

WORLD UNION
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WORLD UNION OF WOUND HEALING SOCIETIES
CONSENSUS DOCUMENT

Surgical wound dehiscence

Improving prevention and outcomes

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FOREWORD

Surgical wound dehiscence (SWD) is a significant issue that affects large numbers of patients and is almost certainly under-reported. The impact of SWD can be considerable: increased mortality, delayed hospital discharge, readmission, further surgery, delayed adjuvant treatment, suboptimal aesthetic outcome and impaired psychosocial wellbeing.

Photographs in:

- Figures 1a), 9b), 9e), 9f), 16a), 16b) and vignettes 3 and 4 are courtesy of Risal Djohan
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Consequently, it is imperative to raise awareness of SWD and improve identification, prevention and management. Prevention of SWD comprises excellence in surgical practice, prevention of surgical site infection, reducing risk of healing impairment and use of strategies such as single-use negative pressure wound therapy in appropriate high-risk patients. Management also involves a holistic approach that includes amelioration of impediments to healing, optimising conditions in the wound bed and using appropriate treatment modalities to ultimately close the wound.

The need for international consensus on the core issues around SWD arose from the doctoral research of Kylie Sandy-Hodgetts. The process started with a meeting of an international group of surgical care experts in July 2017. Development of the subsequent consensus document included extensive review by the Core Expert Working Group and a Review Panel.

This consensus document is aimed at clinicians in all care settings who work with patients with surgical incisions. The main objective of the document is to inspire clinicians to improve outcomes for patients by providing practical guidance on how to improve prevention and management of SWD.

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DEFINING SURGICAL WOUND DEHISCENCE

Figure 1 | The spectrum of SWD



a) Multiple small areas of superficial SWD with signs of infection following mastectomy



b) SWD after reduction mammoplasty



c) SWD with abscess formation and draining pus following total knee arthroplasty



d) Abdominal wound dehiscence post-laparotomy

The term 'surgical wound dehiscence' (SWD) can be interpreted by healthcare professionals in several ways. To some, SWD is reserved exclusively for the serious event of evisceration of abdominal contents that may occur following failure of a large abdominal surgical incision. But to others, the term has a broader meaning and covers a spectrum of problems ranging from superficial separation of part of an incision to complete separation of the full depth of the incision with exposure of body organs or surgical implants (Figure 1). **This document considers SWD to apply to all degrees of separation of the margins of a closed surgical incision.**

Research published on SWD has used a wide range of definitions. Variations in the definitions include:

- The term used for SWD (Box 1)
- Whether the definition relates to a surgical incision resulting from a specific type of surgery only (e.g. abdominal or cardiothoracic surgery) or to all types of surgery
- The tissue layers involved and/or the depth of the dehiscence
- The degree of dehiscence – i.e. involvement of part or the entire length of the incision
- The inclusion or exclusion of infected wounds
- Timing of the dehiscence in relation to surgery
- The need for a specific treatment – e.g. a further surgical procedure¹⁻⁹.

Some of the variation in definitions is due to the individual needs of the study and to aid extraction of data to answer the research question under investigation, e.g. data on a specific type of surgery or manifestation of SWD.

Box 1 | Synonyms for surgical wound dehiscence (SWD)

- Wound disruption
- Wound separation
- Wound opening
- Wound rupture
- Wound breakdown
- Wound failure
- Surgical site failure
- Post-operative wound dehiscence
- Burst abdomen
- Fascial dehiscence

Box 2 | Definition of SWD

Surgical wound dehiscence (SWD) is the separation of the margins of a closed surgical incision that has been made in skin, with or without exposure or protrusion of underlying tissue, organs or implants. Separation may occur at single or multiple regions, or involve the full length of the incision, and may affect some or all tissue layers. A dehisced incision may, or may not, display clinical signs and symptoms of infection.

N.B. Other types of closed wound may also dehisce, e.g. traumatic wounds that have been sutured. However, such wounds would not be considered to be SWD

There is currently no general standardised definition that aids understanding and accurate identification of SWD that can be used to underpin the principles of management. The Core Expert Working Group proposes a definition of SWD that can be applied to all closed surgical incision types (Box 2)



WHAT CAUSES SWD?

The causes of SWD can be categorised as:

- **Technical issues** with the closure of the incision – e.g. unravelling of suture knots
- **Mechanical stress** – e.g. coughing can cause breakage of the sutures or rupture of the healing incision after suture or clip removal/reabsorption
- **Disrupted healing** – e.g. due to comorbidities or treatments that hamper healing, or as a result of a surgical site infection (SSI) (Figure 2).



A wide variety of technical, mechanical and healing issues may contribute to SWD individually or in combination

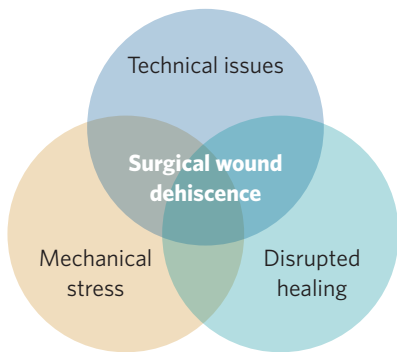


Figure 2 | Causes of SWD (adapted from¹⁰)

Technical issues

SWD may occur because of technical issues with the closure of the incision. Surgical incisions are closed to bring together the sides of the wound to facilitate healing and minimise scar formation^{11,12}. Surgical incision closure is achieved with sutures, staples, adhesive tapes or topical tissue adhesives. The most appropriate closure material and technique for a surgical incision depends on a wide variety of factors including the number of tissue layers to be closed, the anatomical location of the incision, the condition of the patient, and surgeon experience/preference¹³.

SWD may occur if the method of incisional closure fails or is not strong enough to hold the edges and sides of the incision together. For example, SWD may occur if suture knots slip or unravel, or sutures break, stretch, or cut through tissue because they have been placed too close to the edge of the incision, too far apart and/or put under too much tension^{14,15} (Figure 3). A retrospective study of 363 patients with SWD following laparotomy attributed 8% of SWD to broken sutures and 4% to loose knots¹⁶.



In addition to being caused by disrupted healing and mechanical stress, SWD can result from failure of the material used to close the incision, including stretching, slippage or breakage

Box 3 | Examples of causes of incisional mechanical stress that may result in SWD

- Forced tension closure with inadequate tissue mobilisation or undermining
- Local oedema – e.g. due to inflammation, infection, position of the incision on a dependent anatomical area
- General oedema – e.g. in critical illness
- Incisional haematoma or seroma
- External trauma

Abdominal or thoracic incisions

- Increased intra-abdominal and/or intra-thoracic pressure – e.g. due to coughing, retching, vomiting, lifting heavy weights, abdominal compartment syndrome

Mechanical stress

Mechanical stress placed on a closed surgical incision can cause SWD by disrupting the material used for closure and/or rupturing the healing tissues (Box 3). Mechanical stress can result from excessive forced tension during wound closure or swelling of the tissues around the incision due to oedema. The latter may occur as part of the inflammatory phase of the healing process or in response to infection¹⁷ (Figure 4, page 7). Oedema may be an issue particularly for lower limb surgical incisions, e.g. following surgery for lower limb trauma¹⁸, and in patients with cardiac failure or who are critically ill and in fluid overload¹⁹.

Mechanical stress may also be due to a haematoma, seroma or abscess below the surface of the incision²⁰.



Figure 3 | SWD due to suture breakage

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In patients with abdominal and cardiothoracic incisions, mechanical stress may also arise from activities that cause a sudden increase in intra-abdominal and/or intra-thoracic pressure, e.g. retching, vomiting, coughing, sneezing and lifting heavy weights⁸. Raised intra-abdominal pressure may also occur following abdominal surgery and, if sufficiently high, may compromise organ function (causing abdominal compartment syndrome) and contribute to SWD²¹.



Patients should be advised to avoid placing undue stress on a closed surgical incision by following advice individually tailored according to patient factors and surgery type on: activity levels, avoiding overexertion, supporting/splinting the incision (e.g. with a surgical support bra or abdominal support), managing oedema and preventing trauma to the incision

Disrupted healing

The complex process of wound healing in a closed surgical incision (known as healing by primary intention) can be divided into four distinct, necessary, but overlapping, phases: haemostasis, inflammation, proliferation and remodelling²² (Table 1).

Re-epithelialisation of a closed surgical incision is usually complete within 24–48 hours²³.



Even if healing progresses normally, the tissues of a healed surgical incision will never regain pre-surgery strength (Table 2)

Disruption of the healing of a closed surgical incision can occur for a multitude of reasons and may occur during any phase of healing. Broadly, the factors that can disrupt healing can be divided into local factors and systemic factors (Box 4, page 7).

Table 1 | Overview of the phases of wound healing of a surgical incision^{22,24–26}

Phase	Purpose	Timing after creation of surgical incision	Events
Haemostatic	To prevent blood loss	Seconds to minutes	<ul style="list-style-type: none"> ■ Cessation of bleeding through vasoconstriction, platelet aggregation and the release and activation of blood clotting factors to form a blood clot ■ Platelets release chemoattractants and growth factors for the recruitment of inflammatory cells
Inflammatory	To prevent infection and induce the proliferative phase of healing	Day 0 to up to several days	<ul style="list-style-type: none"> ■ Vasodilatation and increased vascular permeability cause fluid leakage into the extravascular space (oedema/exudate) ■ Neutrophils are recruited to the wound site where they kill bacteria, degrade damaged or necrotic tissue and recruit other inflammatory cells such as macrophages ■ Macrophages and other immune cells support pathogen clearance and release a range of chemical factors that promote cell proliferation and synthesis of extracellular matrix
Proliferative	To repair the wound	Day 2 to up to several weeks	<ul style="list-style-type: none"> ■ Fibroblasts migrate to the incision site and proliferate; collagen (especially type III) and extracellular matrix are synthesised; granulation tissue and new blood vessels are formed; keratinocytes migrate to re-epithelialise the wound
Remodelling/maturation	To strengthen the repair	Day 21 to up to 2 years	<ul style="list-style-type: none"> ■ Some type III collagen in the extracellular matrix is replaced by stronger type I collagen; myofibroblasts contract the wound to reduce scar surface area

Table 2 | Tissue strength during healing²⁴

Time after incision	% of pre-incision breaking strength
1 week	3
3 weeks	30
3 months	80

Table 3 | Proportion of dehiscenced wounds that are infected

Type of dehiscence	Proportion of dehiscenced wounds that are infected
Abdominal dehiscence ^{4,16,36}	52%–61%
Dehiscence following colorectal surgery ⁵	36.7%
Sternal incision dehiscence ³	49%
Episiotomy dehiscence ³⁷	Up to 80%

Figure 4 | Incisional oedema and SWD related to oedema



a) Incisional oedema



b) Failure of reconstructive flap due to oedema resulting in exposure of underlying implant

SWD and other surgical site complications

Post-operative surgical site complications other than SWD include SSI, seroma, haematoma, delayed healing, poor quality or abnormal scar formation, and incisional hernia. Some surgical site complications increase the risk of SWD, e.g. SSI, seroma and haematoma. However, conversely, SWD increases the risk of SSI, delayed healing, poor quality scar formation and incisional hernia^{20,32} (Figure 5).

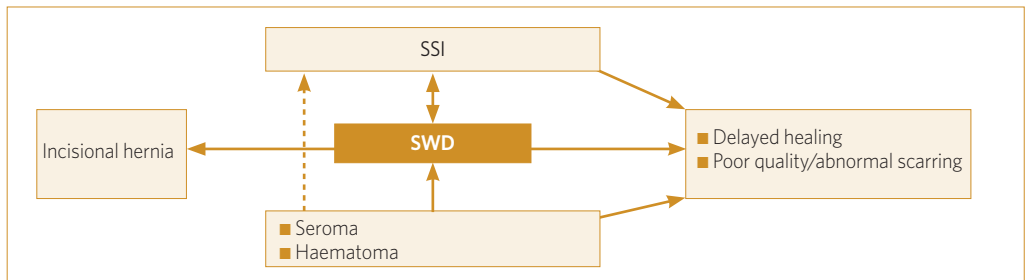


Figure 5 | The relationship between SWD and other post-operative surgical site complications

SWD and SSI

Infection occurs when microorganisms in a wound proliferate to a level that produces a local and/or systemic response³³. Infection increases the production of degradative enzymes by immune cells and bacteria which can disrupt healing and weaken wound tissues¹⁶. As a result, SSI can cause SWD. This link between SWD and SSI is acknowledged in the Centers for Disease Control and Prevention definition of deep incisional SSI³⁴ (Appendix 1, page 38). Conversely, however, not all infected incisions dehisce.



The link between SSI and SWD means that SSI can be a cause of and a risk factor for SWD

Although it is clear that some dehisced wounds are not due to infection (Table 3, page 6), rates of infection in dehisced wounds are infrequently reported³⁵. In addition, infection can develop in a dehisced wound. Therefore, where infection rates are reported, it may not be clear whether infection occurred before or after dehiscence.

Unfortunately, some clinicians view SWD as synonymous with infection. In the age of awareness of the need for antimicrobial stewardship, accurate identification of infection in the context of SWD and the appropriate use of antimicrobials is ever more important.



Although there is a link between SWD and SSI, not all dehisced wounds are infected or require treatment for infection – and not all infected or inflamed wounds dehisce

Box 4 | Examples of factors and conditions that may be associated with delayed or impaired wound healing²⁷⁻³¹

Local factors

- Hypoxia/ischaemia – e.g. due to peripheral arterial disease, oedema, respiratory disease
- Devitalised tissue
- Infection/contamination
- Inflammatory conditions – e.g. pyoderma gangrenosum, vasculitis
- Larger initial wound size
- Ongoing mechanical stress or trauma

Systemic factors

- Advanced or very young age

- Psychological stress
- Chronic disease/comorbidities – e.g. diabetes mellitus, obesity, chronic kidney disease/uraemia, jaundice, chronic respiratory disease, immunosuppression
- Medication – e.g. corticosteroids, chemotherapy
- Radiotherapy
- Smoking, alcoholism, substance misuse
- Malnutrition
- Connective tissue disorders – e.g. Ehlers-Danlos syndrome
- Poor compliance with treatment plans

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HOW COMMON IS SWD?

The difficulty of gaining a clear insight into the rates of occurrence of SWD is complicated by variations in the terminology used to describe SWD (Box 1, page 4), the use of composite endpoints such as ‘wound complications’, and the lack of a generally accepted, standardised definition for SWD.

Under-reporting of SWD is also likely to occur for several other reasons including:

- Dehiscence, particularly of superficial, small areas of a wound, may not be recognised and recorded as SWD
- SWD may be overlooked and recorded as infection only, even when severe
- The trend for earlier discharge from hospital means that SWD is increasingly likely to occur in the community and may not be captured in hospital-based surveillance studies, and, particularly if relatively minor, may not be reported by patients or recognised by clinicians
- Negative implications for reimbursement and access to operating facilities may disincentivise reporting of surgical site complications.

Table 4 provides examples of SWD rates for different types of surgery.



There is considerable variation in SWD rates between surgical procedures, e.g. 0.65% for cardiothoracic surgery³⁸ and 41.8% for pilonidal sinus surgery³⁹

A prospective study that analysed SWD rates following laparotomy by surgical wound class (i.e. clean, clean-contaminated, contaminated, or dirty or infected) reported that dehiscence was more common in the contaminated or dirty categories⁴⁰ (Table 5).



In community settings, the most likely sites of SWD are the abdomen, leg and chest⁵³

Table 4 Examples of SWD rates	
Surgical domain	Incidence
Laparotomy ^{9,36,44}	0.4%–3.8%
Cardiothoracic (sternotomy) ^{3,38}	0.65%–2.1%
Orthopaedic surgery ^{41–43}	1.1%–3.6%
Caesarean section ^{7,45,46}	1.9%–7.6%
Oncoplastic breast reconstruction ^{47,48}	4.6%–13.3%
Saphenous vein harvesting ⁴⁹	8.9%
Pilonidal sinus (primary closure) ^{39,50}	16.9–41.8%
Abdominoplasty following bariatric surgery ^{51,52}	18.7%–21.5%

Table 5 SWD rates following laparotomy according to surgical wound class ⁴⁰	
Surgical wound category	Number of patients
Clean	0
Clean-contaminated	6 (12%)
Contaminated	22 (44%)
Dirty	22 (44%)
Total	50 (100%)

Impact of SWD

SWD can have a negative impact on patients' mental health and physical and social functioning^{54,55}. Mortality following sternal SWD can be very high (11%–53%), especially in the presence of infection or chronic obstructive pulmonary disease^{3,56}. Mortality following abdominal SWD can also be high at 3%–35%^{5,54,57}. Furthermore, patients with abdominal SWD have a high risk of incisional hernia of up to 83%⁵⁴.

Analyses of data from US databases have illustrated the increased morbidity and mortality experienced by patients with SWD. An analysis of 2008 data from one database found that patients with SWD had in comparison with matched controls an additional:

- 9.6% mortality
- 9.4 days of hospitalisation
- US\$40,323 of hospital charges⁵⁸.

An analysis of 2003–2007 data from Veterans Health Administration reported that patients with SWD have a 61% higher odds of readmission within 30 days than patients without SWD⁵⁹.



SWD can have a severe impact on a patient's psychosocial wellbeing and carries considerable costs for healthcare systems

Costs and burden of SWD in the context of other wound types

It is becoming increasingly apparent that a considerable proportion of wounds with healing problems are surgical wounds and that these wounds are costly to manage. Contributors to costs may include frequent dressing changes, complications (such as infection) and hospital readmission⁶⁰. Indirect costs may include loss of income, inability to participate in domestic or social activities, and welfare, social security or insurance payments⁶¹.

A recent US study of Medicare data from 2014 reported that:

- 14.5% of all Medicare beneficiaries were diagnosed with at least one type of wound or wound-related infection
- Infected surgical wounds were the most commonly treated wound type and affected 4% of all Medicare beneficiaries
- Costs for nonhealing and infected surgical wounds were the highest of any wound type (approximately US\$13.1 billion), and greater than for the cost of treatment for diabetic foot ulcers
- There has been a considerable shift in total cost of care for all wounds from hospital inpatient to hospital outpatient settings, with outpatient costs about double inpatient costs⁶².

A UK study reported that more than half (57.1%) of wounds due to SWD healing by secondary intention, were being cared for in a community (rather than in a primary or secondary) setting⁶³.

Furthermore, a study of the annual costs to the UK's National Health Service (NHS) of caring for surgical wounds in a primary care setting reported that surgical wounds were the most costly and accounted for about 18.9%–21.8% of total expenditure on wound care⁶⁴.

Data from large community-based organisations in Canada representing wound patients (n=24,678) have demonstrated that 43.9% of the wounds being managed are surgical wounds healing by secondary intention⁶⁵. Patients with these wounds have required nursing care and clinical support over 6–69 weeks⁶⁵.

A recent Australian study reported that the cost of management in a community nursing setting was AUD\$509 for a patient with an uninfected SWD and AUD\$1,025 with an infected SWD⁵³.



SWD is not restricted to inpatient hospital care: it results in a high cost and resource burden in outpatient and community settings

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RISK FACTORS FOR SWD

An understanding of the factors that increase a patient’s risk of SWD will guide the most appropriate prophylactic pre-, intra- and post-operative care.

The bulk of published research on risk factors specifically for SWD focuses on abdominal and sternal dehiscence with limited reporting across other surgical domains³⁵.

Table 6 lists general risk factors for SWD. The table differentiates between factors associated specifically with SWD and those that have often been reported as risk factors for SSI, haematoma or seroma (conditions that may themselves increase risk of SWD)²⁰. Table 7, page 11, lists risk factors specific to SWD in a selection of different surgery types.



Major risk factors for SWD are obesity (body mass index (BMI) $\geq 35\text{kg}/\text{m}^2$), diabetes mellitus, current or recent smoking, emergency surgery, age >65 years, extended duration of surgery, inadequate surgical closure, peri-operative hypothermia and wound infection

Table 6 Main general risk factors for SWD ^{5-7,9,15,16,36,37,45,57,58,66-84}				
Category of risk factor	Patient-related modifiable risk factors	Pre-operative risk factors	Intra-operative risk factors	Post-operative risk factors
Major	<ul style="list-style-type: none"> ■ BMI $\geq 35.0\text{kg}/\text{m}^2$ ■ Diabetes mellitus ■ Current or recent smoking 	<ul style="list-style-type: none"> ■ Emergency surgery ■ Age >65 years 	<ul style="list-style-type: none"> ■ Extended duration of surgery ■ Inadequate surgical closure ■ Perioperative hypothermia* 	<ul style="list-style-type: none"> ■ Wound infection (SSI)
Moderate	<ul style="list-style-type: none"> ■ COPD‡ ■ Malnutrition: hypoalbuminaemia (serum albumin $<3.0\text{g}/\text{dl}$) ■ Anaemia ■ BMI $30.0-35.0\text{kg}/\text{m}^2$ ■ Alcohol abuse 	<ul style="list-style-type: none"> ■ Male gender ■ ASA Physical Status ≥ 2 ■ Previous dehiscence/ wound healing problems ■ Immunosuppression ■ Long-term steroid use ■ Malignant disease ■ Chemotherapy ■ Radiotherapy ■ Uraemia ■ Peripheral vascular disease ■ Suboptimal timing or omission of prophylactic antibiotics* 	<ul style="list-style-type: none"> ■ Blood transfusion ■ Junior surgeon ■ High wound tension closure ■ Tissue trauma/ large area of dissection and/ or undermining 	<ul style="list-style-type: none"> ■ Failure to wean from ventilator ■ One or more complication other than dehiscence ■ Premature suture removal
Minor	<ul style="list-style-type: none"> ■ BMI $25.0-29.9\text{kg}/\text{m}^2$ ■ Congestive cardiac failure ■ Cardiovascular disease 	<ul style="list-style-type: none"> ■ Extended pre-operative hospitalisation or residency in a nursing home* 	<ul style="list-style-type: none"> ■ Failure to obliterate dead space 	<ul style="list-style-type: none"> ■ Trauma across incision
Rare		<ul style="list-style-type: none"> ■ Alpha-1 antitrypsin deficiency ■ Ehler-Danlos syndrome ■ Behçet’s disease ■ Bleeding disorders* 		

‡ May be a risk factor in different types of surgery for different reasons, e.g. because of coughing in abdominal surgery and sternotomy and because of the adverse effects of chronic disease on wound healing in all types of surgery

*These are risk factors for SSI or other surgical wound complications, e.g. haematoma and seroma, that may be associated with SWD²⁰. Other factors listed in the table have been reported to be associated with SWD specifically

ASA: American Society of Anesthesiologists; COPD: chronic obstructive pulmonary disease; SSI: surgical site infection

Table 7 | Examples of the main additional risk factors for SWD in a selection of surgery types

This table lists risk factors for SWD additional to those in Table 6, page 10, in a selection of surgery types.

Type of surgery	Additional risk factors
Abdominal ^{6,15,16,36,57,58,66,76,80,82,85,86}	<p>See Table 6, page 10, for general risk factors for SWD</p> <ul style="list-style-type: none"> ■ Midline laparotomy ■ Damage to the gastrointestinal tract ■ Intestinal or biliary tract surgery ■ Creation of an ostomy ■ Muscle flap creation ■ Loss of visceral domain >20% ■ Peritonitis ■ Sepsis ■ Jaundice ■ Ascites ■ Coughing/pulmonary problems/pneumonia ■ Post-operative anastomotic dehiscence/fistula ■ CVA without residual deficit
Breast/plastic ⁸⁷	<p>See Table 6, page 10, for general risk factors for SWD</p> <ul style="list-style-type: none"> ■ SWD element of the Breast Reconstruction Risk Assessment (BRA) score ■ Previous surgery at same site
Cardiothoracic ^{67,68,81}	<p>See Table 6, page 10, for general risk factors for SWD</p> <ul style="list-style-type: none"> ■ Osteoporosis ■ Antiplatelet medication ■ Previous sternotomy ■ Prolonged cardiopulmonary bypass time ■ Chronic cough ■ NYHA functional class IV ■ Bilateral internal mammary artery harvest ■ Post-operative pneumonia ■ Beta-blocker use ■ Previous surgery in current admission ■ Respiratory failure ■ Urinary tract infection ■ Left ventricular assist device* ■ Transplant* ■ Cardiopulmonary bypass time extended*
Obstetric ^{7,37,45}	<p>See Table 6, page 10, for general risk factors for SWD</p> <p>Episiotomy repair:</p> <ul style="list-style-type: none"> ■ Human papilloma virus (HPV) infection <p>Caesarean section:</p> <ul style="list-style-type: none"> ■ African-American race ■ Vertical incision ■ Stapled wound closure ■ Chorioamnionitis ■ Multiple caesarean sections* ■ Operative blood loss >1.5l* ■ Pre-eclampsia*
Orthopaedic ⁶⁹	<p>See Table 6, page 10, for general risk factors for SWD</p> <ul style="list-style-type: none"> ■ Implant-related surgery ■ Poor compliance by patients with nurses' recommendations ■ Traumatic injury ■ Rheumatoid arthritis*

*Risk factors for SSI or other surgical wound complications, e.g. haematoma and seroma, that may be associated with SWD²⁰. Other factors listed in the table have been reported to be associated with SWD specifically

ASA: American Society of Anesthesiologists; CVA: cerebrovascular accident; NYHA: New York Heart Association functional class

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IDENTIFYING SWD SWD dehiscence can occur at any time after surgery, from one day to more than 20 days after surgery¹⁵, but generally occurs at post-operative days 4-14⁸⁸.

Monitoring the healing progress of a surgical incision will enable the identification of incisions in which healing is progressing well and those in which healing is impaired and has the potential to progress to SWD (Table 8).

Signs of probable SWD

SWD can occur without warning⁸⁹. Incisions at risk of dehiscence may show signs of inflammation beyond the time and extent expected for normal healing, e.g. more exaggerated incisional redness, swelling, warmth and pain that extend beyond post-operative day 5. Palpation of the incision and surrounding area may reveal warmth and a collection of fluid under some or all of the incision (a seroma, haematoma or abscess). A sudden increase in pain or discharge of serosanguineous fluid from the incision may herald SWD¹⁴.



Signs of inflammation at the incisional site, e.g. warmth, erythema, oedema, discolouration and pain, are normal during the first few days after surgery, and do not necessarily indicate infection⁹⁰

Table 8 | Signs of progressing and impaired incision healing^{8,14,91}

Parameter	Relationship to TIME framework*	Signs that incisional healing is progressing well	Signs that healing is impaired
Incision colour	Tissue	<ul style="list-style-type: none"> ■ Days 1-4: red ■ Days 5-14: bright pink ■ Day 15-1 year: pale pink, progressing to white or silver in light-skinned patients or to darker than usual skin colour in patients with darkly-pigmented skin 	<ul style="list-style-type: none"> ■ Days 1-4: may be red, tension in the incision line ■ Days 5-9: edges may be well-approximated and the tension remains ■ Days 10-14: if SWD does not occur, colour may remain red or progress to pink and may be followed ultimately by hypertrophic scarring
Healing ridge		<ul style="list-style-type: none"> ■ Days 5-9: a healing ridge of thickened tissue indicating newly formed collagen can be felt about 1cm either side of the incision along its length, and persists into the remodelling phase 	<ul style="list-style-type: none"> ■ Lack of healing ridge
Peri-incisional area	Infection/ inflammation	<ul style="list-style-type: none"> ■ Signs of inflammation: <ul style="list-style-type: none"> - Mild oedema, erythema, warmth or skin discolouration that resolves by day 5 - Pain 	<ul style="list-style-type: none"> ■ Signs of inflammation may be absent in the first few days after surgery ■ Signs of inflammation and ongoing pain may be present for extended periods
Exudate	Moisture	<ul style="list-style-type: none"> ■ Days 1-4: decreasing in volume from moderate to minimal and changing from sanguineous (blood) to serosanguineous (mixture of blood and serum) to serous (clear, amber serum) ■ Resolves by day 5 	<ul style="list-style-type: none"> ■ Exudate persists beyond days 1-4 ■ Exudate may be serosanguineous, serous or purulent (e.g. cloudy, green, yellow or brown)
Wound margins	Edge	<ul style="list-style-type: none"> ■ Epithelial closure should be seen by day 4 along the entire incision ■ Approximated 	<ul style="list-style-type: none"> ■ Epithelial resurfacing may be only partially present or entirely absent ■ Area(s) of separation (SWD) may be present by day 14

*See Table 9, page 16, for more information about using the TIME framework in the assessment of SWD

Signs of SWD

Areas of separation of the wound margins may vary from tiny 'pin pricks' to larger gaping areas to the entire length and depth of the incision. If the incision opens into a body cavity, SWD may result in evisceration. Sutures or clips may be visible in the separated area and may be broken.

In patients with abdominal or sternal incisions, dehiscence may follow an episode of retching, vomiting or coughing¹⁴. Patients may describe a sensation of pulling or ripping in the area of the incision, or the feeling that something has given way⁸⁹.

Signs of infection

A patient with a surgical incision at increased risk of SWD or that has dehisced can show local and systemic signs and symptoms of infection (Box 5 and Box 6).



The diagnosis of infection (SSI) in surgical incisions or SWD should be made on the basis of clinical signs and symptoms

Box 5 | Local clinical signs and symptoms of infection in a closed surgical incision^{92,93}

See Box 6 for systemic signs and symptoms of infection

- Erythema – localised or spreading (cellulitis)
- Pus/purulent or haemopurulent exudate
- Abscess
- Swelling/induration
- Local warmth
- Malodour
- Crepitus (crackling feeling or sound detected on palpation due to gas in the soft tissues)
- Dehiscence
- Unexpected pain or tenderness

Box 6 | Systemic signs and symptoms that may be associated with infection of a closed or dehisced surgical incision^{93,94}

- Malaise
- Loss of appetite
- Pyrexia or hypothermia
- Tachycardia
- Tachypnoea
- Elevated C-reactive protein (CRP)
- Elevated or suppressed white blood cell count
- Sepsis
- Septic shock

Various systems exist to aid diagnosis of SSI. These include the CDC definitions of SSI and adaptations such as the definitions used by Public Health England (PHE) (Appendix 1, page 38), and the ASEPSIS scoring system. The ASEPSIS system is an objective means of assessing surgical incisions for infection and results in a numerical score that indicates the presence and severity of any infection⁹⁵ (Appendix 2, page 39).

ASSESSMENT
OF SWD

Patients with SWD of any depth or length should receive a structured holistic assessment that includes assessment of the general condition of the patient and of the dehisced incision

Assessment of a patient with SWD will provide important information that will guide management (Figure 6, page 15), including:

- Modifiable factors that may be hindering healing
- Any signs of local or systemic infection
- Whether further investigations are required
- The condition of the dehisced area.



The results of the holistic assessment, which should be fully documented, will guide the most appropriate management

General assessment

Box 7 outlines the components of a general assessment of a patient with SWD, which includes all facets of previous and current health and psychosocial status.



The main aims of general assessment are to identify any factors that may have contributed to or exacerbate the dehiscence or that may impair healing, and to detect any clinical signs of systemic infection

Box 7 | General assessment of a patient with SWD (adapted from ⁹⁶)

See Tables 6 and 7 (pages 10 and 11) for details of risk factors for SWD

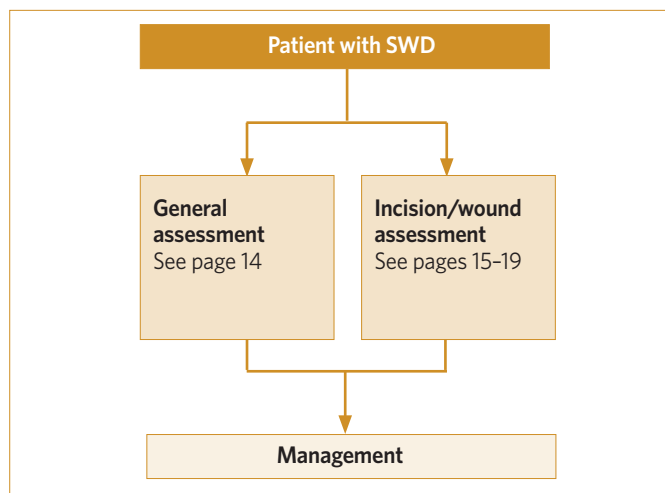
- **Medical and surgical history**, including:
 - Previous problems with wound healing – e.g. SWD, SSI
 - Radiotherapy
 - Chemotherapy
 - Allergies and sensitivities to medication and skin/wound products
- **Nature of the surgical procedure** that resulted in the incision that has dehisced, including:
 - Reason for surgery and date*
 - Emergency/elective
 - Intra-operative and post-operative complications – e.g. haemorrhage, hypothermia, duration of surgery, SSI
 - Closure method
 - Date of suture/clip removal
- **Current health**, including:
 - Need for haemodynamic or ventilatory support
 - Active comorbidities – e.g. diabetes mellitus, obesity, COPD, blood clotting factor deficiencies, anaemia/ blood transfusions, cough/chest infection†, constipation†, dermatological conditions
 - Nutritional status – e.g. presence of malnutrition, level of hydration, ability to eat and drink
 - Physical parameters relating to possible systemic infection – e.g. core temperature, levels of inflammatory markers (e.g. CRP) and white blood cell (WBC) count
- **Lifestyle**, including smoking, alcohol intake, diet, level of physical activity‡
- **Current medication** and reasons for use, including:
 - Anticoagulant/antiplatelet treatment
 - Chronic corticosteroids
 - Immunosuppressants
 - Antibiotics
 - Analgesics
- **Pain**, including current location and severity of pain, whether related to the wound or elsewhere; use of numeric or visual analogue scales can aid objective assessment and monitoring of pain severity; current pain management
- **Psychosocial status**, including:
 - Care setting
 - Family/carer support
 - Occupation and financial situation
 - Patient's understanding of and attitude to their condition and the incision and surgery
 - Ability and willingness to engage in care
 - Impact of wound on quality of life (physical, social and emotional)

*To calculate number of days since surgery; very early dehiscence may be due to technical issues and duration of SWD may influence management

†Of particular relevance in patients which cardiothoracic or abdominal incisions

‡Post-operative mobilisation is important, however, depending on the position of the wound, overexertion may contribute to or exacerbate SWD

Figure 6 | Overview of holistic assessment of a patient with SWD



Incision/wound assessment

Prior to assessment of SWD, the events, if any, leading to the dehiscence, e.g. coughing, vomiting, trauma, suture/clip removal, purulent drainage, should be ascertained. The duration of the dehiscence should also be determined: SWD occurring very soon after surgery and of very recent occurrence may be suitable for re-suturing.

The entire length of an incision with SWD should be fully assessed: the factors that led to the SWD may also be affecting other regions of the incision that remain closed.

The Core Expert Working Group recommends the use of a structured framework, e.g. TIME⁹⁷, to aid assessment of SWD (Table 9, page 16). Sequential photographs can aid monitoring. Photographs should be obtained and stored after gaining patient consent and according to local policy⁹⁸.



If more than one area of dehiscence is present, each area should be assessed individually (Figure 7)



A short area of dehiscence is not necessarily only superficial and may extend deeply



While it is important to determine the depth of an area of dehiscence, any probing should be undertaken very gently and carefully by a clinician with suitable competency to avoid inadvertently exacerbating the dehiscence or causing other damage



All general and wound assessments, further tests, interventions and referrals should be documented

Figure 7 | Abdominal incision with two areas of dehiscence and an abscess



Table 9 | Assessment of SWD using the TIME framework (adapted from^{93,96,97,99})

Parameter	Assess	Specifics
Tissue	Location and extent of dehiscence	<ul style="list-style-type: none"> ■ Location of the incision ■ Proportion of the incision affected ■ Number of areas of dehiscence ■ Presence of sutures/clips and condition (intact/broken)
	Depth of dehiscence	<ul style="list-style-type: none"> ■ Partial or full-thickness dehiscence and tissue layers affected (see Figure 8, page 18); WUWHS SWD Grade (see Table 10, page 18) ■ Extension to or exposure of organs/bone/implant ■ Presence of undermining/tunnelling ■ For abdominal SWD, presence of evisceration
	Tissue viability	<ul style="list-style-type: none"> ■ Condition of exposed tissues ■ Wound bed tissue types and proportions – e.g. of necrotic/devitalised tissue, slough and granulation tissue
	Dimensions	<ul style="list-style-type: none"> ■ Dimensions of the dehisced area(s): maximum length, width, depth
Infection (or inflammation)	For local indicators of infection or inflammation	<ul style="list-style-type: none"> ■ Clinical signs and symptoms ■ See Box 5 and Box 6, page 13, and Box 8, page 17, for signs and symptoms of acute and chronic infection ■ N.B. In patients who are immunosuppressed, signs and symptoms may be less obvious
Moisture	Exudate/drainage colour, consistency, type and odour	<ul style="list-style-type: none"> ■ Purulent (cream, yellow or green) or haemopurulent (red, brown) may indicate infection ■ Yellow or brown exudate may indicate a urinary or enteric fistula ■ Malodour may indicate infection or fistula
	Exudate/drainage level	<ul style="list-style-type: none"> ■ Indications of the level of exudate production can be gained from the condition of the current dressing (i.e. a dry dressing indicates low exudate levels; a saturated or leaking dressing indicates higher levels) and the appearance of the wound bed
Edge	Edges of dehisced area	<ul style="list-style-type: none"> ■ In long-standing areas of dehiscence, the edges may become undermined
	Colour and condition of the surrounding skin	<ul style="list-style-type: none"> ■ Signs of dermatological conditions that may affect healing – e.g. radiation dermatitis ■ Signs of spreading infection – e.g. spreading erythema, warmth and oedema ■ Periwound maceration may indicate high exudate/drainage levels and/or inadequate absorbency of the dressing

Diagnosis of infection

The diagnosis of infection of a surgical incision or a dehisced wound is largely based on local and systemic clinical signs and symptoms (Box 5 and Box 6, page 13, and Box 8, page 17). Fever in the first 48 hours after surgery is unlikely to be due to SSI¹⁰⁰.

The role of sampling and microbiological culture in the diagnosis of SSI continues to be debated. Reasons for this include that superficial sampling, such as swabbing, may reflect only surface bacteria and not bacteria in deeper tissues – an issue of particular relevance to deep surgical wounds^{101,102}.

Technological developments, such as the use of point-of-care fluorescence imaging (e.g. MolecuLight i:X™, distributed by Smith & Nephew) to detect areas of tissue with increased bacterial levels and guide sampling, may help to increase the usefulness of microbiological sampling¹⁰³.



Clinicians should be aware of the limitations of microbiological analysis of wound samples, and should interpret the results in the context of clinical signs and symptoms, noting that a 'negative' swab does not necessarily exclude infection⁹³

Imaging diagnostics

Most patients with SWD do not require further investigation with imaging diagnostics. However, if there is uncertainty about the diagnosis, the depth of dehiscence, or if an area of dehiscence is increasing in size or is not improving despite treatment, imaging may be warranted⁸⁹.

In many cases, ultrasound scanning will be the most appropriate imaging modality, with more expensive modalities such as magnetic resonance imaging (MRI) reserved for further

Box 8 | Clinical signs and symptoms of local wound infection in a chronic SWD⁹³

See Box 6, page 13, for systemic signs and symptoms of infection

- New, increased, or altered pain*
- Delayed healing*
- Malodour or change in odour
- Increased or altered/purulent exudate
- Periwound oedema
- Bleeding or easily damaged granulation tissue
- Altered wound bed colour
- Induration of periwound skin
- Pocketing and bridging

*Individually highly indicative of infection. Infection is highly likely in the presence of two or more of the signs above

investigation. In addition to assessing the tissues, imaging may be used to detect and assess seromas, haematomas and collections of pus, and to evaluate the proximity of the dehiscence to implants such as meshes or prosthetic joints.

Grading of SWD

Systems for grading or classifying SWD often relate to specific types of surgery, e.g. thoracic¹⁰⁴⁻¹⁰⁶ or abdominal surgery¹⁰⁷. Some classifications are adaptations of the adverse event reporting systems, e.g. of the Ottawa Thoracic Morbidity and Mortality system¹⁰⁸ or the Clavien-Dindo system¹⁰⁹.



There is a need for a general classification system for SWD that is applicable to incisions from all surgery types, is easy to use, is suitable for use in all care settings (including community settings), that indicates severity, and that can be linked to appropriate management strategies

The proposed WUWHS SWD Grading System in Table 10, page 18, was developed by the Core Expert Working Group during the consensus meeting and is an adaptation of the Sandy SWD Grading system¹¹⁰.

The system uses depth and the presence of infection as the main determinants of SWD severity. Distinguishing SWD with no clinical signs and symptoms of infection from SWD with clinical signs and symptoms of infection is intended to emphasise the differences in approach to management that may be required.



Assignment of a WUWHS SWD Grade should take place only after full assessment of the patient and the surgical incision, including probing and exploration of the areas of dehiscence if required by a clinician with suitable competency

Even though most SWD occurs 4–14 days post-operatively⁸⁸, a time-period of 30 days has been included in the grading system. The inclusion of a time-period is intended to encourage surveillance and reporting of SWD post-discharge as, in common with SSI, the probable under-reporting of SWD may be related to occurrence of SWD after a patient has left hospital. The time-period of 30 days is broadly in line with reporting requirements for SSI and has been applied to all SWD grades for consistency. As more is learnt about SWD, the time-period may need to be adjusted.



As SWD generally occurs at days 4–14 post-operatively, a significant proportion is likely to occur after discharge

Figure 9, page 19, illustrates how the tissue layers relate to the WUWHS SWD grading in Table 10, page 18.



No matter how long the area of dehiscence is, SWD involving the deep layers of an incision is more serious than that involving more superficial layers

CONSENSUS DOCUMENT

Table 10 | WUWHS SWD Sandy Grading System

Definition: Surgical wound dehiscence (SWD) is the separation of the margins of a closed surgical incision that has been made in skin, with or without exposure or protrusion of underlying tissue, organs or implants. Separation may occur at single or multiple regions, or involve the full length of the incision, and may affect some or all tissue layers. A dehisced incision may, or may not, display clinical signs and symptoms of infection.

WUWHS SWD Grade*		Descriptors
Increasing severity ↓ Single/multiple regions† or full-length separation of the margins of a closed surgical incision‡ occurring up to 30 days after the procedure‡	1 Figure 9a, page 19	Epidermis only, no visible subcutaneous tissue ■ No clinical signs or symptoms of infection
	1a Figure 9b, page 19	As Grade 1 plus clinical signs and symptoms of infection
	2 Figure 9c, page 19	Subcutaneous layer exposed, fascia not visible
	2a Figure 9d, page 19	As Grade 2 plus clinical signs and symptoms of infection
	3 Figure 9e, page 19	Subcutaneous layers and fascia exposed ■ No clinical signs and symptoms of infection
	3a Figure 9f, page 19	As Grade 3 plus clinical signs and symptoms of infection
	4 [^] Figure 9g, page 19	Any area of fascial dehiscence with organ space, vicera, implant or bone exposed
	4a [^] Figure 9h, page 19	As Grade 4 plus clinical signs and symptoms of infection= (e.g. organ/space SSI§)

*Grading should take place after full assessment including probing or exploration of the affected area as appropriate by a clinician with suitable competency

†Where this is >1 region of separation of the wound margins, SWD should be graded according to the deepest point of separation

‡Where day 1 = the day of the procedure

§See Appendix 1, page 38, for the CDC definitions of the different types of SSI

[^]Grade 4/4a dehiscence of an abdominal incision may be called 'burst abdomen'

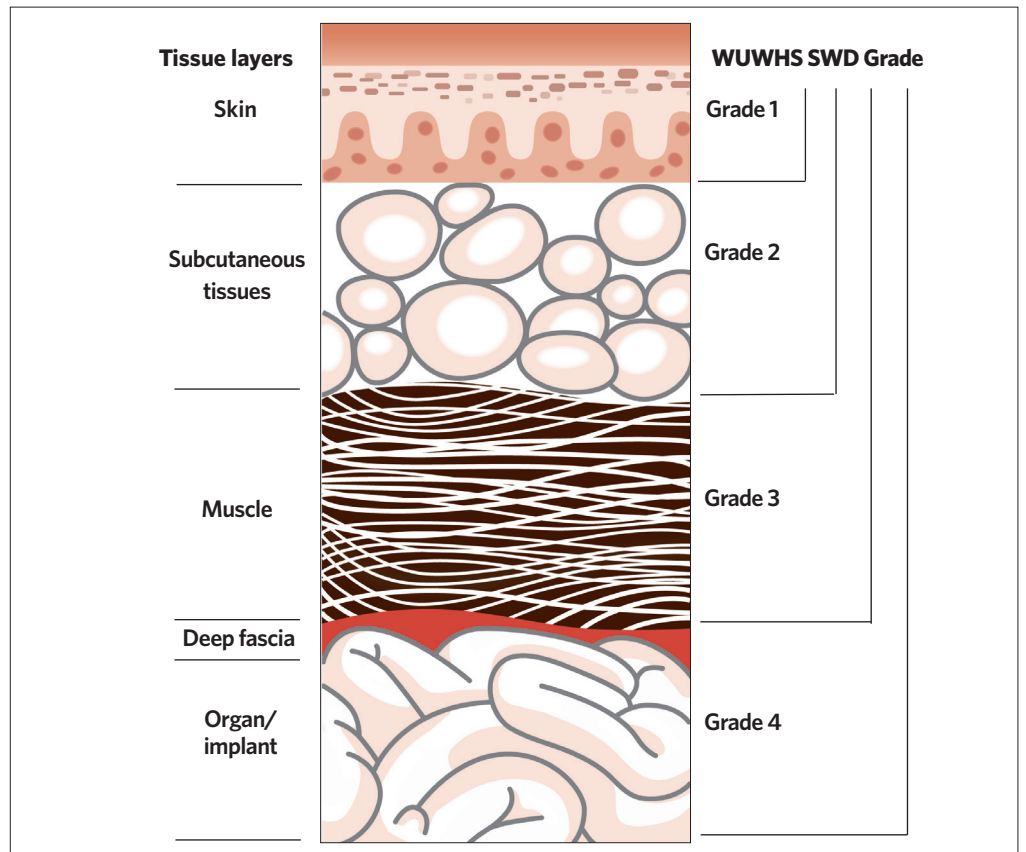
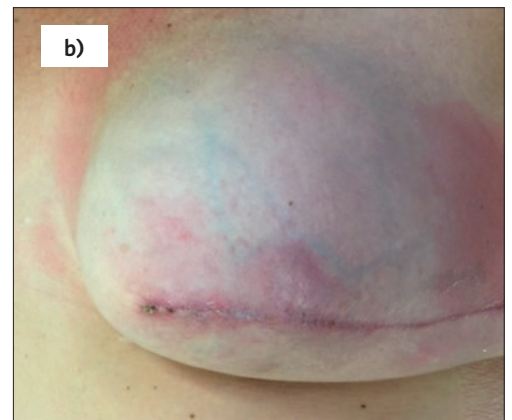
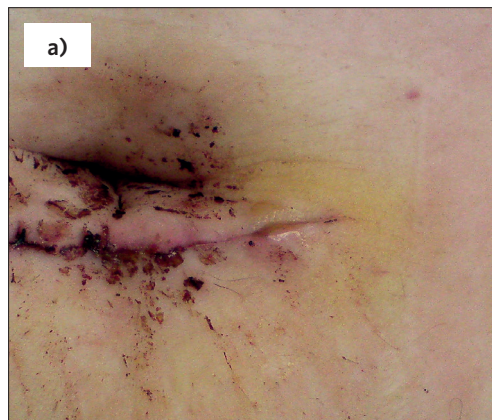


Figure 8 | Proposed WUWHS SWD Grade according to the tissue layers involved in the dehiscence

Figure 9 | Examples of the proposed WUWHS SWD Grades

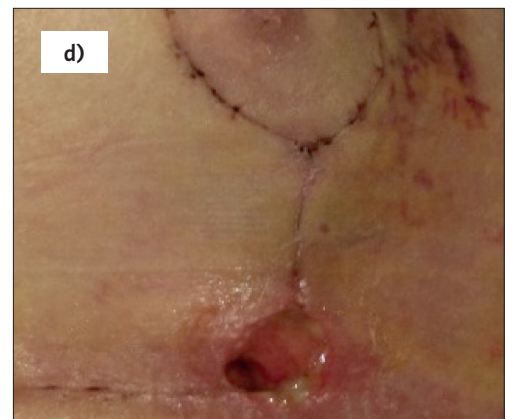
a) WUWHS SWD Grade 1
Small area of dermal separation

b) WUWHS SWD Grade 1a
Post-mastectomy: small areas of dermal separation with inflammation and infection



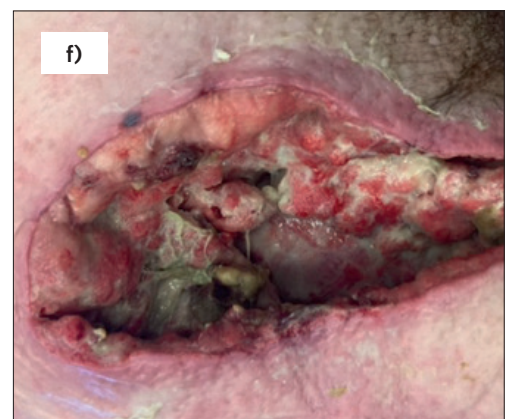
c) WUWHS SWD Grade 2
Obese patient with exposed subcutaneous tissue and tunnel into pannus following surgery for seatbelt trauma

d) WUWHS SWD Grade 2a
Post-mammoplasty: dermal separation with exposure of subcutaneous tissue with inflammation and purulent exudate



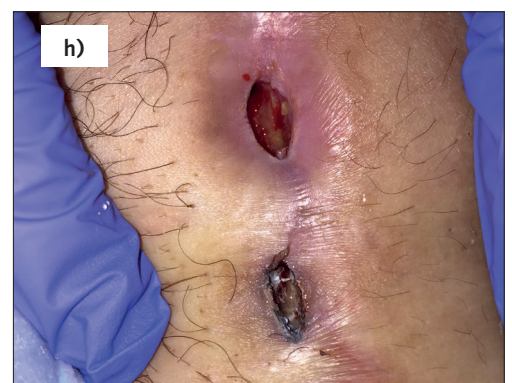
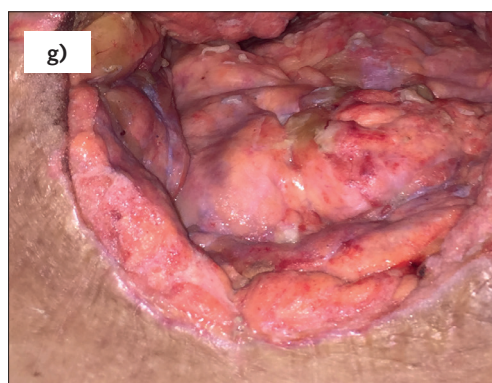
e) WUWHS SWD Grade 3
Post-spinal surgery: full length dehiscence with fascial exposure without signs of infection

f) WUWHS SWD Grade 3a
Leg incision: dehiscence exposing muscle and fascia with pus and cellulitis



g) WUWHS SWD Grade 4
Post-laparotomy: dehiscence with abdominal organ exposure and no signs of infection

h) WUWHS SWD Grade 4a
Separation of suture line with exposed hardware with inflammation and signs of infection



MANAGEMENT OF SWD

SWD can vary from a shallow area of a small proportion of an incision to the full depth of an entire incision with evisceration of organs or exposure of an implant. Even so, the goal of SWD management is usually closure of the wound.



The management of SWD should be tailored to the individual patient and often requires involving and working collaboratively with the patient, family, carers and wider multidisciplinary team



Before planning management, it is essential that the clinician has a clear understanding of the structures (e.g. implants, vital organs or bone) located directly beneath the dehisced wound to ensure correct management and to avoid exacerbating the patient's condition or causing a more serious complication

The principles of management of SWD include:

- Reassurance, management of expectations and education
- Pain management
- Removal or amelioration of risk factors that may have contributed to SWD or that may compromise healing
- Management of systemic infection
- Local management of the dehisced wound, including management of local infection.



The objectives of treatment and the management plan should be fully documented and discussed with the patient, carers and family

Figure 10, page 21, provides an overview of the management of SWD and Figure 11, page 22, details local management according to WUWHS SWD Grade.

Reassurance, management of expectations and patient education

SWD is potentially frightening for patients, even if a relatively small proportion of the incision is involved. Patients will need to be reassured with an explanation tailored to their needs and understanding of what has happened, the possible reasons for it happening, the actions to be taken and the longer-term outlook. Patients should be encouraged to voice any concerns and may find it valuable to talk to a patient who has experienced similar issues.



Education of a patient with SWD should include signs and symptoms of infection (if not already present), how to avoid putting additional stress on the incision, advice about activity levels, and individualised instructions on what to do and who to contact if the condition of the wound or patient deteriorates

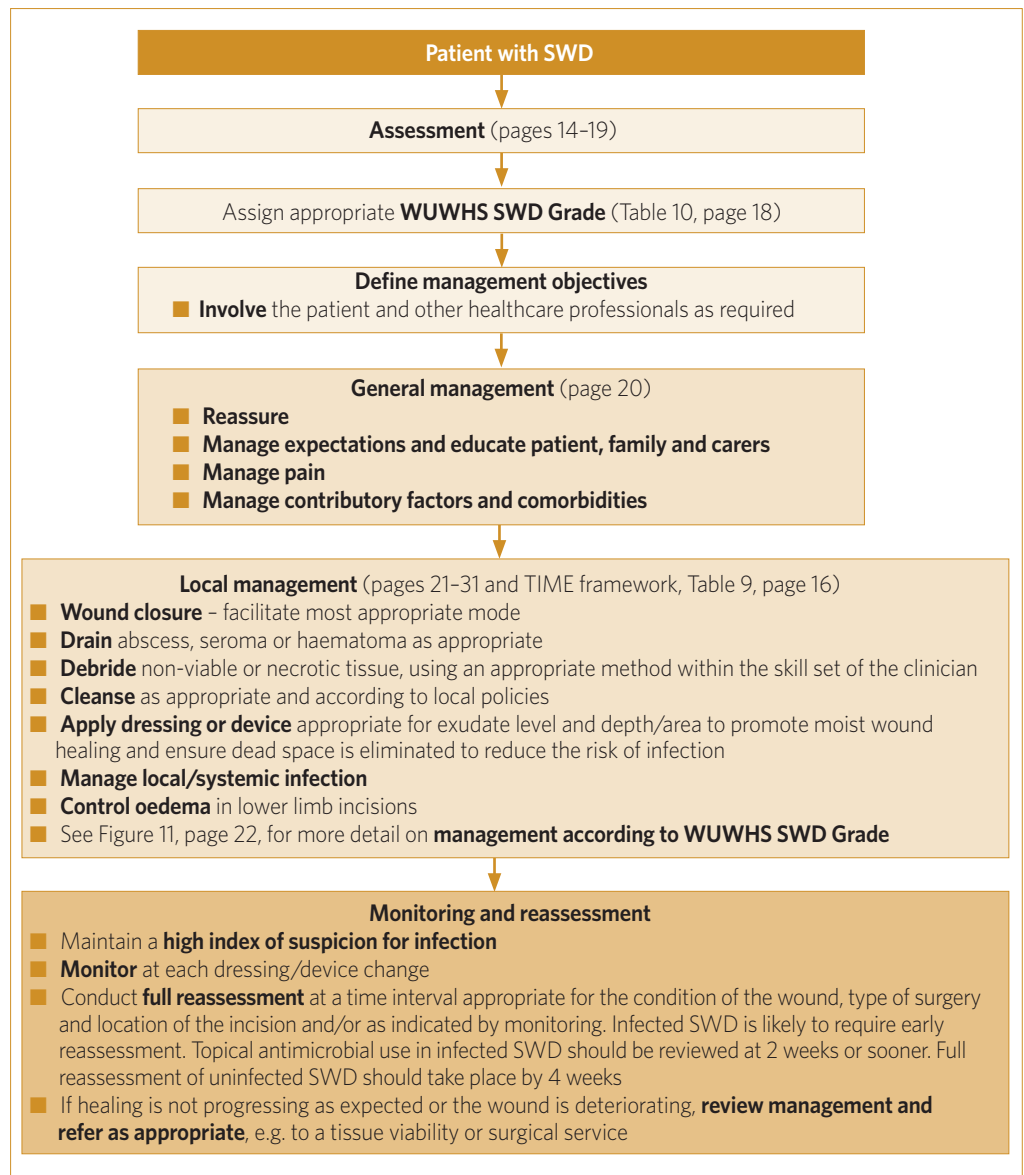
Pain management

Pain management should include management of background pain and pain associated with dressing/device changes and debridement. Pharmacological and non-pharmacological measures should be considered, including education and careful selection of dressings, change frequency and change technique to minimise pain and trauma^{111,112}. The World Health Organization's three-step cancer pain ladder for adults can be applied to the management of pain in other contexts and may be useful in guiding appropriate pharmacological therapy (www.who.int/cancer/palliative/painladder/en/).

Management of comorbidities and contributory factors

Any modifiable factors that might have contributed to SWD or that may impede healing, e.g. chest infection, poor blood glucose control in patients with diabetes mellitus, smoking and inadequate nutrition, should be addressed.

Figure 10 | Overview of the management of SWD



Local management of SWD

The local management of SWD is dependent on a range of factors including the:

- **Severity of the dehiscence** - e.g. depth/WUWHS SWD Grade and exposure of viscera, bone or implants
- **Presence of infection**
- **Timing of the dehiscence** in relation to the surgery that produced the incision
- **Presence of comorbidities** that increase the risk of surgical site complications and/or impair healing.



The results of the holistic assessment will indicate appropriate treatment objectives and guide management planning

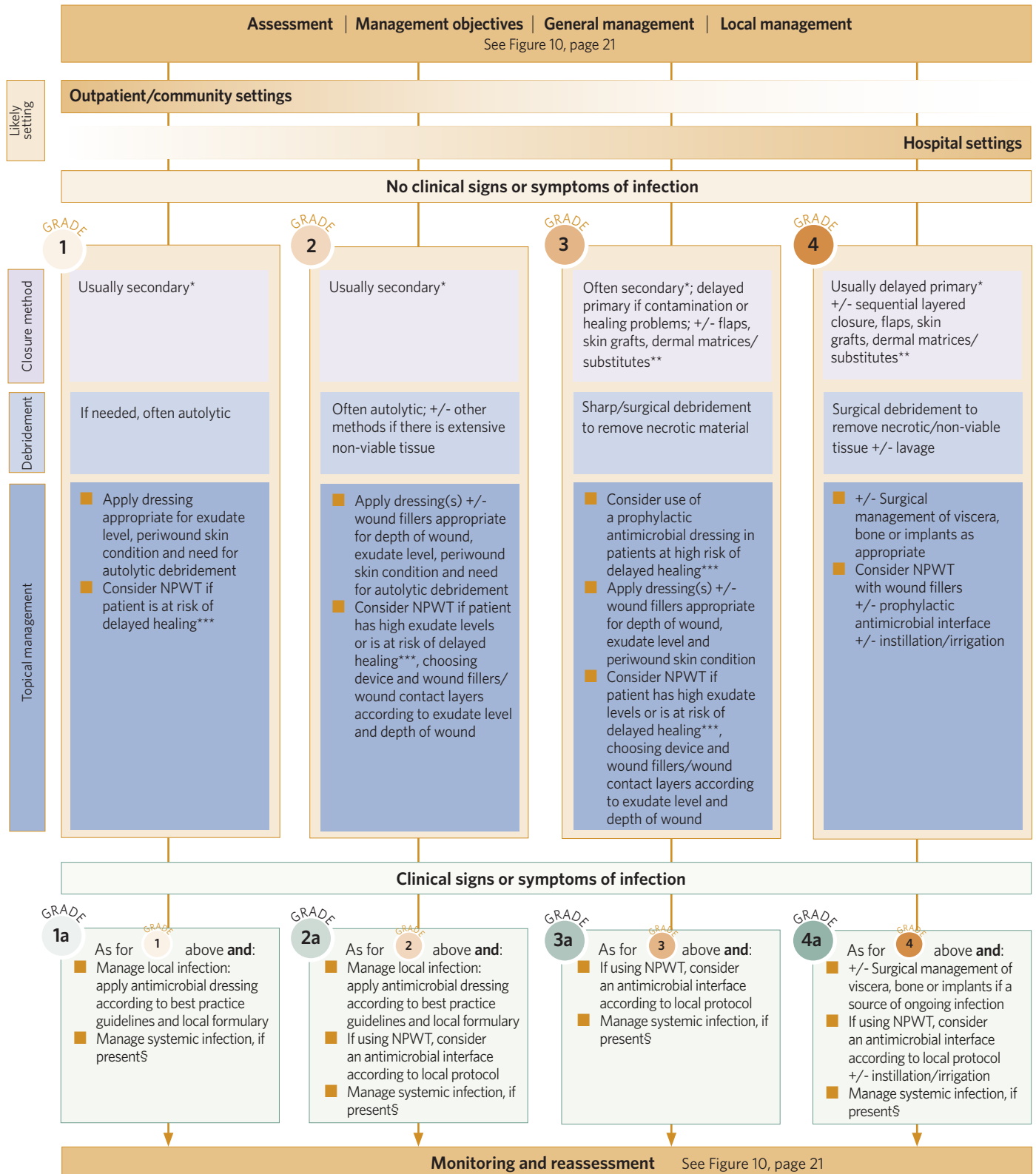


Local management of a dehisced wound can be guided by application of the TIME Framework (Table 9, page 16) with consideration of removal of non-viable tissue (debridement), management of infection, exudate control and promotion of moist wound healing

CONSENSUS DOCUMENT

Figure 11 | Local management of a dehisced wound according to WUWHS SWD Grade

See Table 10, page 18, for the WUWHS SWD Grading System, and the vignettes on page 31 for examples of management of different grades of SWD.



*Primary closure may be appropriate if SWD occurs <48 hours after surgery for technical reasons and is not otherwise contraindicated

**Dermal matrices/substitutes should not be used in the presence of wound infection

***See Box 4, page 7, for examples of factors that may delay healing

\S Manage systemic infection according to best practice guidelines, taking into account local policies and results of any microbiological culture and sensitivity reports

Method of closure

An important initial decision in the management of SWD is about the most appropriate method for achieving closure of the wound. This will largely depend on timing in relation to the surgery that produced the incision, the depth of the dehiscence (i.e. WUWHS SWD Grade), the location of the incision and whether infection is present.

Primary closure

Primary closure following SWD (Figure 12) may be indicated if:

- SWD has occurred within 48 hours of surgery and is clearly the result of a technical issue, e.g. sutures have come undone, clips were not properly applied
- No other problems have contributed to the SWD – i.e. there is no undue tension on the incision and there are no signs of infection
- The patient is not at increased risk of surgical site complications.

Secondary closure

Secondary closure (Figure 12) is frequently used in superficial SWD with or without infection, e.g. WUWHS SWD Grades 1, 1a, 2 and 2a. It may also be used in deeper dehiscence, e.g. WUWHS SWD Grades 3 and 3a, and occasionally WUWHS SWD Grades 4 and 4a, where there is a high risk of SSI, infection is present, or where primary closure is not possible, e.g. because of tissue loss.

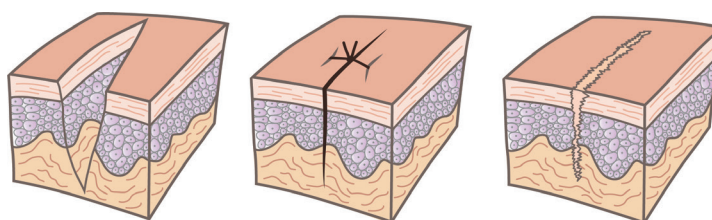
Delayed primary closure

Delayed primary closure (Figure 12), sometimes referred to as healing by tertiary intention, is mainly used in the management of deeper SWD, e.g. WUWHS SWD Grades 3, 3a, 4 and 4a, where the incision is contaminated or infected, or where the risk of recurrence of dehiscence is high because of comorbidities or subcutaneous/visceral swelling that would put tension on a resutured incision. When the time for primary closure arrives, a flap or skin graft may be used if a tissue defect remains.

Figure 12 | Healing of surgical incisions by primary, secondary or tertiary intention (adapted from^{8,113})

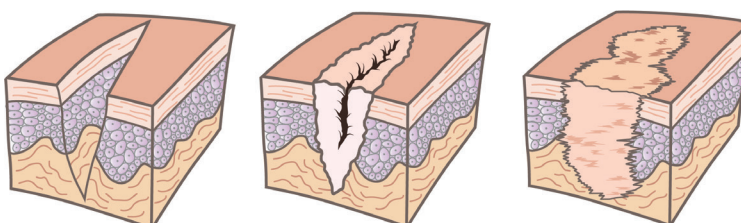
Primary closure

The edges of the incision are closely opposed, e.g. by suturing, stapling or taping, to allow healing by primary intention



Secondary closure

The incision is left open and heals by secondary intention as new tissue infills from the base and sides of the wound



Delayed primary closure

The incision is left open for up to several days or sometimes weeks, to allow for treatment of infection/contamination, removal (sequentially if necessary) of non-viable tissue, and/or for resolution of swelling, before proceeding to primary closure or closure with a flap/graft

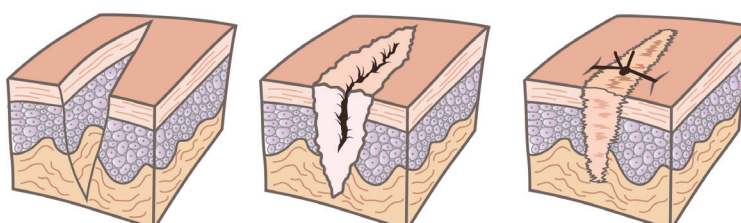




Figure 13 | Abscess under an abdominal incision draining

Management of abscess, seroma and haematoma

The collection of fluid, whether pus, serous fluid or blood, under a closed incision may increase incisional tension and the risk of SWD. Abscesses (Figure 13) should be drained to remove pus and a potential source of ongoing infection. Seromas and haematomas may resolve spontaneously. However, depending on the size, location and impact on the incision, seromas and haematomas may require aspiration or the insertion of a drain.

Debridement

Necrotic and non-viable tissue and foreign material in a dehiscence can act as culture media and foci for bacterial growth and the formation of biofilm and so increase the risk of infection and impaired healing⁹⁷. The presence of microbial biofilm in the incision may be related to up to 80% of SSIs¹¹⁴.

Debridement removes non-viable tissue and foreign material, reducing bioburden, biofilm and inflammatory stimulus. Particularly in sharp or surgical debridement, debridement also stimulates the release of growth factors involved in healing.



There are several methods of debridement (Table 11). Clinicians should work within the limits of their competency when conducting debridement and refer the patient on if a debridement method beyond their competency is required¹¹⁵

Autolytic debridement is often sufficient for dehiscence incisions graded as WUWHS SWD Grades 1/1a and 2/2a. Sharp or surgical debridement are likely to be the most appropriate methods for dehiscence incisions graded as WUWHS SWD Grades 3/3a and 4/4a.

Box 9 | Factors affecting choice of topical antimicrobial type and formulation

- Allergies/sensitivities
- Previous topical antimicrobial use on current wound
- Length, width and depth of the wound
- Use in conjunction with another device - e.g. negative pressure wound therapy (NPWT)
- Exudate level
- Periwound skin condition
- Anticipated dressing change frequency
- Availability
- Cost

Table 11 Main debridement techniques used in dehiscence wounds ¹¹⁵⁻¹¹⁷	
Technique	Description and notes
Autolytic	<ul style="list-style-type: none"> ■ Devitalised tissues are softened and liquefied by enzymes occurring naturally in the wound ■ Facilitated by dressings that support a moist wound environment ■ Selective and non-invasive ■ Can be used before/between other methods of debridement
Mechanical	<ul style="list-style-type: none"> ■ Wet to dry dressings: a moist gauze pad is applied to the wound. As it dries, devitalised tissue becomes attached and is removed with the gauze ■ Monofilament pad or debridement cloth: devitalised tissue is detached and removed through vigorous cleansing of the wound with the pad or cloth; can be used with autolytic debridement
Sharp	<ul style="list-style-type: none"> ■ Devitalised tissue is removed using a scalpel, scissors and/or forceps ■ Quick and selective ■ Requires specialist training; may require local anaesthesia
Surgical	<ul style="list-style-type: none"> ■ Excision of non-viable tissue from wound margins back to viable healthy tissue ■ Selective ■ Requires specialist training; may require general anaesthesia and an operating room
Larval	<ul style="list-style-type: none"> ■ Prepared larvae of the green bottle fly (<i>Lucilia sericata</i>) placed in the wound ingest devitalised tissue and bacteria ■ Selective
Ultrasonic	<ul style="list-style-type: none"> ■ Ultrasound energy is used to break up devitalised tissues; the fragments are washed out with an inbuilt irrigation system ■ Quick and selective ■ Requires specialist training
Hydrosurgical	<ul style="list-style-type: none"> ■ A high-pressure jet of saline is used to cut away devitalised tissue ■ Relatively selective and quick ■ Requires specialist training

Cleansing

Wound cleansing aims to remove loose debris, slough, microbes and the remnants of previous dressings from the wound and the surrounding skin¹¹⁸. Cleansing agent selection should be guided by local policy. Cleansing agents include potable water (i.e. water that is safe to drink) or sterile saline^{119,120}.

If the wound is infected, an antimicrobial irrigation solution may be considered for cleansing¹¹⁸. However, the role of antimicrobial irrigation solutions in the management of infected wounds has not yet been fully elucidated.

Management of systemic infection

Patients with systemic signs and symptoms of SSI or erythema extending >5cm from the incision with induration or necrosis should receive a course of systemic antibiotics¹⁰⁰. The antibiotics should be selected according to the location of the incision, local antibiotic policy and resistance patterns, and the results of microbiological analysis^{100,121}.



Systemic antibiotics are not usually recommended for the management of a patient with SWD who has only local signs and symptoms of infection. However, this may not apply if the infection is in an incision in which it is important to prevent spreading infection because the consequences may be severe, e.g. a sternomy incision

Local management of infection

In keeping with guidance on the management of SSI, sutures and clips remaining in a partially dehisced wound should be removed from areas of the incision in which there are signs and symptoms of infection, including abscess¹⁰⁰.



Suture/clip removal in a partly dehisced incision should be approached with caution as it may result in expansion or new areas of SWD. Removal should be conducted by a clinician with the appropriate competency and in a care setting that has the facilities to manage the consequences of further dehiscence as appropriate for the location of the incision

Topical antimicrobials

Topical antimicrobial agents have two main roles in the management of SWD:

- Management of local infection
- Prevention of infection in patients with SWD who are at increased risk of infection.

A wide range of antimicrobial agents is available for use in wounds, including iodine, silver and polyhexamethylene biguanide (PHMB)¹²². Antimicrobial agents are available in several formulations, including antimicrobial-impregnated dressings (as flat sheets, ribbons or ropes), pastes, gels, powders and irrigation solutions. The properties of an ideal antimicrobial dressing include fast and continued release of the antimicrobial agent into the wound environment to achieve rapid onset and sustained bactericidal activity¹²³. Box 9, page 24, lists the factors that will influence choice of antimicrobial type and formulation.

Two-week challenge

Topical antimicrobials should not be used indefinitely⁹³. Use should be reviewed after two weeks (the '2-week challenge') if monitoring has not indicated that review should take place sooner. If after two weeks the SWD has improved, the antimicrobial should be discontinued. If the SWD has not improved, the patient and the wound should be reassessed and consideration given to changing the topical antimicrobial to a different agent for a further 2-week challenge³³.



Topical antimicrobials should be used according to the principles of the '2-week challenge'

Moist wound healing and exudate management

Dressings applied to areas of SWD need to:

- Maintain a moist wound environment to support healing while absorbing excess exudate that could act as a medium for bacterial growth or cause periwound maceration
- Protect the dehisced wound from external contamination and further ingress of microbes.

As discussed above, a dressing may also be used as the delivery vehicle for a topical antimicrobial or as a means of facilitating autolytic debridement.

The dressing selected should be of an absorbency that maintains a moist wound environment without leakage or causing periwound skin damage and that allows for a suitable interval between dressing changes⁹⁹. Ideally, dressing change frequency should tally with the need for wound monitoring: wounds that are infected require more frequent monitoring than uninfected wounds and so are likely to require more frequent dressing changes.

The performance of an individual dressing is affected by the type and quantity of material from which it is constructed. Therefore, it is difficult to make generalisations about the absorbency and exudate handling capability of different dressings. To compound the issue, dressings often combine material types. In very general terms, dressings containing foam, alginate or carboxymethylcellulose are suitable for management of medium to high exudate levels⁹⁹.

**The properties of an individual dressing are highly reliant on its construction and constituent materials**

The elimination of dead space in deeper SWD is important to prevent accumulation of fluid that may increase risk of infection. Wounds of WUWHS SWD Grades 2 and 3 being treated with dressings will need to be filled with a dressing material (e.g. in rope, ribbon, strip or paste form) appropriate for exudate level. A secondary dressing will be necessary to keep the filler in place. Dehisced wounds of WUWHS SWD Grade 4 are, at least initially, unlikely to be treated with dressings alone.

**The dressing(s) selected for an area of dehiscence should be appropriate for the exudate/drainage level and depth of the wound and for the anticipated dressing change frequency****NPWT**

Negative pressure wound therapy (NPWT) (Box 10, page 27) is particularly suitable for highly exuding, deep or complex dehisced wounds. NPWT fulfils the needs for moist wound healing, exudate/drainage management, elimination of dead space and protection from external contamination in the facilitation of healing by secondary or tertiary healing after SWD.

NPWT has been used for the management of a wide range of acute and chronic wound types for more than 20 years¹²⁴⁻¹²⁸. The extent of the evidence and clinical experience behind this treatment modality has resulted in NPWT being suggested as the 'gold standard treatment' for open abdominal wounds and dehisced sternal wounds¹²⁹.

The considerable number of studies that have investigated the use of NPWT on infected surgical wounds often include mixed populations of patients with and without SWD. Reports focusing largely on the role of NPWT in SWD include for:

- Abdominal wound dehiscence^{51,130,131}
- Post-sternotomy dehiscence^{3,132}
- Post-caesarean dehiscence^{133,134}
- Perineal dehiscence¹³⁵
- Dehiscence after amputation^{136,137}

Box 10 | Negative pressure wound therapy (NPWT) in open wounds^{20,145,146}

- NPWT involves the application of controlled negative pressure (suction) over an open wound (or closed surgical incision*) and perilesional tissues
- A wound filler, e.g. foam or gauze, and sometimes a liner, is placed in the wound and an adhesive film is used to cover the wound and form a seal
- The seal allows delivery of suction generated by an electrically-powered pump (that contains batteries or is plugged into a mains electricity source) or by a mechanically-powered pump
- NPWT devices vary in size, portability and format, e.g. some include a canister of varying volume for collection of fluids while others employ absorption and evaporation for fluid handling; some are designed for single-use
- Some single-use NPWT (sNPWT) devices that use the dressing for fluid management and as a wound interface allow wider coverage of the periwound area
- Some NPWT devices for use in open wounds incorporate instillation of solutions such as normal saline or antimicrobials

*For information on the mode of action of NPWT in closed surgical incisions, see page 36

- Dehiscence following vascular surgery¹³⁸
- Dehiscence following spinal surgery¹³⁹.

More recently, the use of NPWT over closed surgical incisions has been shown to reduce rates of SSI, seroma/haematoma and dehiscence, and to improve scar quality^{140,141}.

Mode of action

NPWT applies controlled negative pressure to a wound or incision, provides a physical barrier to external contamination and removes excess wound drainage. In addition, in open wounds NPWT aids healing by:

- Contracting wound edges to reduce wound size
- Stimulating angiogenesis and granulation tissue formation
- Reducing oedema
- Improving tissue perfusion¹⁴²⁻¹⁴⁵ (Figure 14).

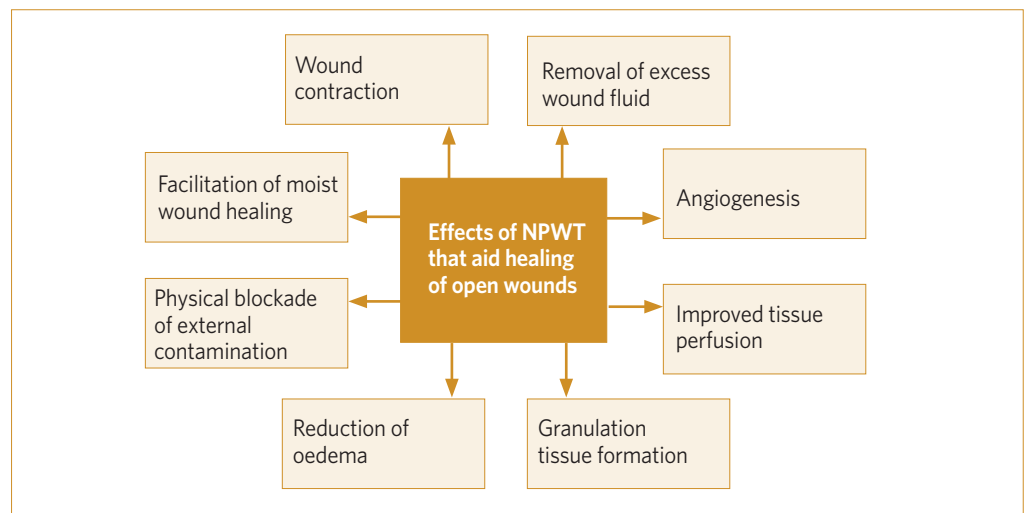


Figure 14 | Mode of action of NPWT in open wounds

Role of NPWT in the management of SWD

NPWT has several potential roles in the management of SWD, e.g. following primary closure of the dehisced wound, during healing by secondary intention and in preparation for delayed primary closure (Figure 15, page 28 and Figure 16, page 29). The type of NPWT device selected is dependent on several factors (Box 11, page 28).



NPWT has been widely used in the management of SWD and is increasingly being used to prevent SWD



NPWT should be used in the context of appropriate wound bed preparation (debridement) and management of infection, if present



Risk of delayed healing (Box 4, page 7) may be an indication for the use of NPWT in the management of patients with SWD



With the increasing use of closed incision NPWT for prophylaxis of surgical site complications, some patients with SWD may previously have received this treatment modality. The potential benefits and harms of using NPWT again on previously treated dehisced wounds are not yet known, and some clinicians would approach reuse of NPWT with caution

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Box 11 | Factors involved in selecting the type of NPWT for use in the management of SWD

- **Contraindications and cautions** (Box 12, page 29) – clinicians should always consult the manufacturer’s instructions for the NPWT device under consideration before implementing use in a patient
- **Location of the incision/dehiscence** – the dressing needs to be able to conform to the three-dimensional shape of the anatomical area sufficiently well to avoid dead space and to form the seal needed for NPWT to work
- **Volume of wound drainage** – the device selected should be able to cope with the anticipated volume of drainage, e.g. if wound drainage is <300ml/week canister-less single-use NPWT (sNPWT) may be appropriate; if drainage is >300ml/week a canister-based device of appropriate capacity will be more suitable
- **Depth of the wound** – e.g. some sNPWT devices should be used on wounds with a maximum depth of 2cm; some sNPWT devices cannot be used with fillers
- **Size (area) of the wound** – the NPWT device selected must be appropriate for the size (area) of the wound
- **Infection** – an antimicrobial interface may be required and should be compatible with the NPWT device being used; if NPWT with instillation is selected, the device needs to be instillation-capable
- **Care setting** – the NPWT device selected should be of a type that can be cared for appropriately and safely in the setting in which it will be used
- **Patient needs and acceptance** – e.g. patients who are active or able to return to work are likely to prefer a portable sNPWT device

NPWT and the management of infection

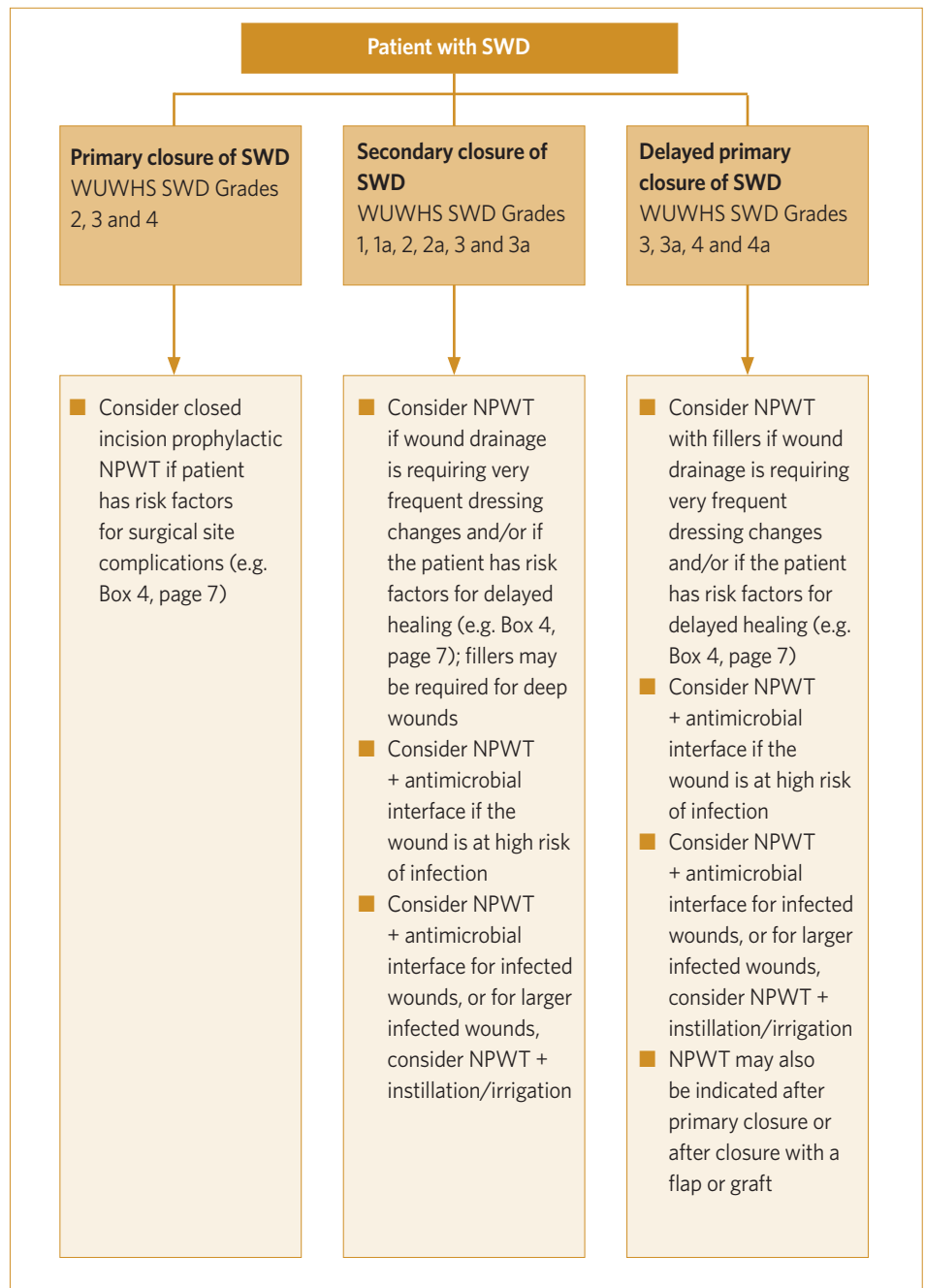
Recent recommendations on the use of NPWT state that NPWT should be used only as an adjunctive treatment in the management of wound infection¹⁴². The same recommendations comment that the use of antimicrobial dressings or fillers under NPWT, e.g. PHMB-impregnated gauze or silver-impregnated foam, may aid infection control¹⁴².



Clinicians should check the indications, contraindications and cautions for the specific NPWT device under consideration

Figure 15 | Potential roles of NPWT in the management of SWD

NPWT should be used in the context of holistic management of the patient (see Figures 10 and 11, pages 21 and 22) and take into account the contraindications/cautions for the NPWT device being considered.



Box 12 | Examples of contraindications and cautions in the use of NPWT^{129,147}

- Necrotic tissue with eschar
- Osteomyelitis
- Non-enteric and unexplored fistulae
- Malignancy in the wound – unless part of palliative care
- Exposed blood vessels
- Exposed nerves
- Exposed anastomotic site
- Exposed organs
- Patients at high risk for bleeding – e.g. from a blood clotting disorder
- Patients on anticoagulants or platelet aggregation inhibitors
- Patients with:
 - Friable and infected blood vessels
 - Vascular anastomosis
 - Treated infected wounds
 - Sharp edges in the wound – e.g. bone fragments
 - Spinal cord injury
 - Enteric fistulae
- Patients requiring:
 - Magnetic resonance imaging (MRI)
 - Treatment in a hyperbaric oxygen chamber (HBOT)
 - Defibrillation
- Use near the vagus nerve (may cause bradycardia)

N.B. The information in this box is a generalised list of contraindications and cautions to the use of NPWT. Clinicians should check the contraindications and cautions for the specific NPWT device under consideration

**Figure 16 | WUWHS SWD
Grade 2 dehiscence treated
with NPWT**



a) Pre-application



b) Single-use NPWT applied

NPWT with instillation

NPWT with instillation has been developed to allow the delivery of topical solutions, such as saline and antimicrobial agents, to the wound bed while maintaining a seal over the wound. During the periodic introduction of the solution to the wound bed, the vacuum pump is halted for a short time, e.g. 20 minutes, and then restarted until the next episode of instillation¹⁴⁸.

NPWT with instillation may be used in the management of infection in acute and chronic wounds because it reduces bioburden¹⁴⁵. Much remains to be learnt about which instillation solutions to use, and when and for

how long, but a review of current evidence suggests that larger (area >40cm²) or deeper wounds and wounds that have high bacterial bioburden may be the most appropriate indications¹⁴⁵.

Changing NPWT modality

With the range of NPWT devices available there is scope for patients to be moved from one device to another as treatment progresses and therapeutic requirements change, e.g. as wound size, depth and/or exudate level decrease, the patient is discharged if in hospital, the patient becomes increasingly mobile and/or returns to work. The need for an alternative NPWT device should be assessed on an individual basis and with reference to local policy/wound care formulary where available. If appropriate, advice should be taken from tissue viability or medical teams.

NPWT in the community

A UK survey found that over half of patients with surgical wounds healing by secondary intention were cared for in community settings⁶³. Because of the trend for decreasing length of hospital inpatient stays and the development of portable NPWT devices, clinicians working in the community are increasingly likely to be involved in the care of patients with SWD who have been discharged with NPWT or who have commenced NPWT post-discharge¹⁴⁹.



Clinicians in the community play important roles in supporting, monitoring and managing patients receiving treatment with NPWT to ensure it is used safely, appropriately and effectively

Such involvement may involve liaising with clinicians in other services and managing transitions between NPWT devices and other methods of wound management as needed.

Patients being treated in community settings need information, education and training, as appropriate, about their NPWT device and how to use it. They also need to know how to contact a clinician and the general and SWD-related signs and symptoms and issues with the NPWT device should trigger contact¹⁵⁰.

Control of oedema

Inflammation, an integral part of the healing response following surgery, increases permeability of blood vessels and causes interstitial fluid accumulation that may manifest clinically as oedema. Post-operative swelling due to oedema may particularly be a problem in lower limb surgery, e.g. following ankle surgery or saphenous vein harvesting, and may contribute to SWD because it delays healing²⁹.



Control of oedema in patients with lower limb SWD may aid healing

Strategies to reduce oedema include limb elevation and/or the use of compression therapy, e.g. bandages, compression stockings or intermittent pneumatic compression¹⁵¹. The ankle-brachial pressure index (ABPI) of patients being considered for lower limb compression therapy should be ascertained to assess arterial blood supply¹⁵¹.

Monitoring and reassessment

Patients with SWD should be monitored carefully at each dressing or device change, including for signs and symptoms of infection. Management should be adjusted as indicated by the reassessment and if necessary referrals made to a tissue viability or surgical service.



A full reassessment of the dehisced wound and current management should take place at two weeks for infected SWD and at four weeks for uninfected SWD unless monitoring indicates the need for full reassessment sooner

Vignette 1: WUWHS SWD Grade 1a

Courtesy of Caroline Dowsett



- 60-year-old woman
- WUWHS SWD Grade 1a of the dermal layer that affected a 2cm section of an otherwise healed incision following laparotomy 10 days previously
- Draining pus; no signs of systemic infection
- Local wound infection resolved after treatment for one week with a topical antimicrobial (silver) dressing
- After discontinuation of the silver dressing, a foam dressing was applied
- Wound was fully healed within 3 weeks of presentation

Vignette 2: WUWHS SWD Grade 2

Courtesy of Caroline Dowsett



- 45-year-old woman
- WUWHS SWD Grade 2 of the dermal layer and subcutaneous layers affecting over 50% of an incision made 8 days previously for removal of a non-malignant breast lump
- No clinical signs or symptoms of infection
- Wound was packed with an alginate dressing and a secondary foam dressing was applied
- Wound was fully healed 2 weeks later

Vignette 3: WUWHS SWD Grade 3

Courtesy of Risal Djohan



- 58-year-old man
- WUWHS Grade 3 SWD affecting the full length of the incision with separation of the full thickness of the skin and subcutaneous tissue and fascial exposure, following spinal surgery 3.5 weeks previously
- Wound was clean and not infected
- Plastic surgery team was consulted and the patient returned to the operating room, where he underwent tissue undermining and paraspinous muscle mobilisation, layered tissue closure, drain insertion and NPWT over the closed incision
- Wound was fully healed within 2 weeks of presentation

Vignette 4: WUWHS SWD Grade 3a

Courtesy of Risal Djohan

- 62-year-old man
- WUWHS Grade 3a SWD of approximately 50% of the incision with separation of the skin and subcutaneous tissue and fascial exposure, following spinal surgery 5 weeks previously
- He had developed haematoma and dehiscence after discharge home. His re-presentation was delayed because he lived a considerable distance from the hospital
- Wound contained pus; there were no signs of systemic infection
- Local wound care was performed with antimicrobial wound dressing changes followed by wound closure with trapezius flap
- Wound was fully healed within 6 weeks of presentation



Vignette 5: WUWHS SWD Grade 4

Courtesy of Fiona Downie

- 70-year-old woman
- WUWHS SWD Grade 4 mechanical dehiscence of a sternal incision that extended to sternal bone following CABG 6 days previously
- Minimal serous exudate; no signs of local or systemic infection
- Had decided not to wear her bra post-operatively, which would have offered support to the incision
- NPWT was commenced with foam filler (no liner) at -120mmHg; discontinued 10 days later
- Wound was then managed with a carboxymethylcellulose and foam adhesive dressing until fully healed at 3 weeks
- Patient was advised to wear her bra and not to undertake any heavy lifting or pulling/pushing for up to 12 weeks post-healing



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PREVENTION OF SWD

The large number of risk factors associated with SWD (Table 6, page 10, and Table 7, page 11) provide multiple opportunities before, during and after surgery to implement interventions that aim to reduce risk.



Keys to prevention of SWD are identifying patients at risk, modifying risk of SWD and SSI where possible, implementing preventative measures, and post-operative monitoring for healing progress and signs of infection or possible dehiscence (Figure 17)

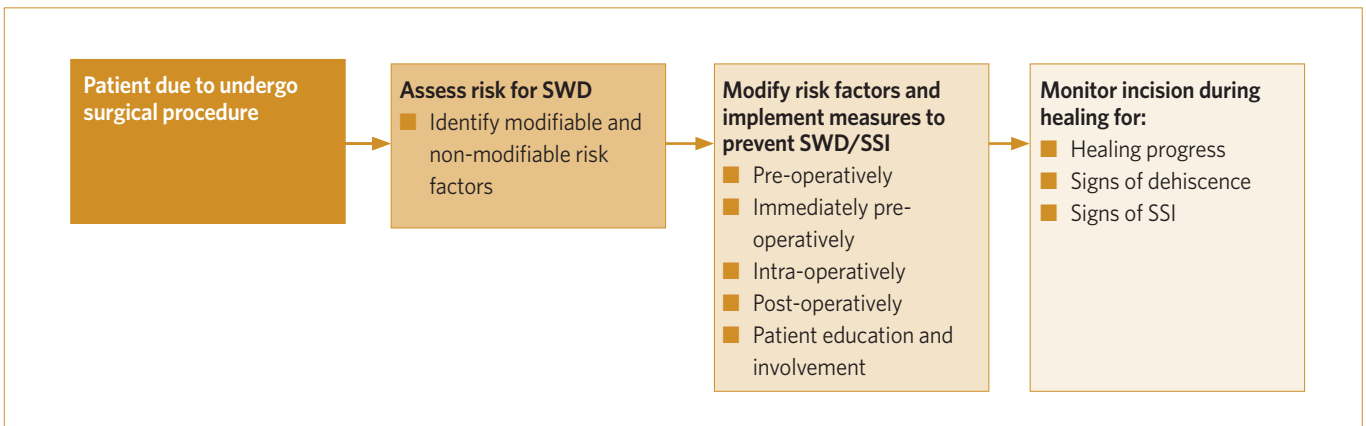


Figure 17 | Principles of SWD prevention

Risk assessment

In elective surgery, pre-operative consultations provide opportunities for thorough risk assessment. The risk assessment can then be used to explain to a patient their individual level of risk for SWD and other post-operative complications, and to plan risk reduction for patient-related modifiable risk factors (such as high BMI and smoking).

In emergency surgery, risk assessment also has an important role. However, opportunities for discussion of risk levels and amelioration of patient-related modifiable risk factors may be limited.



Risk for SWD should be assessed pre-operatively and taken into account when planning surgery. Depending on the indication for surgery, if risk of SWD is high, thought may need to be given to whether surgery remains appropriate

Calculators of risk for SWD

In practice, risk for SWD is often ascertained pre-operatively by clinical observation. However, risk calculators can be used to provide an objective assessment of risk.

Risk calculators specific to SWD

Two scoring systems have been developed and validated for the evaluation of risk for SWD in patients undergoing laparotomy: the Veterans Affairs Medical Center (VAMC) and Rotterdam risk models^{16,66} (Appendix 3, page 40). Both models include post-operative variables, and the VAMC model includes intra-operative variables, suggesting there may be limitations in using these models for pre-operative risk assessment for SWD. A further unvalidated scoring system of risk for SWD has also been developed¹⁵ (Appendix 3, page 40).

A comparison of the VAMC and Rotterdam risk models concluded that both can be used to predict abdominal SWD⁴. A further study of the Rotterdam risk model reported that the global risk score (i.e. the score using all variables) had better accuracy than the pre-operative risk score (i.e. the score that excluded the post-operative variables)¹⁵².

Box 13 | Examples of tools for assessment of risk for SSI

- **National Nosocomial Infection Surveillance (NNIS) Risk Index¹⁵³** – which uses American Society of Anesthesiologists (ASA) pre-operative physical status class, surgical wound classification (see below) and operation duration to provide an indication of risk for SSI on a scale ranging from 0 to 3
- **Surgical wound classification³⁴** – classifies surgical wounds as ‘clean’, ‘clean-contaminated’, ‘contaminated’ or ‘dirty or infected’ according to type of surgery and wound characteristics; clean wounds have the lowest risk and dirty wounds have the highest risk of SSI
- **American College of Surgeons online calculator¹⁵⁴** (www.riskcalculator.facs.org) – estimates risk of a range of 11 post-operative outcomes, including SSI (but not SWD), according to surgical procedure and about 20 patient-related variables, e.g. age, sex, weight, height, functional status and comorbidities
- **Society of Thoracic Surgeons (STS) risk calculator^{155,156}** (<http://riskcalc.sts.org/stswebriskcalc/#/>) – for valve and coronary artery surgery; outcomes include risk for deep sternal wound (DSW) infection
- **EuroSCORE^{157,158}** (www.euroscore.org/calc.html) – originally developed to predict 30-day mortality after cardiac surgery; EuroSCORE values have been found to correlate with risk for SSI in patients undergoing coronary artery bypass grafting (CABG)

Risk calculator that includes SWD

The Breast Reconstruction Risk Assessment (BRA) tool (www.brascore.org) uses a range of patient-related factors including height, weight, age, chemotherapy, comorbidities and bleeding risks to calculate risk for a range of surgical complications for a range of reconstructive modalities. Risks calculated include for dehiscence, SSI and seroma⁴¹.

Assessment of risk for SSI

SSI is a major risk factor for SWD. Tools that indicate increased risk for SSI (Box 13) may therefore indicate increased risk for SWD.



The outcome of pre-operative risk assessment for SWD and other post-operative complications along with the specific risk factors identified should be clearly documented and communicated to all members of the team caring for the patient before, during and after surgery

Reducing risk of SWD

Reducing risk of SWD includes pre-operative modification of comorbidities and optimisation of patient condition, excellent surgical technique, selection of the appropriate closure method, oedema prevention or reduction, minimisation of SSI risk, post-operative monitoring and patient education.

Comorbidity risk modification

Patients should be referred as appropriate for pre-operative risk modification, e.g. weight loss and smoking cessation programmes, improved control of diabetes mellitus, nutrition management. In emergency surgery, however, opportunities to influence modifiable risk factors will be more limited.

In some cases, it may be appropriate to delay surgery to reduce the risk of SWD, e.g. to allow more time for the patient to lose weight and cease smoking or to recover from radiation therapy.



Involvement in attempts to and goal-setting for modification of patient-related risk in the lead up to surgery can encourage patients to take on some responsibility for the course of their post-operative recovery and to become part of the team managing their condition and surgery

Surgical technique

Excellent surgical technique is likely to lessen the risk of SWD by reducing problems with healing, decreasing haematoma and seroma formation, and lessening the risk of SSI¹⁵⁹. Examples of excellent technique include gentle handling of tissues, meticulous control of bleeding, maintenance of blood supply, prevention of tissue drying, removal of devitalised or contaminated tissues, avoidance of dead space, and the use of an appropriate closure technique.

The wound closure technique selected for primary closure should be appropriate for the site of the incision and surgical procedure, and should ensure that the tissue layers are accurately apposed and tension across the incision is minimised. Minimising tension may require suturing of individual tissue layers and careful consideration of the spacing and length of the sutures.

For some patients, primary closure of the incision is not appropriate because of increased risk of SWD or other complications (e.g. infection, haemorrhage or abdominal compartment syndrome). In such cases, the incision may be left open (with an appropriate protective covering/device) until a time when closure is appropriate or possible¹⁶⁰.



Delayed primary closure of the initial incision may be used to avoid dehiscence in patients recognised to be at increased risk of SWD

Oedema reduction/prevention

Oedema may contribute to SWD because it may hinder healing by impairing tissue perfusion and increasing tension in the incision because of tissue swelling.



Gentle tissue handling during surgery, careful fluid management and treatment of infection may reduce the risk of SWD by decreasing oedema formation

Local cooling of the incision, e.g. through the application of icepacks (cryotherapy), is often used to reduce pain following orthopaedic surgery, but may also reduce oedema. Compression may also help to reduce oedema formation and has been reported to reduce surgical wound complications following total ankle arthroplasty¹⁶¹. Combinations of cryotherapy and compression may also be used¹⁶².



The ankle-brachial pressure index (ABPI) of a patient being considered for lower limb compression following surgery should be ascertained to exclude arterial insufficiency

Incision management

Epithelialisation of surgical incisions is usually complete, i.e. the wound is usually sealed, within 48 hours of surgery. Therefore, dressings applied to an incision are usually left in place for at least the first 48 hours post-operatively while being inspected regularly¹⁶³. The ideal post-operative dressing acts as a barrier to bacteria, is vapour-permeable (i.e. allows water to evaporate), allows monitoring of fluid accumulation, and has a low risk of causing trauma or blistering¹⁶⁴.

The World Health Organization (WHO) guideline on the prevention of SSI has made a conditional recommendation regarding NPWT: "The panel suggests the use of prophylactic negative pressure wound therapy (pNPWT) in adult patients with primarily closed surgical incisions in high-risk wounds, for the purpose of the prevention of SSI..."¹⁶³. NPWT on closed incisions has been reported to also decrease the incidence of SWD^{141,165-168}. In common with many other wound products, research into NPWT is ongoing. The protocols for several randomised controlled studies have been published^{10,169-171} or are available at: clinicaltrials.gov.

Overview of interventions to reduce SWD and SSI

Several national and international guidelines aimed at reducing the occurrence of SSI have been developed^{121,163,172,173}. As there is overlap between the risk factors for SWD and those for SSI, and SSI can cause SWD, the interventions recommended in the guidelines on SSI prevention also have relevance to the prevention of SWD.

Table 12, page 35, and Appendix 4, pages 41-42, list interventions aimed at reducing risk of surgical site complications such as SWD and SSI arranged according to the phase (planning, pre-operative, intra-operative and post-operative) of surgery to which they relate.



The use of interventions to reduce the risk of SWD and SSI should take place in the context of a full assessment of the patient and the implementation of other safety interventions, e.g. prevention of deep vein thrombosis (DVT) and pressure ulcers (PUs)

Table 12 | Interventions for reduction of risk of surgical site complications such as SWD and SSI

See Appendix 4, pages 41-42, for more detail.

Phase	Intervention	Planning	Pre-operative	Intra-operative	Post-operative
Planning	Education of patient/carer/family and management of expectations	✓	✓		✓
	Assessment and management/optimisation of comorbidities - e.g. obesity, malnutrition, diabetes mellitus, COPD, anaemia, cardiovascular disease	✓	✓	✓	✓
	Screening for nasal carriage of <i>Staphylococcus aureus</i> and decolonisation according to local protocol - e.g. test patients undergoing cardiac surgery or surgery involving an implant (e.g. arthroplasty or breast implant) and those who are healthcare workers or institutional residents	✓			
	Management of bleeding/thrombotic risk in patients on oral anticoagulants	✓	✓	✓	✓
	Consider nutritional supplementation	✓	✓		✓
Pre-operative	Use of an operative safety checklist - e.g. WHO Surgical Safety Checklist		✓	✓	✓
	Maintenance of normothermia, unless otherwise indicated		✓	✓	✓
	Monitor and control blood glucose of patients with diabetes mellitus		✓	✓	✓
	Showering or bathing by patient on day of surgery using plain or antimicrobial soap/cleanser		✓		
	Use of clippers (rather than a razor) for hair removal		✓		
	Location of heparin injection sites away from operative site		✓		✓
	Management of hydration/fluid levels to produce normovolaemia, while avoiding fluid overload and hypovolaemia		✓	✓	✓
	Maintenance of adequate tissue perfusion		✓	✓	✓
	Timely administration of prophylactic antibiotics as indicated by local guidelines		✓	✓	✓
	Administration of antifibrinolytic agents as indicated by local guidelines to reduce blood loss and need for blood transfusion		✓	✓	✓
Intra-operative	Compliance with hygiene measures by operating room personnel			✓	
	Minimisation of operating room traffic			✓	
	Optimal oxygenation			✓	✓
	Skin preparation with an antiseptic immediately prior to incision			✓	
	Use of an iodophor-impregnated drape, unless the patient has an iodine allergy, if an incise drape is necessary			✓	
	Use of excellent surgical technique with gentle handling of tissues, meticulous control of bleeding and avoidance of dead space			✓	
	Avoidance of tension across incision			✓	
	Use of wound edge protectors/guards during laparotomy			✓	
	Intra-operative wound irrigation			✓	
	Change of gloves during procedure and/or before closure of wound; double gloving			✓	
	Senior/experienced surgeon performing closure			✓	
	Use of gentamicin-impregnated collagen sponges			✓	
	Use of triclosan-coated sutures			✓	
	Covering of the incision(s) with a dry absorbent sterile dressing under sterile conditions and before the patient leaves the operating room			✓	
Consider prophylactic NPWT (e.g. single-use NPWT) for patients at increased risk of SSI or SWD			✓		
Post-operative	Maintenance of the dressing over the incision for at least 48 hours unless there are signs and symptoms indicating earlier inspection is warranted				✓
	Cryotherapy (e.g. application of ice) and compression				✓
	Visitor restrictions and hygiene measures - e.g. hand cleansing/protective clothing as appropriate				✓
	Monitor incision for healing progress and signs/symptoms of dehiscence or infection				✓
	Patient Reported Outcome/Experience Measures (PROMS/PREMS) or questionnaires				✓
	Perform surveillance of post-operative wound complications and compliance with surgical wound complication reduction bundles				✓

CONSENSUS DOCUMENT

Box 14 | Effects of prophylactic NPWT on stresses in closed incisions

- During computer modelling, prophylactic NPWT reduced the lateral tension inherent in the incision by 45%-70%^{179,180}
- About 50% more force was required in a physical model to disrupt an incision to which prophylactic NPWT was applied than to disrupt an incision closed with sutures or clips^{179,180}
- Prophylactic NPWT increased the breaking strength of wounds in animal studies¹⁸¹⁻¹⁸³

Box 15 | Examples of higher consequence/higher incidence procedures for surgical site complications²⁰

- Complex surgery – e.g. major colorectal surgery, oesophagogastrectomy, extensive combined procedures which include a long skin-to-skin time, especially in redo or multiple redo procedures
- Arthroplasty revision
- Surgery involving high energy below knee fractures
- Major oncological procedures in children
- After radiotherapy

N.B. The procedures given here are examples and do not comprise a complete list of procedures which have a high rate of surgical wound complications that could have severe consequences, e.g. failure of surgery, life-changing implications and death. Individual patients undergoing the same procedure may experience different levels of risk and severity of consequences of surgical site complications as a result of variation in the presence of other risk factors

Prevention of SWD with prophylactic NPWT

In addition to roles in the management of surgical incisions healing by secondary intention or being managed with delayed primary closure, there is established and growing evidence that prophylactic NPWT, including single-use NPWT (sNPWT), reduces the incidence of surgical site complications, including SWD and SSI^{20,129,174}. A recent study of patients undergoing routine primary hip and knee replacements found that use of prophylactic sNPWT produced cost-savings in an analysis of all patients, with greater savings in subgroups of patients at higher risk of surgical site complications¹⁷⁵.

Mode of action of prophylactic NPWT on closed surgical incisions

In open wounds, NPWT has been found to have effects that may be relevant to closed incisions, e.g. stimulation of angiogenesis and reduction of oedema^{176,177}. In addition to aiding exudate management and protecting the incision from external contamination, prophylactic NPWT used in the management of closed surgical incisions has also been shown to¹⁴¹:

- Reduce lateral tension (Box 14)
- Improve lymphatic clearance
- Reduce seroma and haematoma formation¹⁴⁰.

Prophylactic NPWT may also have effects in the tissues surrounding the incision (the 'zone of injury') by reducing oedema and levels of inflammatory markers¹⁷⁸ and may promote collagen synthesis¹⁸³. Together these effects may contribute to faster and stronger healing, and reduced risk of SWD²⁰.

Effect of prophylactic NPWT on rates of dehiscence

Individual studies of prophylactic NPWT, including studies of sNPWT, in orthopaedic and breast surgery and a recent meta-analysis of effect in a range of surgery types have found significant reductions in rates of SWD^{141,165-168} (Table 13, page 37). However, other published systematic reviews and meta-analyses have found that study heterogeneity prevented analysis or that the evidence for reductions in SWD is inconclusive^{35,140,184-187}. Protocols for ongoing trials into the effect of prophylactic NPWT on rates of SWD have been published^{10,171}.

Selecting patients for prophylactic NPWT

Figure 18, page 37, proposes a role for prophylactic NPWT in the prevention of SWD in patients likely to be at increased risk. It is an adaptation of the proposed role of NPWT for the prevention of surgical site complications in closed surgical incisions that appears in a recent international consensus document²⁰.

The prophylactic NPWT device selected will depend on factors including the location and size of the closed surgical incision, the anticipated level of drainage from the incision, and the other needs of the patient. For example, a canister-less prophylactic sNPWT device may be selected for a patient who has a closed surgical incision that is likely to have low levels of drainage and who is able to regain mobility and return to work soon after surgery.

For more information on the evidence for and practicalities of using prophylactic NPWT in closed incision management, see: World Union of Wound Healing Societies (WUWHS) Consensus Document. Closed surgical incision management: understanding the role of NPWT. Available at: www.woundsinternational.com

Post-operative patient education

Post-operatively, patients should be advised on appropriate levels of activity, dressing/device care, signs and symptoms of SWD and SSI, and when and who to contact with problems.

Table 13 | Reductions in rates of SWD in studies of prophylactic NPWT on closed surgical incisions

Author	Type(s) of surgery	Details	SWD rates
Strugala & Martin, 2017 ¹⁴¹ (MA)	Mixed: breast, orthopaedic, caesarean section, coronary artery bypass graft	Meta-analysis of 6 studies; 1068 patients; 1291 incisions	n=611 NPWT*; n=680 control SWD: 12.8% vs 17.4% (p<0.05)
Stannard et al, 2012 ¹⁶⁵ (RCT)	Orthopaedic (lower limb)	249 patients; 263 fractures	n=141 NPWT**; n=122 control SWD: 8.6% vs 16.5% (p<0.05)
Galiano et al, 2014 ¹⁶⁶ (RCT)	Breast	199 patients; 398 incisions	n=199 NPWT*; n=199 control SWD at 21 days: 16.2% vs 26.4% (p<0.05)
Adogwa et al, 2014 ¹⁶⁷ (RS)	Orthopaedic (spine)	160 patients	n=46 NPWT**; n=114 control SWD: 6.38% vs 12.28% (p<0.05)
Holt & Murphy, 2015 ¹⁶⁸ (CS)	Therapeutic mammoplasty and symmetrising reduction	24 patients	n=24 NPWT*; n=24 control SWD: 4.2% vs 16.7% (p not reported)

*PICO Single Use Negative Pressure Wound Therapy (Smith & Nephew); ** V.A.C. (KCI/Acelity)

CS: case series; MA: meta-analysis; RCT: randomised controlled trial; RS: retrospective study

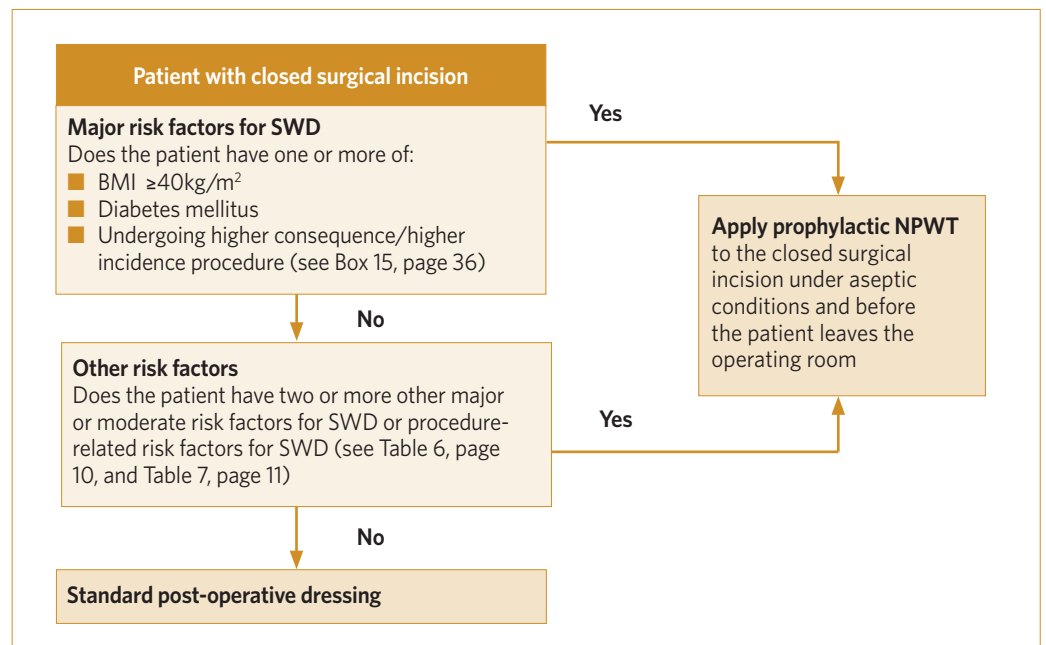


Figure 18 | Proposed role of prophylactic NPWT in the prevention of SWD

RESEARCH NEEDS

Evidence is accumulating of the large scale of surgical wound healing problems and the high economic and social costs they bring to healthcare systems and patients^{53,62,64}. More research is needed to further clarify the health economic impact of SWD, including incidence (associated and not associated with infection), quality of life data, costs of management in hospital and community settings and the impact of interventions to prevention SWD.

CONSENSUS DOCUMENT

Appendix 1. Centers for Disease Control and Prevention (CDC) definitions of SSI³⁴

Type of SSI	Definition
Superficial incisional SSI*	<p>Infection occurs within 30 days after any operative procedure (where day 1 = the procedure date) AND involves only skin and subcutaneous tissue of the incision AND the patient has at least one of the following:</p> <ol style="list-style-type: none"> purulent drainage from the superficial incision organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture- or non-culture-based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g. not Active Surveillance Culture/Testing (ASC/AST)) superficial incision that is deliberately opened by a surgeon, attending physician or other designee and culture or non-culture based testing is not performed <p>AND</p> <p>The patient has at least one of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat.</p> <ol style="list-style-type: none"> diagnosis of a superficial incisional SSI by the surgeon or attending physician or other designee
Deep incisional SSI*	<p>Infection occurs within 30 or 90 days** after the procedure (where day 1 = the procedure date) AND involves deep soft tissues of the incision (e.g. fascial and muscle layers) AND the patient has at least one of the following:</p> <ol style="list-style-type: none"> purulent drainage from the deep incision a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g. not Active Surveillance Culture/Testing (ASC/AST)) or culture or non-culture based microbiologic testing method is not performed <p>AND</p> <p>The patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion</p> <ol style="list-style-type: none"> an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic examination, or imaging test
Organ/space SSI***	<p>Infection occurs within 30 or 90 days** after the procedure (where day 1 = the procedure date) AND infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure AND</p> <p>The patient has at least one of the following:</p> <ol style="list-style-type: none"> purulent drainage from a drain that is placed into the organ/space (e.g. closed suction drainage system, open drain, T-tube drain, CT guided drainage) organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g. not Active Surveillance Culture/Testing (ASC/AST)) an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic examination, or imaging test evidence suggestive of infection

*Superficial incisional SSI and deep incisional SSI may both be further categorised as primary or secondary according to whether the incision in question is the primary incision or is the secondary incision in an operation with more than one incision

**90-day surveillance is for breast surgery, cardiac surgery, coronary artery bypass graft with both chest and donor site incisions, coronary artery bypass graft with chest incision only, craniotomy, spinal fusion, open reduction of fracture, herniorrhaphy, hip prosthesis, knee prosthesis, pacemaker surgery, peripheral vascular bypass surgery, ventricular shunt. Some SSI classifications do not specify length of surveillance according to procedure type other than to specify 30 days if no implant is in place, or within one year if an implant is in place¹⁸⁸

***Some SSI classifications based on the CDC classification include diagnosis of organ/space SSI by a surgeon or physician¹⁸⁸

Public Health England (PHE) definitions of SSI¹⁸⁸

The definitions of SSI used by Public Health England are based on those established by the US Centers for Disease Control and Prevention (CDC) with minor modifications:

- A requirement for pus cells in addition to a positive culture from wound samples (for all SSI types)
- The need for at least two symptoms to accompany a clinical diagnosis (superficial SSIs only)
- Timing is appearance of SSI within 30 days for all procedures, unless an implant is in place when it is one year.

Appendix 2. ASEPSIS grading system ⁹⁵						
	Criterion					Points
A	Additional treatment: <ul style="list-style-type: none"> ■ Antibiotics ■ Drainage of pus under local anaesthetic ■ Debridement of wound (general anaesthetic) 					10 5 10
S	Serous discharge*					Daily 0-5
E	Erythema*					Daily 0-5
P	Purulent exudate*					Daily 0-10
S	Separation of deep tissue*					Daily 0-10
I	Isolation of bacteria					10
S	Stay as inpatient prolonged over 14 days					5
*Scoring is according to proportion of wound affected:						
	0%	<20%	20%-39%	40%-59%	60%-79%	≥80%
Serous exudate	0	1	2	3	4	5
Erythema	0	1	2	3	4	5
Purulent exudate	0	2	4	6	8	10
Separation of deep tissues	0	2	4	6	8	10
Category of infection						
ASEPSIS score			Category			
0-10			Satisfactory healing			
11-20			Disturbance of healing			
20-30			Minor infection			
31-40			Moderate to severe infection			
>40			Severe infection			

CONSENSUS DOCUMENT

Appendix 3. Veterans Affairs Medical Center (VAMC), Rotterdam and Mir risk scoring systems for abdominal SWD following laparotomy

	VAMC ⁶⁶		Rotterdam ¹⁶		Mir et al, 2016 ¹⁵		
	Variable	Score	Variable	Score	Variable	Score	
Variables and scores	CVA with no residual deficit	4	Age (years)	40-49	0.4	Male gender	1.209
	History of COPD	4		50-59	0.9	COPD	1.548
	Current pneumonia	4		60-69	0.9	Corticosteroid use	1.179
	Emergency procedure	6		>70	1.1	Smoking	2.454
	Operative time >2.5 hours*	2	Male gender	0.7	Obesity	1.721	
	PGY 4 resident as surgeon*	3	Chronic pulmonary disease	0.7	Anaemia	1.564	
	Clean wound classification*	-3	Ascites	1.5	Jaundice	3.197	
	Superficial wound infection*	5	Jaundice	0.5	Ascites	2.411	
	Deep wound infection*	17	Anaemia	0.7	Sepsis	2.422	
	Failure to wean from ventilator*	6	Emergency surgery	0.6	Hepatobiliary surgery	3.281	
	One or more complications other than dehiscence**	7	Type of surgery	Gallbladder/bile duct	0.7	Vascular, spleen, adrenal or kidney surgery	3.062
	Return to OR during admission**	-11		Oesophagus	1.5	Upper or lower GI bowel surgery	1.786
				Gastroduodenum	1.4	Coughing	1.387
				Small bowel	0.9	Wound infection	3.251
		Large bowel		1.4			
		Vascular		1.3			
		Coughing**		1.4			
		Wound infection**	1.9				
Scoring and related risk	Score	Risk of SWD	Score	Risk of SWD	Score	Risk of SWD	
	11-14	5%	0-2	0.1%	Range 0 to 25.7	Higher value predicts higher risk	
	>14	10%	2-4	0.7%			
			4-6	5.5%			
			6-8	26.2%			
		>8	66.5%				

*Intra-operative risk factors

**Post-operative risk factors

COPD: chronic obstructive pulmonary disease; CVA: cerebrovascular accident; OR: operating room; PGY: postgraduate year

Appendix 4. Interventions for reduction of risk of surgical site complications such as SWD and SSI

	Intervention	Planning	Pre-operative	Intra-operative	Post-operative	Notes
Planning	Education of patient/carer/family and management of expectations	✓	✓		✓	<ul style="list-style-type: none"> Patients should be advised on appropriate levels of activity, hygiene measures, signs and symptoms of SWD and SSI, and when and who to contact with problems Management of expectations regarding pain may optimise the effectiveness of post-operative analgesia¹⁸⁹
	Assessment and management/optimisation of comorbidities – e.g. obesity, malnutrition, diabetes mellitus, COPD, anaemia, cardiovascular disease	✓	✓	✓	✓	<ul style="list-style-type: none"> Amelioration or removal of patient-related modifiable risk factors for SWD may reduce risk of SWD Meta-analyses have found that supplementation with fish oil decreased infectious morbidity¹⁹⁰ and administration of probiotic bacteria reduced SSI rates¹⁹¹
	Screening for nasal carriage of <i>Staphylococcus aureus</i> and decolonisation according to local protocol – e.g. test patients undergoing cardiac surgery or surgery involving an implant (e.g. arthroplasty or breast implant) and those who are healthcare workers or institutional residents	✓				<ul style="list-style-type: none"> Nasal carriage of <i>S. aureus</i> increases the risk of SSI after major heart surgery, breast reconstruction and implant surgery, and orthopaedic surgery¹⁹²⁻¹⁹⁴
	Management of bleeding/thrombotic risk in patients on oral anticoagulants	✓	✓	✓	✓	<ul style="list-style-type: none"> Management will depend on the anticoagulant in use, reason for use, risk of bleeding, procedure type and urgency, but may include cessation of the anticoagulant or replacement with a shorter acting agent¹⁹⁵
	Consider nutritional supplementation	✓	✓		✓	<ul style="list-style-type: none"> WHO guidelines on the prevention of SSI suggest consideration of the administration of oral or enteral nutritional supplementation with multiple nutrient-enhanced formulas (containing arginine, glutamine, omega-3 fatty acids and/or nucleotides) in underweight patients who undergo major surgical operations¹⁶³
Pre-operative	Use of an operative safety checklist – e.g. WHO Surgical Safety Checklist		✓	✓	✓	<ul style="list-style-type: none"> A systematic review and meta-analysis concluded that evidence is suggestive that use of the WHO Surgical Safety Checklist¹⁹⁶ reduces post-operative complications¹⁹⁷ A recent review concluded that the effect of the checklist seemed to be greatest in developing countries¹⁹⁸
	Maintenance of normothermia (i.e. avoidance of hypothermia, unless otherwise indicated)		✓	✓	✓	<ul style="list-style-type: none"> Inadvertent peri-operative hypothermia impairs wound healing¹⁶³ Peri-operative body warming in comparison with no warming reduces risk of SSI¹⁶³
	Monitor and control blood glucose of patients with diabetes mellitus		✓	✓	✓	<ul style="list-style-type: none"> Blood glucose levels of diabetic patients should be monitored and controlled to <11mmol/l or <200mg/dl¹⁹⁹
	Showering or bathing by patient on day of surgery using plain or antimicrobial soap/cleanser		✓			<ul style="list-style-type: none"> Good clinical practice, but effect on surgical site complication rates is unclear and ideal type of soap/cleanser is not known²⁰
	Use of clippers (rather than a razor) for hair removal		✓			<ul style="list-style-type: none"> Hair should only be removed if necessary: a meta-analysis has shown that hair removal does not reduce SSI rates; however, when hair is removed, clipping significantly reduces SSI rate in comparison with shaving¹⁶³
	Location of heparin injection sites away from operative site		✓		✓	<ul style="list-style-type: none"> Haematoma is more common if the heparin injection site is relatively close to the incision^{200,201}
	Management of hydration/fluid levels to produce normovolaemia, while avoiding fluid overload and hypovolaemia		✓	✓	✓	<ul style="list-style-type: none"> Fluid overload may cause soft tissue oedema which may impair tissue oxygenation and wound healing; hypovolaemia may cause hypoxia¹⁶³
	Maintenance of adequate tissue perfusion		✓	✓	✓	<ul style="list-style-type: none"> Haemodynamic goal-directed therapy (titration of fluids and inotropic drugs to reach target cardiac output and oxygen delivery) appears to reduce SSI²⁰²
	Timely administration of prophylactic antibiotics as indicated by local guidelines		✓	✓	✓	<ul style="list-style-type: none"> Antibiotics should be administered within the optimal time (often within 120 minutes before incision) according to the pharmacokinetics of the antibiotics in use¹⁶³ Antibiotics combined with mechanical bowel preparation in patients undergoing colorectal surgery reduces risk of SSI¹⁶³
	Administration of antifibrinolytic agents as indicated by local guidelines to reduce blood loss and need for blood transfusion		✓	✓	✓	<ul style="list-style-type: none"> Antifibrinolytic agents, e.g. tranexamic acid and aprotinin, have been found to significantly reduce the need for blood transfusion²⁰³

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Appendix 4. Continued

	Intervention				Notes	
Intra-operative	Compliance with hygiene measures by operating room personnel			✓	<ul style="list-style-type: none"> For example, removal of hand jewellery, artificial nails and nail polish, covering hair, face masks, operating room suits, surgical hand/forearm preparation, sterile gloves and gowns²⁰ 	
	Minimisation of operating room traffic			✓	<ul style="list-style-type: none"> SSI usually originates from the patient's own flora, but airborne microbes (the level of which is directly proportional to the number of people in the operating room) may play a role²⁰⁴ 	
	Optimal oxygenation			✓	✓	<ul style="list-style-type: none"> Supplemental oxygen reduces SSI occurrence²⁰⁵ Patients should receive oxygen intra-operatively and, ideally, for 2-6 hours post-operatively¹⁶³
	Skin preparation with an antiseptic immediately prior to incision			✓	<ul style="list-style-type: none"> It is not clear which is the most effective antiseptic solution for skin preparation¹⁷³. However, the WHO recommends alcohol-based antiseptic solutions based on chlorhexidine gluconate (CHG)¹⁶³ 	
	If an incise drape is necessary, use an iodophor-impregnated drape			✓	<ul style="list-style-type: none"> Iodophor-impregnated incise drapes should not be used on patients who are allergic to iodine¹²¹ In a comparison with standard incise drapes, patients who received iodophor-impregnated incise drapes had a significantly lower SSI rate²⁰⁶ 	
	Use of excellent surgical technique with gentle handling of tissues, meticulous control of bleeding and avoidance of dead space			✓	<ul style="list-style-type: none"> Tissue trauma, poor haemostasis and failure to obliterate dead space may increase risk of SSI and impede wound healing¹⁵⁹ 	
	Avoidance of tension across incision			✓	<ul style="list-style-type: none"> High incisional tension increases the risk of SWD¹⁵ 	
	Use of wound edge protectors/guards during laparotomy			✓	<ul style="list-style-type: none"> Wound protectors decrease the incidence of SSI in abdominal surgery^{163,172} 	
	Intra-operative wound irrigation			✓	<ul style="list-style-type: none"> Intra-operative wound irrigation reduces SSI rates, with the most marked effect in colorectal surgery²⁰⁷ WHO and CDC guidelines recommend the use of aqueous iodophor solution^{163,173} 	
	Change of gloves during procedure and/or before closure of wound; double gloving			✓	<ul style="list-style-type: none"> Widely practiced, especially for high risk/contaminated procedures, but effect on SSI rates is unclear¹⁶³ 	
	Senior/experienced surgeon performing closure			✓	<ul style="list-style-type: none"> There is an inverse association between the level of experience of a surgeon and SSI rates: autonomously performed closure has been found to have a significantly lower SSI rate than closure performed under supervision²⁰⁸ In comparison with a more experienced surgeon, surgery performed by a postgraduate year 4 surgeon is associated with an increased rate of SWD⁷⁹ 	
	Use of gentamicin-impregnated collagen sponges			✓	<ul style="list-style-type: none"> Reduce rates of SSI in cardiac, colorectal and femoropopliteal bypass surgery²⁰⁹⁻²¹¹ 	
	Use of triclosan-coated sutures			✓	<ul style="list-style-type: none"> Triclosan-coated sutures should be considered because they reduce rates of SSI^{163,173,212} 	
Post-operative	Covering of the incision(s) with a dry absorbent sterile dressing under sterile conditions and before the patient leaves the operating room			✓	<ul style="list-style-type: none"> Dressings provide a physical barrier to external contamination²⁰ Widely practiced. However, there is no evidence to show that dressings reduce SSI rates, and it is not yet clear whether the use of a dressing containing an antimicrobial agent is able to prevent SSI¹⁶³ 	
	Consider prophylactic NPWT (e.g. single-use NPWT) for patients at increased risk of SSI or SWD			✓	<ul style="list-style-type: none"> The WHO recommends the prophylactic use of NPWT on closed surgical incisions in high risk patients to prevent SSI¹⁶³ 	
	Maintenance of the dressing over the incision for at least 48 hours unless there are signs and symptoms indicating earlier inspection is warranted			✓	<ul style="list-style-type: none"> Epithelialisation of surgical wounds is usually complete, i.e. the wound is sealed, within 48 hours. Therefore, dressings should be inspected regularly but left in place for at least first 48 hours post-operatively¹⁶³ If a dressing change is required before 48 hours, the dressing should be changed using an aseptic technique²⁰ 	
	Cryotherapy (e.g. application of ice) and compression			✓	<ul style="list-style-type: none"> Cryotherapy and compression aim to aid healing by reducing oedema that may be impairing tissue perfusion^{162,213} A retrospective study of patients who underwent total ankle arthroplasty reported that a compression wrap protocol reduced wound-related complications (a composite endpoint that included SWD)¹⁶¹ Cryotherapy is widely used for pain relief following orthopaedic surgery and may be combined with compression therapy¹⁶² 	
	Visitor restrictions and hygiene measures - e.g. hand cleansing/ protective clothing as appropriate			✓	<ul style="list-style-type: none"> An SSI bundle for patients undergoing cardiac surgery that included visitor restrictions resulted in a lower incidence of SSIs²¹⁴ 	
	Monitor incision for healing progress and signs/symptoms of dehiscence or infection			✓	<ul style="list-style-type: none"> Early recognition of problems followed by appropriate interventions is likely to improve longer term outcomes 	
Post-operative	Patient Reported Outcome/Experience Measures (PROMS/PREMS) or questionnaires			✓	<ul style="list-style-type: none"> Increasingly used for monitoring and may be linked to reimbursement in some healthcare systems²¹⁵ 	
	Perform surveillance of post-operative wound complications and compliance with surgical wound complication reduction bundles			✓	<ul style="list-style-type: none"> Active surveillance may decrease SSI rates²¹⁶ Aids feedback to individual surgeons and team members and monitoring of trends/effect of implementation of measures to reduce SWD/SSI²¹⁷ 	

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NOTES

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