean difference in the return of bowel sounds (8.7±5.4 hours), passage of flatus (13.2±7.7 hours) and bowel movement (48.8±21.8 hours). This finding agrees with several related studies.[5,6,8,13,14,17-19,22,24,25] Mba et al (8 hours vs. 48 hour oral feeding) reported that early initiation of oral intake hastened the return of bowel functions as bowel sounds were heard 17 hours earlier.[8] Adelekan et al (6 hours vs. 24 hours oral feeding) reported that bowel sounds return faster (12 hours earlier) in the early feeding group.[17] Jalilian et al (2 hours vs. 8 hours oral feeding) reported that early oral feeding was significantly associated with shorter time to return of bowel motility compared with delayed oral feeding as bowel sounds returned 4 hours earlier.[22] Similar study done in India by Sukesh also noted that, compared with delayed oral feeding, early oral feeding promoted a quicker return of bowel sounds (10 hours) and flatus (14 hours).[26] The variations in the figures reported could be due to the interval between the early and the delayed group, the geographical difference in the nature of diet and how soon after surgery oral feeding was initiated.

The findings from this study showed that there was no statistically significant difference in the incidence of paralytic ileus between early and delayed feeding groups following elective caesarean section. Therefore, it can be concluded that the incidence of paralytic ileus was not

affected by commencement of feeding 2 hours after elective caesarean section. However, the time interval for the return of bowel function was significantly longer in the delayed (24 hours) feeding group than in the early feeding group. Thus, it can be concluded that early (2-hour) feeding reduces the time interval for the return of bowel function in women undergoing elective caesarean section in RSUTH, Port Harcourt, Rivers State.

Clinically, this study did not suggest any association between the timing of commencement of oral feeding after elective caesarean section and prolonged post operative ileus because none of the participants in both study groups had symptoms suggestive of prolonged post operative ileus. This finding suggests that there is no need delaying oral feeds because of the fear of post operative ileus. More so, return of bowel functions suggest that early oral feeding may be associated with faster recovery.

Limitations of the study

There was no blinding of any form due to its peculiarity as an open-label study, since the participants and the researcher were aware of the type of intervention. Also, some study outcome variables like time of passage of flatus and bowel movements were depended on participants record, hence minimal errors could not be eliminated. In addition, minimal error in the actual time of onset of bowel sounds could also be possible because participants monitoring was done 2 hourly, hence exact time of onset of bowel sound might have been earlier. This could have overestimated the outcome measure per group but not the group comparison.

CONCLUSION

Findings from this study suggest that early initiation of oral feeding after uncomplicated elective caesarean delivery done under spinal anaesthesia is safe and well tolerated as the symptoms of paralytic ileus were not significantly increased. It was rather associated with early return of bowel functions. Thus, there were no obvious advantages in withholding fluid and food after uncomplicated elective caesarean sections.

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