
doi:10.1016/j.surg.2010.10.004

Commentary on “Vacuum-assisted closure in severe abdominal sepsis with or without retention sutured sequential fascial closure: A clinical trial”

To the Editors:

We thank Dr Velmahos1 for his interest in our study.2 Although Dr Velmahos was thorough in analyzing our study2 and comparing it with the study of Cothren et al,3 he missed the following points that are different between those studies:

1. In our study,2 we used a well-documented protocol that determined the centimeters of approximation, taking into consideration the changes of intra-abdominal pressure.
2. We used a standardized vacuum-assisted closure (VAC) device,2 whereas Cothren et al3 used the vacuum-pack technique.
3. None of the patients of Cothren et al1 had a septic abdomen, whereas in our study, all patients had severe sepsis.2
4. Cothren et al3 study is a case series, mainly demonstrating the technique. Our study is a randomized controlled trial, demonstrating that VAC with retention sutures is better than VAC alone.2

After considering these points, we easily could explain the differences concerning primary closure, average time to closure, and average number of re-explorations. The similarities of the 2 studies reside only in the technique of sequential fascial closure. The post-trauma (nonseptic) patient is easier to handle than the septic one.

The following list is in regard to the rest of the points concerning Dr Velmahos4:

1. The agreement rate of the relatives of the critically ill patients undergoing laparostomy to participate in the randomized clinical trial is indeed high for U.S. standards, which is a result of the etiology of laparostomy. The social background of a trauma patient requiring laparostomy (the most common reason for laparostomy in the United States) is different from that of a septic (nontrauma) abdomen (the most common reason for laparostomy in Europe). For example, it is certainly more complicated to find the relatives of a gunshot victim in an emergency situation than to discuss with an actively involved family background. The difference concerning the mentality of this background is well illustrated in the movie My Big Fat Greek Wedding (2002).
2. Concerning the low primary closure rate (40%) that we had in comparison with the rate reported in Dr Velmahos’s clinic (two-thirds of patients with open abdomen), we believe that the reason for this difference resides in the etiology of laparostomy, as mentioned previously. Our primary closure rate is consistent with prior publications (range, 30–67%).5
3. Delayed herniation is a phenomenon requiring at least 2 years of observation; we therefore expect to have more reliable results by the end of 2011. The results up to date, however, are encouraging.
4. Finally, no information was found concerning fascial dehiscence because we did not encounter this problem (neither did Cothren et al).

We were encouraged by Dr Velmahos’ comment, whose great experience and skeptic regard pointed out several interesting inquiries. We join him in his last of phrases and wish that our study would be a stimulus to other surgeons to use this technique and to decide for themselves on its purported benefits. Furthermore, we commit ourselves to continue to publish our experience with more patients and long-term results.

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doi:10.1016/j.surg.2010.11.021