EDITORIAL

Gastrointestinal fistulae

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Gastrointestinal fistulae most frequently develop after surgical interventions but they can also evolve spontaneously (for example in patients with inflammatory bowel disease) or following irradiation. Their impact on morbidity and mortality of patients as well as on health care costs for diagnosis and treatment is tremendous. Morbidity from gastrointestinal fistulae includes pain, wound problems, nutritional deficiencies, and recurrent septic states, as well as psychological consequences for the patient. These conditions cause a complex reduction in quality of life, generally lasting for several months. Because most gastrointestinal fistulae are the result of treatment (that is, a complication of surgical or medical interventions), this subject is in some ways hidden in the medical literature and in the past has not been studied adequately, failing to explore the huge clinical relevance of this problem. It is not surprising therefore that evidence based data on the management of gastrointestinal fistulae are scarce.

It is my particular pleasure to edit a series of four review articles that in a very comprehensive way concentrate on all aspects of gastrointestinal fistulae management, including diagnosis, prevention, and general treatment aspects, as well as pharmacological therapy using somatostatin and its analogues.

The authors of these articles are among the few experts in the field who in the past have conducted clinical trials in patients with gastrointestinal fistulae. These articles represent in depth reviews of the literature. The initiative to review the whole subject was taken up by UCB SA Pharma Sector Belgium who also sponsored four meetings (1998–2000) in Brussels and Verona to discuss the evidence in a stepwise manner. The expert group extracted the real evidence and thereby provided balanced data on the role of somatostatin and its analogues in the prevention and treatment of gastrointestinal fistulae: in summary, somatostatin and its analogues reduce fistula output (volume), particularly in high output fistulae, and thereby reduce fistula closing time. In contrast, overall fistula closing rate was not influenced and the cost effectiveness of somatostatin treatment in established gastrointestinal fistulae has not been proved to date. Contrary to established fistula management, evidence based positive results on the effect of

somatostatin and especially its analogue octreotide have been demonstrated in the prevention of pancreatic fistulae and reduction of the overall complication rate after elective pancreatic surgery. There are now eight randomised controlled trials available^{1–8} on prevention of postoperative complications using somatostatin or octreotide, with six demonstrating a reduction. In addition, there is a pharmacoeconomic and meta-analytic study⁹ available for this indication and some European arguments on why the two American trials were negative.¹⁰

I would like to thank the authors, sponsors, and the *Gut* editorial team for their excellent work in producing this supplement. Clearly, in the future we need many more qualified trials on the management of gastrointestinal fistulae but this issue of *Gut* may serve as a basic information resource to plan such studies.

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