

**Letter to the Editor****Editöre Mektup****Treatment of superficial incisional infection**

Dear Editor,

We read the manuscript entitled “Stapling for wound dehiscence after cardiac implantable electronic device implantation” with great interest.<sup>[1]</sup>

We congratulate the authors, but there are some points that should be clarified.

Surgical site infection (SSI) is defined as an infection that occurs 30 days after surgery with no implant, or within 1 year of an implant and the infection appears to be related to the surgery, even in the absence of a positive culture. A superficial incisional SSI typically presents with erythema, localized swelling, heat, and/or pain. SSI may also present with incisional dehiscence.<sup>[2]</sup> We think that the authors’ cases can be categorized as superficial incisional infection with wound dehiscence, but not as isolated generator pocket infection. Blood, pocket swab, and tissue cultures should be obtained when identifying the causative organism in all these patients. The guidelines recommend pathogen-directed antimicrobial therapy for 2 weeks for these patients. It is not easy to understand why the authors did not obtain cultures from all of the patients and why they used oral antibiotics for as long as 45 days in addition to intravenous antibiotics for some patients, in which the duration was not noted.

In general, the effective therapy for culture negative, incisional SSI consists solely of incision and drainage without the additional use of antibiotics. Antibiotic therapy is reserved for patients with a significant presence of cellulitis, or who concurrently manifest a systemic inflammatory response syndrome. The open

wound often is allowed to heal by secondary intention, with dressings changed twice a day and without suturing, and especially without metal stapling, which can create an additional infection nidus.<sup>[3]</sup> We think that the authors’ figures demonstrate secondary healing, not the success of stapling.

We think that these patients must have a consultation with a surgeon and infection specialist before starting therapy.

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#### References

1. Habash F, Paydak O, Pothineni NV, Card P, Sewani A. Stapling for wound dehiscence after cardiac implantable electronic device implantation. Turk Kardiyol Dern Ars 2018;46:242-7.
2. de Mestral C, Nathens AB. Prevention, diagnosis, and management of surgical site infections: relevant considerations for critical care medicine. Crit Care Clin 2013;29:887-94. [CrossRef]
3. Townsend C, Beauchamp RD, Evers BM, Mattox K. Sabiston textbook of surgery. 20th ed. Philadelphia: Elsevier/ Health Sciences; 2016.

generator pocket infection. None of our cases had any alarming signs of pocket infection or abscess.

In relation to the septic workup, 8 of 11 patients were admitted to the hospital, where labs, blood cultures, and wound cultures were collected. Those patients received intravenous antibiotics for 48 hours and they were discharged home on oral antibiotics when their blood cultures were negative for any growth. The

**Authors reply**

Dear Editor,

We thank the author for this letter and the questions that were raised. Our 11 cases of wound dehiscence were categorized as a superficial incisional surgical site infection with wound dehiscence, but without