**Name of Journal: *World Journal of Gastrointestinal Surgery***

**ESPS Manuscript NO: 22749**

**Manuscript Type: Review**

**Implications of preoperative hypoalbuminemia in colorectal surgery**

Truong A *et al.* Preoperativehypoalbuminemia in colorectal surgery

**Adam Truong, Mark H Hanna, Zhobin Moghadamyeghaneh, Michael J Stamos**

**Adam Truong, Mark H Hanna, Zhobin Moghadamyeghaneh, Michael J Stamos**, Division of Colon and Rectal Surgery, Department of Surgery, University of California, Irvine Medical Center, Orange, CA 92868, United States

**Author contributions:** All authors equally contributed to this paper with conception and design of the study, literature review and analysis, drafting and critical revision and editing, and final approval of the final version.

**Conflict-of-interest statement**: No potential conflicts of interest.

**Open-Access:** This article is an open-access article which was selected by an in-house editor and fully peer-reviewed by external reviewers. It is distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited and the use is non-commercial. See: <http://creativecommons.org/licenses/by-nc/4.0/>

**Correspondence to: Michael J Stamos, MD**, Division of Colon and Rectal Surgery, Department of Surgery, University of California, Irvine Medical Center, 33 City Blvd. West Suite 1600, Orange, CA 92868, United States. [mstamos@uci.edu](mailto:mstamos@uci.edu)

**Telephone:** +1**-**714-4566262

**Received:** October 19, 2015

**Peer-review started:** October 21, 2015

**First decision:** December 28, 2015

**Revised:** January 7, 2016

**Accepted:** March 7, 2016

**Article in press:**

**Published online:**

**Abstract**

Serum albumin has traditionally been used as a quantitative measure of a patient’s nutritional status because of its availability and low cost. While malnutrition has a clear definition within both the American and European Societies for Parenteral and Enteral Nutrition (ASPEN/ESPEN) clinical guidelines, individual surgeons often determine nutritional status anecdotally. Preoperative albumin level has been shown to be the best predictor of mortality after colorectal cancer surgery. Specifically in colorectal surgical patients, hypoalbuminemia significantly increases the length of hospital stay, rates of surgical site infections, enterocutaneous fistula risk, and deep vein thrombosis formation. The delay of surgical procedures to allow for preoperative correction of albumin levels in hypoalbuminemic patients has been shown to improve the morbidity and mortality in patients with severe nutritional risk. The importance of preoperative albumin levels and the patient’s chronic inflammatory state on the postoperative morbidity and mortality has led to the development of a variety of surgical scoring systems to predict outcomes efficiently. This review attempts to provide a systematic overview of albumin and its role and implications in colorectal surgery.

**Key words:** Colorectal Surgery; Malnutrition; Nutrition; Albumin; Serum albumin; Hypoalbuminemia; Prealbumin

**© The Author(s) 2016.** Published by Baishideng Publishing Group Inc. All rights reserved.

**Core tip:** Although albumin remains a flawed marker of nutrition, it offers clear prognostic value in predicting patient outcomes after colorectal surgery. Hypoalbuminemia significantly influences the length of hospital stay, rates of surgical site infections, enterocutaneous fistula risk, and deep vein thrombosis formation. Despite the fact that hypoalbuminemia is classically defined < 3.0 g/dL, clinical judgment must account for albumin levels ≤ 3.4 g/dL as even modest hypoalbuminemia can affect outcomes. The subjective global assessmen, modified Glasgow Prognostic Score, and Colorectal preoperative Surgical Score scoring systems provide convenient and valuable prognostic information that may help in the counseling and risk adjustment of patients undergoing colorectal surgery.

Truong A, Hanna MH, Moghadamyeghaneh Z, Stamos MJ. Implications of preoperative hypoalbuminemia in colorectal surgery. *World J Gastrointest Surg* 2016; In press

**INTRODUCTION**

Albumin is a single polypeptide responsible for five main functions (1) maintenance of colloid osmotic pressure; (2) binding and transport of solutes; (3) free radical scavenging; (4) platelet function inhibition and antithrombotic effect; and (5) beneficial effects on vascular permeability in the setting of shock and sepsis[1]. Albumin is a major source of sulfhydryl groups, which sequester both leukotoxin and nitric oxide, limiting vascular permeability and dilation respectively. Serum albumin has traditionally been used as a quantitative measure of a patient’s nutritional status because of its ready availability and low cost. The reliability of albumin as an assessment of malnutrition is controversial because hypoalbuminemia is an acute phase reactant and is affected by systemic inflammation[2]. The increased demand for specific amino acids for acute phase protein synthesis degrades available body protein, including albumin[3-5]. Therefore, nutritional status is often determined anecdotally by individual care providers based on their own clinical experience and judgment in clinical practice. In this review, we cover in-depth the clinical indications and implications of serum albumin levels in the setting of colorectal surgery. We investigate the correlation between albumin and postoperative complications, inflammatory bowel disease (IBD) treatment, nutritional response, and new prognostic models.

**LITERATURE RESEARCH**

We performed a systematic literature review through an electronic search of MEDLINE from PubMed and the Cochrane Library until May 2015. We used the following search terms and associations: albumin, hypoalbuminemia, serum protein, nutrition, malnutrition, colorectal surgery, GI surgery, complications, and mortality. Articles were assessed in a tiered fashion. We first screened the titles, assessed abstracts for relevance, then analyzed the entire text of the papers. Only papers in the English language were included. After removing duplicates, 379 total records were found, 339 of which were in English. 35 articles remained after screening and their full texts were analyzed. We completed our search by visiting the bibliographies of relevant articles.

**HYPOALBUMINEMIA IN SURGICAL PATIENTS**

In the early 1950’s, hypoalbuminemia was noted to negatively influence postoperative recovery[6,7]. This finding was followed by work from Harvey who reported that a low serum albumin was the best indicator of concurrent sepsis[8]. A high incidence of malnutrition in the hospital setting was only first described in 1974 by Butterworth[9,10]. Contemporary data currently shows that malnutrition has a prevalence of 30% to 50% in hospitalized patients, and is one of the most important patient outcome determinants, affecting length of hospitalization, cost, morbidity, and ultimately mortality[11,12]. Most notably, hypoalbuminemia is associated with poor tissue healing, decreased collagen synthesis, and granuloma formation in surgical wounds, ultimately delaying wound healing[13-17]. Serum albumin levels have traditionally been used as a biochemical marker of individual nutritional status prior to surgery. It is regarded as an accurate pre-operative prognostic indicator in a variety of surgical procedures including cardiac[18], trauma[19], and general surgery[6,20-22]. This was perhaps best illustrated in a large-scale non-randomized retrospective study using the National Veteran’s Affairs Surgical Database of 54215 patients from 44 tertiary care centers by Gibbs *et al*[23] on major non-cardiac surgeries. 30-d morbidity and mortality were measured by C-index (C) where a value of 0.0-0.5 indicates any association between variables are likely due to chance, and C of 0.5-1.0 indicates a strong predictive value or correlation[24]. Univariate analysis revealed that albumin < 3.5 g/dL was the strongest preoperative predictor of both 30-d morbidity (C = 0.68) and mortality (C = 0.78), just ahead of ASA (American Society of Anesthesiology) class. Furthermore, multivariate analysis showed that albumin levels were the strongest predictor of both morbidity [Odds ratio (OR) = 0.68; 95% confidence Interval (CI): 0.56–0.60] and mortality (OR = 0.44; 95%CI: 0.41-0.48). Albumin levels also independently predicted complication rates of systemic sepsis, acute renal failure, coma, failure to wean from ventilation, and bleeding/transfusions amongst 16 other complications (C = 0.78, 0.76, 0.76, 0.75, 0.72 respectively; all *P* < 0.001). Additionally, analysis of preoperative albumin and major post operative complications in 2003 by Kudsk *et al*[25] identified clinical hypoalbuminemia as an independent determinant of hospital stay, serious postoperative complications (albumin < 4.25 g/dL), and mortality (albumin < 3.25 g/dL).

On the other hand, an ongoing debate continues to exist regarding the value of albumin as a clinical marker of malnutrition. There is no clear consensus amongst healthcare professionals about the definition of malnutrition. Suggested markers include albumin and prealbumin, which are widely used today, and transferrin and retinol binding protein, which are newer evolving nutritional markers[9]. Recent studies have attempted to dispel several myths regarding malnutrition. Albumin and prealbumin have historically been touted as indicators of nutritional risk in the hospital setting, however early literature was based off subjective data and the underlying assumption that albumin and prealbumin accurately reflected nutritional status[26-28]. Golden previously showed that kwashiorkor was caused by lack of antioxidants, not dietary proteins[29] and in a small study by Carlson *et al*[30] of 10 military burn patients, no correlation was found between nitrogen balance and albumin level, further dispelling serum protein beliefs. A retrospective study of all nutrition consults within 2 years totaling 528 patients suggested that patients’ underlying acute or chronic conditions, not nourishment, was responsible for the changes in perioperative albumin[8]. Despite this mounting evidence, consensus exists that although albumin may be a poor marker of nutrition, hypoalbuminemia offers clear prognostic value in predicting surgical outcomes[26,31].

**HYPOALBUMINEMIA AND COLORECTAL SURGERY**

Despite the growing fund of research surrounding albumin status in general surgery patients, colorectal surgery maintains a unique relationship with nutritional status and albumin level. Colorectal surgery patients are often malnourished due to advanced malignancy or inflammatory bowel disease that results in poor oral intake, intestinal blockages, intestinal fistulas, poor absorptive capacity, and large volume losses from the gastrointestinal (GI) tract[32]. Kudsk *et al*[25] emphasized the potential for bias if the surgical site is not considered. Malnutrition is observed in up to 80% of patients with advanced colorectal cancer putting them at increased risk for postoperative complications[33-35]. Burden *et al*[36] showed that 1 in 5 pre-operative colorectal cancer patients undergoing surgery were malnourished when measuring body weight (weight loss > 10%) and had a significantly lower handgrip strength (*P* = 0.013), a measure of nutritional status[37]. Hypoalbuminemia has also been associated with delayed recovery of postoperative bowel function, further worsening postoperative nutritional recovery[38]. Preoperative albumin levels have been shown to be the best predictor of mortality after colorectal cancer surgery[12,39]. It is important to concede that the current research surrounding albumin levels is limited and heterogeneous; each study uses different qualifications and methods. Below is a review of the current literature surrounding hypoalbuminemia and its relationship to colorectal surgery.

**COMPLICATIONS**

Although the classic definition for hypoalbuminemia is < 3.0 g/dL, studies’ definitions vary widely from < 2.7 in some studies to < 3.5 g/dL in others[12,40,41]. Using the American College of Surgeons National Quality Improvement Program (ACS NSQIP) database to measure 30-d postoperative surgical outcomes, Moghadamyeghaneh *et al*[12] emphasized the effect of modest hypoalbuminemia as defined by serum albumin levels between 3.0 and 3.4 g/dL. The mortality rate in patients with modest hypoalbuminemia and without hypoalbuminemia was 6% and 1.7% respectively, and the morbidity risk was greater as well [adjusted odds ratio (AOR) = 1.876; 95%CI = 1.51-2.05; *P* < 0.01]. Not surprisingly, the highest morbidity (60.4%) and mortality (26.2%) rates occurred at serum albumin levels lower than 2 g/dL. Additionally, this study showed a linear correlation between albumin level and postoperative mortality, meaning any decrease in serum albumin level from the normal value (> 4 g/dl) had serious effects on the outcomes following colorectal resections. The rate of increase in mortality and morbidity was estimated to be approximately 49% and 24% respectively for each 1 g/dL decrease in albumin level (*P* < 0.05). Colon cancer patients had a higher rate of modest hypoalbuminemia compared to rectal cancer patients (AOR = 1.55; *P* < 0.01).

**HOSPITAL STAY**

Two studies published in 2010 evaluated the association between albumin level and length of hospital stay. Using a cohort of 95 patients admitted for either upper GI surgery or colorectal surgery over a 19-month period in Australia, Garth *et al*[11] showed that preoperative albumin level was linear and inversely related to the length of hospital stay (R = -0.325; *P* < 0.01). Interestingly, grouped analysis revealed upper GI patients presented with significantly lower albumin than colorectal patients. 31% of the upper GI group had albumin levels < 3.5 g/dL *vs* 14% of the colorectal group (*P* < 0.05). Hennessey *et al*[16] showed that an albumin level < 3.0 g/dL was associated with prolonged inpatient stay with a negative linear relationship (19.5 d *vs* 12 d; *P* < 0.001; R2 = -0.319; *P* < 0.001). Additionally, in 2014 a compilation of 108,898 patients, the largest sample to date of hypoalbuminemic colorectal surgery patients by Moghadamyeghaneh *et al*[12] showed that the median length of stay after surgery was an average of 2 d longer in patients with even modest hypoalbuminemia (albumin 3.0–3.4 g/dL) compared to patients with serum albumin > 3.4 g/dL (95%CI = 1.83-2.34; *P* < 0.01). A study from Thailand showed that an albumin level <3.5 g/dL increased the length of hospital stay from 6.8 +/- 2.6 d to 9.6 +/- 4.7 d (*P* = 0.001)[38].

**ILEUS**

Postoperative bowel function is a major determinant of the length of hospital stay and nutritional recovery of a patient. A key retrospective study of 80 patients undergoing right hemicolectomy by Lohsiriwat *et al*[38] showed that an albumin level < 3.5 g/dL compared to an albumin > 3.5 g/dL was associated with increased postoperative complications (0 and 14 respectively; *P* < 0.001), time to first bowel movement (55.3 h and 69.5 h respectively; *P* = 0.018), and time to resume a normal diet (4.0 d to 4.9 d respectively; *P* < 0.001). In multivariate analysis, only delayed time to first bowel movement was associated with preoperative hypoalbuminemia. Similarly, Millan *et al*[42] showed that albumin levels < 35 mg/dL were significantly associated with postoperative ileus (*P* = 0.042) in a retrospective study of 773 patients. Kronberg *et al*[43] also showed in a study of 413 patients that preoperative serum albumin concentration was lower in patients who developed postoperative ileus (3.83 *vs* 4.09 mg/dL; *P* = 0.039; OR 0.90). Prolonged postoperative ileus symptoms include nausea and vomiting, inability to tolerate an oral diet, abdominal distention, and delayed passage of flatus and stool[44,45]. Decreasing preoperative albumin was a predictor for prolonged postoperative ileus (OR = 1.11 per g/L change; 95%CI = 1.02-1.22; *P* = 0.047)[46].

**SURGICAL SITE INFECTION**

A study of 524 patients undergoing GI surgery (of which 339 (64%) underwent colorectal surgery) in 4 institutions in Ireland showed that patients who developed a surgical site infection had a lower median preoperative serum albumin than those who did not develop an infection, 3.0 g/dL and 3.6 g/dL respectively (*P* < 0.001)[16]. 138 patients (26.3%) had a low pre-operative albumin level (< 3.0 g/dL) and were found to be at increased risk for severe surgical site infections. Of the patients developing a superficial wound infection, 46.4% had a low albumin level (*P* = 0.001). In those with deep wound infections, 80% had low albumin levels (*P* = 0.004), and in those with organ space infection, 83.3% had low albumin levels (*P* = 0.397).

**FISTULAS**

Enteric or enterocutaneous fistulas are abnormal communications between the gastrointestinal tract to another cavity or through the skin respectively. Although uncommon, they are a significant concern within colorectal surgery due to their relatively high incidence and considerable morbidity and mortality, first described in a classic case study of 157 patients in 1960[47-49]. An estimated 75%-85% of enterocutaneous fistulas are postoperative complications following bowel injury *via* inadvertent enterotomy and/or anastomotic leakage[50] and 30-80% eventually require surgical treatment despite advances in medical treatment[51-53].

Not surprisingly, serum albumin level has been shown to be a vital prognostic factor of healing enteric fistulas[49,54]. In a retrospective chart review of 53 GI cancer patients with postoperative enteric fistula complications, Lu *et al*[49] showed a significant correlation between enteric fistula healing/recovery and an increased serum albumin level (*P* = 0.29) and lower fistula drainage amount (< 500 mL/d) (*P* = 0.013) after multivariate analysis. Additionally, amongst patients with both increasing albumin levels and < 500 mL/d of fistula drainage, over 90% of fistulas fully resolved with conservative therapy after total parenteral nutrition (TPN)[49,55]. However, although TPN nutritional support has been shown to aid recovery, careful monitoring for underlying or uncontrolled sepsis is required as patients are prone to rapidly deteriorate[52].

Once it is obvious that operative repair is unavoidable, the decision between early surgical fistula treatment *vs* initial nutritional support with delayed surgery is a difficult one. In a report of 135 consecutive patients with enterocutaneous fistulas by Visschers *et al*[53,56] hypoalbuminemic patients failed to recover well after restorative surgery[53]. Patients with an albumin level below 2.5 g/dL continued to show signs of inflammation postoperatively despite being treated for infection, which lead to eventual deterioration and death in the majority (17/25; 68%) of patients while those who had albumin >2.5 g/dL had lower mortality (8/25; 32%). Operative fistula repair in hypoalbuminemic patients is therefore recommended only after a nutritive recovery period of at least 6 wk.

**DEEP VEIN THROMBOSIS/ PULMONARY EMBOLISM**

There is limited data regarding the predictive factors of postoperative venous thromboembolism in patients undergoing colorectal resection. Using data from the large national NSQIP database from 2005 to 2011, Moghadamyeghaneh *et al*[41] showed that a serum albumin < 3.5 mg/dL significantly increased the risk of developing a postoperative deep vein thrombosis (DVT) (AOR = 1.69; 95%CI = 1.49-1.93; *P* < 0.01). Additionally, hypoalbuminemia was also associated with an increased risk of pulmonary embolism (PE) (AOR = 1.21; 95%CI = 1.02-1.42; *P* < 0.02) although the strongest risk factor for PE was not surprisingly a DVT.

**INFLAMMATORY BOWEL DISEASE AND HYPOALBUMINEMIA**

Inflammatory bowel disease is broadly classified into two variants, ulcerative colitis (UC) and Crohn’s disease (CD). The mainstay of UC and CD therapy is medical management, however up to 1/3 of Crohn’s patients will undergo abdominal surgery within the first 5 years of diagnosis[57]. In Crohn’s disease, hypoalbuminemia has been shown to be a predictor of intraabdominal septic complications after intestinal anastomosis by Yamamoto *et al*[58] in a retrospective chart review of 343 patients undergoing 1008 intestinal anastomoses between 1980 and 1997. In this study, albumin levels < 3.0 g/dL were considered hypoalbuminemic and significantly affected the incidence of intra-abdominal sepsis in univariate and multivariate analysis with P values of 0.01 and 0.04 respectively. Intraabdominal sepsis occurred in 21% of patients with hypoalbuminemia in contrast to 12% in those without. If all significant risk factors in this study (hypoalbuminemia, steroid use at least one month immediately before surgery, and abscess or fistula at the time of laparotomy) were present, the incidence of sepsis reached 50%. Because reoperations for early postoperative complications were not included in this study, the impact of serious postoperative or refractory hypoalbuminemia could not be assessed.

Intraabdominal sepsis and delayed wound healing are significant consequences of hypoalbuminemia in IBD patients[59]. For these reasons, ileal pouch anal anastomosis (IPAA), the treatment of choice for UC, has traditionally been avoided due to the large number of suture or staple lines and wide pelvic dissection in malnourished patients[60,61]. An 8-year single-institution prospective study identifying 405 patients showed that an albumin level < 3.5 g/dL was significantly associated with IPAA pouch failure within 30 d to 10 years, development of anastomotic leak, postoperative transfusion, and prolonged inpatient stay using univariate analysis[62]. Multivariate analysis revealed preoperative hypoalbuminemia as a strong predictor for anastomotic leak and prolonged median length of stay after pouch surgery, which was 60% longer than in patients with normal albumin levels.

Because of the high complication rate of pouch creation in IBD patients, a staged operation is a favored treatment followed by IPAA as the second stage. Nisar *et al*[62] showed that hypoalbuminemic patients with IBD who underwent a single-stage total proctocolectomy (TPC) with concurrent pouch creation had a significantly longer inpatient stay and increased postoperative transfusion requirement compared to two-stage subtotal colectomy (STC) with subsequent completion proctocolectomy and IPAA. A higher risk of anastomotic leak in hypoalbuminemic patients was found in single-stage TPC and IPAA (22%) compared to initial STC with follow-up completion proctectomy and IPAA (11%). However, the sample only comprised 24 TPC patients and 10 with STC. Interestingly, this study was one of very few which analyzed serum albumin levels as a continuous variable and thus found that the improvement in albumin between the time of STC and IPAA correlated significantly with the baseline albumin (R2 = 0.814) (*P* < 0.0001).

In a retrospective case series of 78 patients with Crohn’s disease but without hypoalbuminemia, Zerbib *et al*[63] showed that weaning steroids and applying enteral nutrition at > 30 kcal/kg ideal body weight/d in intestinal non-occluded patients or TPN in patients with intestinal occlusion together with abscess drainage and antibiotic therapy for 2-3 wk preoperatively minimized the usage of a temporary diverting stoma (7.7% (6/78) of patients) while achieving uneventful operative outcomes in 58% of the total patients. This rate of diverting stoma was significantly lower than a previously reported series for penetrating CD by Goyer *et al*[64] who reported a rate of 39%. This suggests a strong correlation between preoperative nutrition and Crohn’s disease surgical outcomes.

**PREOPERATIVE TREATMENT OF HYPOALBUMINEMIA**

While the deleterious effects of hypoalbuminemia on the rate of postoperative complications have been well established, pre-surgical correction of hypoalbuminemia remains a subject of debate.While some believe a low albumin level indicates malnutrition, others postulate that the hypoalbuminemia stems from the chronic disease state and resultant inflammation and is not due to malnutrition, thus hindering any beneficial effects of nutritional therapy[3]. Although enteral and parenteral nutrition have been shown to improve outcomes in malnourished patients undergoing major elective surgery[65], preoperative nutrition not been well studied in populations undergoing colorectal surgery. The consensus is to stabilize baseline nutritional status and to administer enteral or parenteral nutrition to severely hypoalbuminemic patients preoperatively, even if a delay in surgery is necessary.

In 1982, a study by Rombeau *et al*[66] of 33 consecutive IBD patients demonstrated that preoperative TPN given for at least 5 d resulted in significantly fewer postoperative complications (*P* < 0.05). All patients had an albumin < 3.5 g/dL or a transferrin level < 150 mg/dL. In a case series by Jacobson, 15 consecutive CD patients given preoperative TPN were compared to 105 control patients matched for known postoperative complication factors[67]. TPN was given between 18 and 90 (avg = 46) d preoperatively before undergoing intestinal resection with primary hand-sewn anastomoses. In this study the average albumin level was significantly increased from 3.4 to 3.9 g/dL (*P* < 0.01) through TPN. There was a significantly higher rate of complications in the non-TPN group (29/105) compared to the TPN group (0/15) (*P* < 0.05). Although the TPN group was without postoperative complications, the risk of preoperative complications should be recognized. In the TPN group, repeated central venous catheter thromboses requiring up to 5 replacements occurred in 4 patients and a pneumothorax which resolved after 5 d of evacuation occurred in one other patient.

Lashner *et al*[68] further quantified the significance of preoperative TPN. In a retrospective single- center/single-surgical team study of 103 CD patients, preoperative TPN was only beneficial to CD patients by reducing the length of bowel resection during small bowel resection by more than 20 cm (*P* < 0.04). There was no difference in complication rates. During ileocectomy, TPN patients had a shorter resection by ~ 11cm when compared to non-TPN patients (*P* < 0.02). However, it appears that the cost of shorter bowel resections in TPN patients was longer hospital stays (12 d; *P* < 0.001). Although this study included patients undergoing large bowel resection, none of them received preoperative TPN. In this study, TPN was given between 5-7 d and administration > 10 d was not recommended. In contrast, the European Society for Clinical Nutrition and Metabolism (ESPEN) guidelines state that if a severe nutritional risk is present, preoperative nutrition therapy, if possible, by enteral route for 10-14 d before surgery is recommended even if the surgery has to be delayed[69]. Additionally, Visschers *et al*[53] recommended delaying enterocutaneous fistula repair at least 6 wk to stabilize baseline nutritional status in severely malnourished patients.

**NEW COLORECTAL SURGERY SCORING SYSTEMS**

Broad efforts have been made to use albumin levels together with other clinical markers to create a scoring system predicting postoperative morbidity or mortality. The Subjective Global Assessment (SGA) scale combines both subjective aspects of the patient’s history such as gastrointestinal symptoms and dietary change and objective aspects such as ankle edema, albumin levels, and tumor grade[70]. The SGA stratifies patients into A, B and C categories yielding significant differences in median survival in their cohort of 235 patients (Log Rank 13.36; *P* = 0.0013). The SGA provides useful prognostic information in patients with advanced colorectal cancer and may identify malnourished patients quickly but suffers due to the inclusion of subjective measures exposing it to observer bias.

The modified Glasgow Prognostic Score (mGPS) ranges from 0-2 and is composed of C-reactive protein (CRP) and albumin levels. mGPS was shown by Park *et al*[71] in a retrospective single-center study to tightly correlate with overall survival (OS) in patients undergoing elective resection of colon cancer (*P* < 0.001). When mGPS and TNM staging were combined, they effectively stratified outcomes of patients undergoing potentially curative resection of colorectal cancer. A TNM stage I/mGPS = 0 yielded a 5-year cancer specific survival (CSS) and overall survival of 97% and 87% respectively; whereas a TNM stage III/mGPS =2 exhibited a 5-year CSS and OS of 32% and 26% respectively (*P* < 0.001). Additionally, the mGPS stratified the survival of patients who received adjuvant chemotherapy after resection of stage III colon cancer. Patients with mGPS = 0 had a 50% relative increase in survival at 5 years with adjuvant therapy, whereas those with mGPS = 1-2 received no benefit (*P* = 0.003). The mGPS provides important prognostic information in patients undergoing colorectal resections and can help guide adjuvant therapy, especially when combined together with TNM staging.

The Colorectal preoperative Surgical Score (CrOSS) was proposed by Kong *et al*[39] in 2015 as a response to other scoring systems, which require postoperative variables or may be too complex or difficult to assess at the patient’s bedside. Their multivariate logistic regression analysis of 46 variables yielded 4 independent predictors for mortality following colorectal surgery: age ≥ 70, urgent surgery, albumin level ≤ 3.0 g/dL, and CHF, together composing the CrOSS score. CrOSS accurately predicted mortality with a receiver operating characteristic (ROC) of 0.870 and calibration *P*-value of 0.937. The score was internally and externally validated to the Portsmouth and Colorectal Physiological and Operative Severity Score for enUmeration of Mortality and Morbidity (POSSUM) and the 2012 Barwon Health model (BH) (ROC = 0.788, *P* = 0.24). CrOSS offers a simple yet robust preoperative risk stratification model, specifically tested in colorectal surgery.

**NEW MARKERS FOR MALNUTRITION AND INFLAMMATION**

Although albumin remains the widest studied marker for malnutrition, several other markers have been proposed to aid perioperative assessment of a colorectal surgery patient. Prealbumin, transferrin and retinol binding protein (RBP) are considered traditional markers of nutrition; however, recent data demonstrates their poor relationship to nutrition status[9]. Because the markers for a patient’s nutrition status are often negative acute-phase reactants, efforts have been made to quantify a patient’s inflammatory status as an indirect measure of nutrition and postoperative morbidity and mortality.

In 2012, Oberhofer *et al*[72] showed an increase in CRP in the early postoperative period after colorectal surgery was correlated with a significant increase in complication rates (*P* < 0.001), which agreed with Welsch *et al*[73] who demonstrated that CRP values greater than 140 mg/L on postoperative day 3 or 4 predicted infectious complications and anastomotic leaks after colorectal surgery. Conversely, preoperative CRP levels were not correlated with postoperative complication incidence. Oberhofer *et al*[72] also concluded that postoperative procalcitonin increased significantly more in patients with postoperative complications than those patients without complications, with the highest predictive value on postoperative day 5 (*P* < 0.001). Procalcitonin is also a reliable laboratory marker for early diagnosis of surgical site infection and sepsis after colorectal cancer surgery (*P* < 0.001)[74,75].

Prealbumin (PAB), also known as transthyretin, is a visceral protein and a negative acute phase reactant similar to albumin. PAB’s advantage over albumin is its shorter half-life (2-3 d), thus it may be more useful for detecting acute changes in nutritional status. However, similar to albumin, PAB has been shown to be a poor marker of nutritional status as evidenced by studies of extreme cases of starvation, which fail to show consistent or reversible decreases in PAB levels[9,76,77]. In addition, PAB has been shown to be inferior to albumin as a predictor of colon cancer recurrence. A study of 158 patients with operable colorectal carcinoma in Japan, 56 patients (35.4%) with decreased preoperative PAB and 15 patients (9.5%) with decreased preoperative albumin levels, showed that both a low preoperative serum PAB and albumin were associated with early disease recurrence (*P* = 0.0005 and *P* = 0.0002 respectively)[78]. However, only albumin maintained its significance in multivariate analysis (*P* = 0.048) while PAB lost significance, indicating that only albumin is an independent predictor of early colorectal carcinoma recurrence.

Additionally, IL-6 has recently been shown to correlate with more advanced colorectal cancer[79] and was found to cause reactive thrombocytosis, upregulation of CRP, and downregulation of albumin production by the liver, all processes of acute inflammation[80]. Preoperative thrombocytosis with a platelet count greater than 300 x109/L was related to overall survival in multivariate analysis (*P* = 0.039; OR = 1.642; 95%CI = 1.025–2.629)[81].

Recent studies demonstrate positive survival outcomes after colorectal surgery by targeting the systemic inflammatory response with anti-inflammatory agents such as broad-spectrum NSAIDs or aspirin[82,83]. Adequate dietary habits are also associated with both decreased colorectal cancer risk and postoperative outcomes. Increased marine *n-3* polyunsaturated fatty acids (*n-3* PUFA) consumption was protective against postoperative complications after colorectal cancer surgery[84-86].

**CONCLUSION**

Although albumin remains a flawed marker of nutrition, it offers clear prognostic value in predicting patient outcomes after colorectal surgery. Hypoalbuminemia significantly influences the length of hospital stay and complication rates, specifically surgical site infection, enterocutaneous fistula, and DVT formation. However, these studies are mostly small-cohort non-randomized retrospective studies or large scale studies using national data bases and this topic would benefit from further study. Although clinical hypoalbuminemia is classically defined as serum concentrations < 3.0 g/dL, clinical judgment must account for albumin levels ≤ 3.4 g/dL as even modest hypoalbuminemia can affect outcomes. Surgical delay for preoperative nutrition has been shown to improve the morbidity and mortality in patients with severe nutritional risk. Hypoalbuminemic patients may benefit from a staged colorectal resection *vs* a single operation, especially in the setting of IBD. Efforts to quantify a patient’s nutritional status indirectly with inflammatory markers show promise, but the data is superficial and overall inferior to albumin. However, addressing systemic inflammation with anti-inflammatory agents has demonstrated positive survival outcomes in pilot studies. How these developing new markers will be used in combination with albumin is an interesting frontier, meanwhile the SGA, mGPS, and CrOSS scoring systems provide convenient and valuable prognostic information that may help in the counseling and risk adjustment of patients undergoing colorectal surgery.

**REFERENCES**

1 **Don BR**, Kaysen G. Serum albumin: relationship to inflammation and nutrition. *Semin Dial* 2004; **17**: 432-437 [PMID: 15660573 DOI: 10.1111/j.0894-0959.2004.17603.x]

2 **Gabay C**, Kushner I. Acute-phase proteins and other systemic responses to inflammation. *N Engl J Med* 1999; **340**: 448-454 [PMID: 9971870 DOI: 10.1056/NEJM199902113400607]

3 **Al-Shaiba R**, McMillan DC, Angerson WJ, Leen E, McArdle CS, Horgan P. The relationship between hypoalbuminaemia, tumour volume and the systemic inflammatory response in patients with colorectal liver metastases. *Br J Cancer* 2004; **91**: 205-207 [PMID: 15213726 DOI: 10.1038/sj.bjc.6601886]

4 **McMillan DC**, Watson WS, O'Gorman P, Preston T, Scott HR, McArdle CS. Albumin concentrations are primarily determined by the body cell mass and the systemic inflammatory response in cancer patients with weight loss. *Nutr Cancer* 2001; **39**: 210-213 [PMID: 11759282 DOI: 10.1207/S15327914nc392\_8]

5 **Preston T**, Slater C, McMillan DC, Falconer JS, Shenkin A, Fearon KC. Fibrinogen synthesis is elevated in fasting cancer patients with an acute phase response. *J Nutr* 1998; **128**: 1355-1360 [PMID: 9687556]

6 **Franch-Arcas G**. The meaning of hypoalbuminaemia in clinical practice. *Clin Nutr* 2001; **20**: 265-269 [PMID: 11407875 DOI: 10.1054/clnu.2001.0438]

7 **Rhoads JE**, Alexander CE. Nutritional problems of surgical patients. *Ann N Y Acad Sci* 1955; **63**: 268-275 [PMID: 13340629 DOI: 10.1111/j.1749-6632.1955.tb32095.x]

8 **Harvey KB**, Moldawer LL, Bistrian BR, Blackburn GL. Biological measures for the formulation of a hospital prognostic index. *Am J Clin Nutr* 1981; **34**: 2013-2022 [PMID: 7293933]

9 **Banh L**. Serum proteins as markers of nutrition: What are we treating? *Practice Gastroenterology* 2006; **30**: 46-64

10 **Butterworth CE**. [The skeleton in the hospital closet. 1974]. *Nutr Hosp* 2005; **20**: 302-307, 301; discussion 302-307 [PMID: 16045133]

11 **Garth AK**, Newsome CM, Simmance N, Crowe TC. Nutritional status, nutrition practices and post-operative complications in patients with gastrointestinal cancer. *J Hum Nutr Diet* 2010; **23**: 393-401 [PMID: 20337847 DOI: 10.1111/j.1365-277X.2010.01058.x]

12 **Moghadamyeghaneh Z**, Hwang G, Hanna MH, Phelan MJ, Carmichael JC, Mills SD, Pigazzi A, Dolich MO, Stamos MJ. Even modest hypoalbuminemia affects outcomes of colorectal surgery patients. *Am J Surg* 2015; **210**: 276-284 [PMID: 25892597 DOI: 10.1016/j.amjsurg.2014.12.038]

13 **Testini M**, Margari A, Amoruso M, Lissidini G, Bonomo GM. [The dehiscence of colorectal anastomoses: the risk factors]. *Ann Ital Chir* 2000; **71**: 433-440 [PMID: 11109667]

14 **Ward MW**, Danzi M, Lewin MR, Rennie MJ, Clark CG. The effects of subclinical malnutrition and refeeding on the healing of experimental colonic anastomoses. *Br J Surg* 1982; **69**: 308-310 [PMID: 6805546 DOI: 10.1002/bjs.1800690604]

15 **Reynolds JV**, Redmond HP, Ueno N, Steigman C, Ziegler MM, Daly JM, Johnston RB. Impairment of macrophage activation and granuloma formation by protein deprivation in mice. *Cell Immunol* 1992; **139**: 493-504 [PMID: 1310262 DOI: 10.1016/0008-8749(92)90088-7]

16 **Hennessey DB**, Burke JP, Ni-Dhonochu T, Shields C, Winter DC, Mealy K. Preoperative hypoalbuminemia is an independent risk factor for the development of surgical site infection following gastrointestinal surgery: a multi-institutional study. *Ann Surg* 2010; **252**: 325-329 [PMID: 20647925 DOI: 10.1097/SLA.0b013e3181e9819a]

17 **Blumetti J**, Luu M, Sarosi G, Hartless K, McFarlin J, Parker B, Dineen S, Huerta S, Asolati M, Varela E, Anthony T. Surgical site infections after colorectal surgery: do risk factors vary depending on the type of infection considered? *Surgery* 2007; **142**: 704-711 [PMID: 17981191 DOI: 10.1016/j.surg.2007.05.012]

18 **Rich MW**, Keller AJ, Schechtman KB, Marshall WG, Kouchoukos NT. Increased complications and prolonged hospital stay in elderly cardiac surgical patients with low serum albumin. *Am J Cardiol* 1989; **63**: 714-718 [PMID: 2923060 DOI: 10.1016/0002-9149(89)90257-9]

19 **Goiburu ME**, Goiburu MM, Bianco H, Díaz JR, Alderete F, Palacios MC, Cabral V, Escobar D, López R, Waitzberg DL. The impact of malnutrition on morbidity, mortality and length of hospital stay in trauma patients. *Nutr Hosp* 2006; **21**: 604-610 [PMID: 17044607]

20 **Buzby GP**, Mullen JL, Matthews DC, Hobbs CL, Rosato EF. Prognostic nutritional index in gastrointestinal surgery. *Am J Surg* 1980; **139**: 160-167 [PMID: 7350839 DOI: 10.1016/0002-9610(80)90246-9]

21 **Delgado-Rodríguez M**, Medina-Cuadros M, Gómez-Ortega A, Martínez-Gallego G, Mariscal-Ortiz M, Martinez-Gonzalez MA, Sillero-Arenas M. Cholesterol and serum albumin levels as predictors of cross infection, death, and length of hospital stay. *Arch Surg* 2002; **137**: 805-812 [PMID: 12093337 DOI: 10.1001/archsurg.137.7.805]

22 **Detsky AS**, Baker JP, O'Rourke K, Johnston N, Whitwell J, Mendelson RA, Jeejeebhoy KN. Predicting nutrition-associated complications for patients undergoing gastrointestinal surgery. *JPEN J Parenter Enteral Nutr* 1987; **11**: 440-446 [PMID: 3656631 DOI: 10.1177/0148607187011005440]

23 **Gibbs J**, Cull W, Henderson W, Daley J, Hur K, Khuri SF. Preoperative serum albumin level as a predictor of operative mortality and morbidity: results from the National VA Surgical Risk Study. *Arch Surg* 1999; **134**: 36-42 [PMID: 9927128 DOI: 10.1001/archsurg.134.1.36]

24 **Hanley JA**, McNeil BJ. The meaning and use of the area under a receiver operating characteristic (ROC) curve. *Radiology* 1982; **143**: 29-36 [PMID: 7063747 DOI: 10.1148/radiology.143.1.7063747]

25 **Kudsk KA**, Tolley EA, DeWitt RC, Janu PG, Blackwell AP, Yeary S, King BK. Preoperative albumin and surgical site identify surgical risk for major postoperative complications. *JPEN J Parenter Enteral Nutr* 2003; **27**: 1-9 [PMID: 12549591 DOI: 10.1177/014860710302700101]

26 **Fuhrman MP**, Charney P, Mueller CM. Hepatic proteins and nutrition assessment. *J Am Diet Assoc* 2004; **104**: 1258-1264 [PMID: 15281044 DOI: 10.1016/j.jada.2004.05.213]

27 **Mears E**. Outcomes of continuous process improvement of a nutritional care program incorporating serum prealbumin measurements. *Nutrition* 1996; **12**: 479-484 [PMID: 8878138 DOI: 10.1016/S0899-9007(96)91721-9]

28 **Sayarath VG**. Nutrition screening for malnutrition: potential economic impact at a community hospital. *J Am Diet Assoc* 1993; **93**: 1440-1442 [PMID: 8245380 DOI: 10.1016/0002-8223(93)92249-W]

29 **Golden MH**. Oedematous malnutrition. *Br Med Bull* 1998; **54**: 433-444 [PMID: 9830208 DOI: 10.1093/oxfordjournals.bmb.a011699]

30 **Carlson DE**, Cioffi WG, Mason AD, McManus WF, Pruitt BA. Evaluation of serum visceral protein levels as indicators of nitrogen balance in thermally injured patients. *JPEN J Parenter Enteral Nutr* 1991; **15**: 440-444 [PMID: 1895488 DOI: 10.1177/0148607191015004440]

31 **Seres DS**. Surrogate nutrition markers, malnutrition, and adequacy of nutrition support. *Nutr Clin Pract* 2005; **20**: 308-313 [PMID: 16207668 DOI: 10.1177/0115426505020003308]

32 **Maykel JA**. Perioperative nutrition support in colorectal surgery. In: Steele SR, Maykel JA, Champagne BJ, Orangio GR. Complexities in colorectal surgery: Decision-making and management. Springer Science and Business Media, 2014 [DOI: 10.1007/978-1-4614-9022-7\_3]

33 **Gupta D**, Lis CG, Granick J, Grutsch JF, Vashi PG, Lammersfeld CA. Malnutrition was associated with poor quality of life in colorectal cancer: a retrospective analysis. *J Clin Epidemiol* 2006; **59**: 704-709 [PMID: 16765273 DOI: 10.1016/j.jclinepi.2005.08.020]

34 **Karthaus M**, Frieler F. [Eating and drinking at the end of life. Nutritional support for cancer patients in palliative care]. *Wien Med Wochenschr* 2004; **154**: 192-198 [PMID: 15244044 DOI: 10.1007/s10354-004-0065-0]

35 **Schwegler I**, von Holzen A, Gutzwiller JP, Schlumpf R, Mühlebach S, Stanga Z. Nutritional risk is a clinical predictor of postoperative mortality and morbidity in surgery for colorectal cancer. *Br J Surg* 2010; **97**: 92-97 [PMID: 20013933 DOI: 10.1002/bjs.6805]

36 **Burden ST**, Hill J, Shaffer JL, Todd C. Nutritional status of preoperative colorectal cancer patients. *J Hum Nutr Diet* 2010; **23**: 402-407 [PMID: 20487172 DOI:]

37 **Cederholm T**, Jägrén C, Hellström K. Nutritional status and performance capacity in internal medical patients. *Clin Nutr* 1993; **12**: 8-14 [PMID: 16843269 DOI:]

38 **Lohsiriwat V**, Chinswangwatanakul V, Lohsiriwat S, Akaraviputh T, Boonnuch W, Methasade A, Lohsiriwat D. Hypoalbuminemia is a predictor of delayed postoperative bowel function and poor surgical outcomes in right-sided colon cancer patients. *Asia Pac J Clin Nutr* 2007; **16**: 213-217 [PMID: 17468075]

39 **Kong CH**, Guest GD, Stupart DA, Faragher IG, Chan ST, Watters DA. Colorectal preOperative Surgical Score (CrOSS) for mortality in major colorectal surgery. *ANZ J Surg* 2015; **85**: 403-407 [PMID: 25823601 DOI: 10.1111/ans.13066]

40 **Ondrula DP**, Nelson RL, Prasad ML, Coyle BW, Abcarian H. Multifactorial index of preoperative risk factors in colon resections. *Dis Colon Rectum* 1992; **35**: 117-122 [PMID: 1735312 DOI: 10.1007/BF02050665]

41 **Moghadamyeghaneh Z**, Hanna MH, Carmichael JC, Nguyen NT, Stamos MJ. A nationwide analysis of postoperative deep vein thrombosis and pulmonary embolism in colon and rectal surgery. *J Gastrointest Surg* 2014; **18**: 2169-2177 [PMID: 25213583 DOI: 10.1007/s11605-014-2647-5]

42 **Millan M**, Biondo S, Fraccalvieri D, Frago R, Golda T, Kreisler E. Risk factors for prolonged postoperative ileus after colorectal cancer surgery. *World J Surg* 2012; **36**: 179-185 [PMID: 22083434 DOI: 10.1007/s00268-011-1339-5]

43 **Kronberg U**, Kiran RP, Soliman MS, Hammel JP, Galway U, Coffey JC, Fazio VW. A characterization of factors determining postoperative ileus after laparoscopic colectomy enables the generation of a novel predictive score. *Ann Surg* 2011; **253**: 78-81 [PMID: 21233608 DOI: 10.1097/SLA.0b013e3181fcb83e]

44 **Holte K**, Kehlet H. Postoperative ileus: a preventable event. *Br J Surg* 2000; **87**: 1480-1493 [PMID: 11091234 DOI: 10.1046/j.1365-2168.2000.01595.x]

45 **Artinyan A**, Nunoo-Mensah JW, Balasubramaniam S, Gauderman J, Essani R, Gonzalez-Ruiz C, Kaiser AM, Beart RW. Prolonged postoperative ileus-definition, risk factors, and predictors after surgery. *World J Surg* 2008; **32**: 1495-1500 [PMID: 18305994 DOI: 10.1007/s00268-008-9491-2]

46 **Vather R**, Josephson R, Jaung R, Robertson J, Bissett I. Development of a risk stratification system for the occurrence of prolonged postoperative ileus after colorectal surgery: a prospective risk factor analysis. *Surgery* 2015; **157**: 764-773 [PMID: 25724094 DOI: 10.1016/j.surg.2014.12.005]

47 **Edmunds H**, Williams GM, Welch CE. External fistulas arising from the gastrointestinal tract. And prospective overview. 1960. *Nutrition* 2003; **19**: 182-186 [PMID: 12591558 DOI: 10.1016/S0899-9007(02)00906-1]

48 **Lloyd DA**, Gabe SM, Windsor AC. Nutrition and management of enterocutaneous fistula. *Br J Surg* 2006; **93**: 1045-1055 [PMID: 16804873 DOI: 10.1002/bjs.5396]

49 **Lu CY**, Wu DC, Wu IC, Chu KS, Sun LC, Shih YL, Chen FM, Hsieh JS, Wang JY. Serum albumin level in the management of postoperative enteric fistula for gastrointestinal cancer patients. *J Invest Surg* 2008; **21**: 25-32 [PMID: 18197531 DOI: 10.1080/08941930701833959]

50 **Berry SM**, Fischer JE. Classification and pathophysiology of enterocutaneous fistulas. *Surg Clin North Am* 1996; **76**: 1009-1018 [PMID: 8841361 DOI: 10.1016/S0039-6109(05)70495-3]

51 **Martinez JL**, Luque-de-León E, Ballinas-Oseguera G, Mendez JD, Juárez-Oropeza MA, Román-Ramos R. Factors predictive of recurrence and mortality after surgical repair of enterocutaneous fistula. *J Gastrointest Surg* 2012; **16**: 156-63; discussion 163-4 [PMID: 22002412 DOI: 10.1007/s11605-011-1703-7]

52 **Soeters PB**, Ebeid AM, Fischer JE. Review of 404 patients with gastrointestinal fistulas. Impact of parenteral nutrition. *Ann Surg* 1979; **190**: 189-202 [PMID: 111638 DOI: 10.1097/00000658-197908000-00012]

53 **Visschers RG**, Olde Damink SW, Winkens B, Soeters PB, van Gemert WG. Treatment strategies in 135 consecutive patients with enterocutaneous fistulas. *World J Surg* 2008; **32**: 445-453 [PMID: 18175171 DOI: 10.1007/s00268-007-9371-1]

54 **Ravindran P**, Ansari N, Young CJ, Solomon MJ. Definitive surgical closure of enterocutaneous fistula: outcome and factors predictive of increased postoperative morbidity. *Colorectal Dis* 2014; **16**: 209-218 [PMID: 24521276 DOI: 10.1111/codi.12473]

55 **Falconi M**, Pederzoli P. The relevance of gastrointestinal fistulae in clinical practice: a review. *Gut* 2001; **49** Suppl 4: iv2-i10 [PMID: 11878790 DOI: 10.1136/gut.49.suppl\_4.iv2]

56 **Visschers RG**, van Gemert WG, Winkens B, Soeters PB, Olde Damink SW. Guided treatment improves outcome of patients with enterocutaneous fistulas. *World J Surg* 2012; **36**: 2341-2348 [PMID: 22669399 DOI: 10.1007/s00268-012-1663-4]

57 **Peyrin-Biroulet L**, Oussalah A, Williet N, Pillot C, Bresler L, Bigard MA. Impact of azathioprine and tumour necrosis factor antagonists on the need for surgery in newly diagnosed Crohn's disease. *Gut* 2011; **60**: 930-936 [PMID: 21228429 DOI: 10.1136/gut.2010.227884]

58 **Yamamoto T**, Allan RN, Keighley MR. Risk factors for intra-abdominal sepsis after surgery in Crohn's disease. *Dis Colon Rectum* 2000; **43**: 1141-1145 [PMID: 10950014 DOI: 10.1007/BF02236563]

59 **Wild T**, Rahbarnia A, Kellner M, Sobotka L, Eberlein T. Basics in nutrition and wound healing. *Nutrition* 2010; **26**: 862-866 [PMID: 20692599 DOI: 10.1016/j.nut.2010.05.008]

60 **Remzi FH**, Fazio VW, Gorgun E, Ooi BS, Hammel J, Preen M, Church JM, Madbouly K, Lavery IC. The outcome after restorative proctocolectomy with or without defunctioning ileostomy. *Dis Colon Rectum* 2006; **49**: 470-477 [PMID: 16518581 DOI: 10.1007/s10350-006-0509-2]

61 **Melton GB**, Fazio VW, Kiran RP, He J, Lavery IC, Shen B, Achkar JP, Church JM, Remzi FH. Long-term outcomes with ileal pouch-anal anastomosis and Crohn's disease: pouch retention and implications of delayed diagnosis. *Ann Surg* 2008; **248**: 608-616 [PMID: 18936574 DOI: 10.1097/SLA.0b013e318187ed64]

62 **Nisar PJ**, Appau KA, Remzi FH, Kiran RP. Preoperative hypoalbuminemia is associated with adverse outcomes after ileoanal pouch surgery. *Inflamm Bowel Dis* 2012; **18**: 1034-1041 [PMID: 22605611 DOI: 10.1002/ibd.21842]

63 **Zerbib P**, Koriche D, Truant S, Bouras AF, Vernier-Massouille G, Seguy D, Pruvot FR, Cortot A, Colombel JF. Pre-operative management is associated with low rate of post-operative morbidity in penetrating Crohn's disease. *Aliment Pharmacol Ther* 2010; **32**: 459-465 [PMID: 20497144 DOI: 10.1111/j.1365-2036.2010.04369.x]

64 **Goyer P**, Alves A, Bretagnol F, Bouhnik Y, Valleur P, Panis Y. Impact of complex Crohn's disease on the outcome of laparoscopic ileocecal resection: a comparative clinical study in 124 patients. *Dis Colon Rectum* 2009; **52**: 205-210 [PMID: 19279413 DOI: 10.1007/DCR.0b013e31819c9c08]

65 **Braga M**, Gianotti L, Nespoli L, Radaelli G, Di Carlo V. Nutritional approach in malnourished surgical patients: a prospective randomized study. *Arch Surg* 2002; **137**: 174-180 [PMID: 11822956 DOI: 10.1001/archsurg.137.2.174]

66 **Rombeau JL**, Barot LR, Williamson CE, Mullen JL. Preoperative total parenteral nutrition and surgical outcome in patients with inflammatory bowel disease. *Am J Surg* 1982; **143**: 139-143 [PMID: 6797311 DOI: 10.1016/0002-9610(82)90144-1]

67 **Jacobson S**. Early postoperative complications in patients with Crohn's disease given and not given preoperative total parenteral nutrition. *Scand J Gastroenterol* 2012; **47**: 170-177 [PMID: 22242614 DOI: 10.3109/00365521.2011.648954]

68 **Lashner BA**, Evans AA, Hanauer SB. Preoperative total parenteral nutrition for bowel resection in Crohn's disease. *Dig Dis Sci* 1989; **34**: 741-746 [PMID: 2496960 DOI: 10.1007/BF01540346]

69 **Braga M**, Ljungqvist O, Soeters P, Fearon K, Weimann A, Bozzetti F. ESPEN Guidelines on Parenteral Nutrition: surgery. *Clin Nutr* 2009; **28**: 378-386 [PMID: 19464088 DOI: 10.1016/j.clnu.2009.04.002]

70 **Gupta D**, Lammersfeld CA, Vashi PG, Burrows J, Lis CG, Grutsch JF. Prognostic significance of Subjective Global Assessment (SGA) in advanced colorectal cancer. *Eur J Clin Nutr* 2005; **59**: 35-40 [PMID: 15252422 DOI: 10.1038/sj.ejcn.1602029]

71 **Park JH**, Watt DG, Roxburgh CS, Horgan PG, McMillan DC. Colorectal Cancer, Systemic Inflammation, and Outcome: Staging the Tumor and Staging the Host. *Ann Surg* 2016; **263**: 326-336 [PMID: 25575264]

72 **Oberhofer D**, Juras J, Pavicić AM, Rancić Zurić I, Rumenjak V. Comparison of C-reactive protein and procalcitonin as predictors of postoperative infectious complications after elective colorectal surgery. *Croat Med J* 2012; **53**: 612-619 [PMID: 23275327 DOI: 10.3325/cmj.2012.53.612]

73 **Welsch T**, Müller SA, Ulrich A, Kischlat A, Hinz U, Kienle P, Büchler MW, Schmidt J, Schmied BM. C-reactive protein as early predictor for infectious postoperative complications in rectal surgery. *Int J Colorectal Dis* 2007; **22**: 1499-1507 [PMID: 17639424 DOI: 10.1007/s00384-007-0354-3]

74 **Keramidaris D**, Koronakis N, Lagoudianakis EE, Pappas A, Koukoutsis I, Chrysikos I, Karavitis G, Toutouzas K, Manouras A. Procalcitonin in patients with colorectal cancer. *J BUON* 2013; **18**: 623-628 [PMID: 24065474]

75 **Takakura Y**, Hinoi T, Egi H, Shimomura M, Adachi T, Saito Y, Tanimine N, Miguchi M, Ohdan H. Procalcitonin as a predictive marker for surgical site infection in elective colorectal cancer surgery. *Langenbecks Arch Surg* 2013; **398**: 833-839 [PMID: 23784676 DOI: 10.1007/s00423-013-1095-0]

76 **Zimmerman MD**, Appadurai K, Scott JG, Jellett LB, Garlick FH. Survival. *Ann Intern Med* 1997; **127**: 405-409 [PMID: 9273834 DOI: 10.7326/0003-4819-127-5-199709010-00013]

77 **Nova E**, Lopez-Vidriero I, Varela P, Toro O, Casas JJ, Marcos AA. Indicators of nutritional status in restricting-type anorexia nervosa patients: a 1-year follow-up study. *Clin Nutr* 2004; **23**: 1353-1359 [PMID: 15556257 DOI: 10.1016/j.clnu.2004.05.004]

78 **Fujii T**, Sutoh T, Morita H, Katoh T, Yajima R, Tsutsumi S, Asao T, Kuwano H. Serum albumin is superior to prealbumin for predicting short-term recurrence in patients with operable colorectal cancer. *Nutr Cancer* 2012; **64**: 1169-1173 [PMID: 23163845 DOI: 10.1080/01635581.2012.718034]

79 **Guthrie GJ**, Roxburgh CS, Horgan PG, McMillan DC. Does interleukin-6 link explain the link between tumour necrosis, local and systemic inflammatory responses and outcome in patients with colorectal cancer? *Cancer Treat Rev* 2013; **39**: 89-96 [PMID: 22858249 DOI: 10.1016/j.ctrv.2012.07.003]

80 **Ohsugi Y**. Recent advances in immunopathophysiology of interleukin-6: an innovative therapeutic drug, tocilizumab (recombinant humanized anti-human interleukin-6 receptor antibody), unveils the mysterious etiology of immune-mediated inflammatory diseases. *Biol Pharm Bull* 2007; **30**: 2001-2006 [PMID: 17978466 DOI: 10.1248/bpb.30.2001]

81 **Ishizuka M**, Nagata H, Takagi K, Iwasaki Y, Kubota K. Preoperative thrombocytosis is associated with survival after surgery for colorectal cancer. *J Surg Oncol* 2012; **106**: 887-891 [PMID: 22623286 DOI: 10.1002/jso.23163]

82 **Roxburgh CS**, McMillan DC. Cancer and systemic inflammation: treat the tumour and treat the host. *Br J Cancer* 2014; **110**: 1409-1412 [PMID: 24548867 DOI: 10.1038/bjc.2014.90]

83 **Liao X**, Lochhead P, Nishihara R, Morikawa T, Kuchiba A, Yamauchi M, Imamura Y, Qian ZR, Baba Y, Shima K, Sun R, Nosho K, Meyerhardt JA, Giovannucci E, Fuchs CS, Chan AT, Ogino S. Aspirin use, tumor PIK3CA mutation, and colorectal-cancer survival. *N Engl J Med* 2012; **367**: 1596-1606 [PMID: 23094721 DOI: 10.1056/NEJMoa1207756]

84 **Berstad P**, Haugum B, Helgeland M, Bukholm I, Almendingen K. Preoperative body size and composition, habitual diet, and post-operative complications in elective colorectal cancer patients in Norway. *J Hum Nutr Diet* 2013; **26**: 359-368 [PMID: 23190256 DOI: 10.1111/jhn.12002]

85 **Xu J**, Zhong Y, Jing D, Wu Z. Preoperative enteral immunonutrition improves postoperative outcome in patients with gastrointestinal cancer. *World J Surg* 2006; **30**: 1284-1289 [PMID: 16830214]

86 **Felekis D**, Eleftheriadou A, Papadakos G, Bosinakou I, Ferekidou E, Kandiloros D, Katsaragakis S, Charalabopoulos K, Manolopoulos L. Effect of perioperative immuno-enhanced enteral nutrition on inflammatory response, nutritional status, and outcomes in head and neck cancer patients undergoing major surgery. *Nutr Cancer* 2010; **62**: 1105-1112 [PMID: 21058198 DOI: 10.1080/01635581.2010.494336]

**P-Reviewer:** Chai FY, Kirshtein B **S-Editor:** Qiu S **L-Editor: E-Editor:**