

Classification, an Important Step to Improve the Management of Patients with an Open Abdomen: Reply to Letter

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Dear Dr Rausei and colleagues,

We are grateful for the interest you have shown in our article, suggesting a classification system of patients treated with an open abdomen [1]. Although the classification was a result of a consensus process, it is natural that a novel classification system may not be perfect. Future revisions may be necessary after the system has been applied in prospective clinical studies and evaluated. We have the following comments to your letter.

You wrote: “Focusing their attention only on descriptive aspects of intraoperative pattern, etc.” This is not a correct description of our article. On the contrary, we wrote the following: “We have focused this paper on the OA, but when discussing management it must be remembered that the focus is the patient, not the abdomen. Nutrition, ambulation, control of infection, and inflammatory reaction are all important for prognosis. Early enteral nutrition is probably beneficial [5]. When evaluating different TACs, and their respective cost-effectiveness, these issues should also be addressed.”

You stated in your letter: “The open abdomen treatment is an iatrogenic complication, etc.” This is not a correct statement and, in fact, a common misconception. In the paper we described the four principal pathways that may end up with having to treat the patient with an open abdomen: “(1) The septic contaminated abdomen that cannot be closed for infectious reasons and/or where a second-look laparotomy is mandatory; (2) the patient with

a tense abdomen after massive resuscitation or a prolonged major surgical procedure, who is at risk of developing ACS; (3) a ‘damage control’ situation where the patient remains inadequately resuscitated and who needs a period of intensive care therapy prior to a definitive surgical procedure; (4) the patient with primary or secondary ACS, who needs a life-saving decompressive laparotomy.”

You wrote: “So, this treatment variability makes difficult each attempt of categorization.” We agree that it is indeed difficult to classify these complex patients, and this may be the reason why no previous attempt has been published. This is also the reason why we spent a lot of time and effort before we reached a consensus.

Furthermore, you wrote: “However, the authors classified only six grades, but many intermediate patterns can lie among these grades, etc.” We think and hope that the classification system is straightforward and that most, or even all, patients are possible to classify. This is indeed one of the aspects of the classification system that needs to be evaluated. The four main grades (1–4), and the two subgrades (1A and 1B as well as 2A and 2B), are probably sufficiently complex to be able to classify the patients in a clinically relevant way. Each classification system must include a certain degree of simplification in order to be operational.

We hope that both your group and other researchers will use the classification system and report back to the scientific community.

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Reference

1. Björck M, Bruhin A, Cheatham M et al (2009) Classification, an important step to improve the management of patients with an open abdomen. *World J Surg* 33:1154–1157