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Commentary on "Acute Abdomen After Abdominoplasty: Differential Diagnosis"

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This paper focuses attention on an uncommon but important situation for all surgeons to consider: the immediate postoperative illness requiring additional surgery unrelated to the index procedure. As surgeons, we are prepared for the occasional postoperative complication, and it is natural to assume that patient complaints are secondary to our work rather than a new surgical issue.

In the reported case, if the patient had not been recovering from abdominoplasty, a more extensive workup for a cause of the patient's complaint would have been expected, perhaps making the diagnosis earlier before the secondary procedure was complicated with suppurative changes in the appendix. The take-home message for surgeons is that they should consider all potential causes for a patient's complaint and do a thorough investigation before attributing a cause to postoperative complications.

The authors listed a number of possible intraabdominal conditions for which the surgeon should be aware. Although the reported patient represented a postcholecystectomy case, biliary issues are very common and should always be considered in the postoperative period. Gynecologic causes such as ruptured ovarian cyst, ovarian torsion, and pelvic inflammatory disease (PID) should not be overlooked. Severe constipation, leading to fecal impaction and even stercoral ulceration, must be considered, especially with sedentary patients using narcotics.

Even after the diagnosis has been determined, the clinician must not overlook distortion of the usual surface anatomic landmarks after abdominoplasty. Relocation of the umbilicus and the linea alba might make location of port placement difficult. In addition, by opening subcutaneous planes with liposuction on an otherwise localized port site, postoperative infection can extend across the abdominal wall, with disastrous results.

The authors mention the importance of follow-up assessment by the surgeon performing the index procedure, which of course is always good practice. But requesting consultation from another surgical specialty should be considered early if the cause for the complaints is not immediately identified or if the treatment response is not as expected.

Patient history is always the starting point of the diagnostic decision tree. Even with fresh incisions, physical examination still can be helpful in locating the quadrant involved. However, radiologic and laboratory values likely will be of greatest assistance for complete diagnostic accuracy in identifying postoperative complications from a new surgical problem.

Care of the patient does not end when we exit the operating room. We must use our basic surgical diagnostic skills when the postoperative course takes an unexpected turn.

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