Preoperative chest disease and postoperative pulmonary complications: Anticipated results still need further examination – Author's reply

Dear Editor,

We appreciate the interest and awareness of the authors over our study.[1] First, the aim of our study was to determine the parameters that could predict the postoperative pulmonary complications (POPCs), to examine the effect of these parameters and POPCs on hospitalization and mortality, and to determine the value of some practical indexes in predicting POPCs.

American Society of Anesthesiologists (ASA) score is a widely used risk scoring system, and all patients planned to undergo a surgical procedure are routinely consulted with the department of anesthesiology before the surgery. In our study, there were 63 (20.5%) patients with ASA Class 1, 167 (54.4%) patients with Class 2, 67 (21.8%) patients with Class 3, and 7 (2.3%) patients with Class 4. ASA Class I score indicates a normal healthy patient while ASA Class II means a patient with mild systemic disease. The patients included in the study underwent a great variety of surgical procedures, and many of them were healthy individuals without systemic disease. The consultation with chest diseases commonly performed due to institutional policies, due to medico-legal issues, or through recommendations from another discipline. Many pulmonary consultation reports include only common recommendations without a respiratory risk assignment. Therefore, we do not think to be an improper ASA assignment in the study.

We understand their concerns on the potential bias of chronic obstructive pulmonary disease (COPD) patients and determination of postoperative respiratory failure. There were 39 patients previously diagnosed as COPD in our study, and 21 of them experienced a POPC. Table 3 summarizes these 21 patients and the types of POPCs. Elven of those 21 COPD patients developed respiratory failure in the postoperative period. We totally agree with your statement that it is even hard to maintain SpO_2 values over 90% in COPD patients. Although it is not included in the text, the determination of respiratory failure in this subgroup was based on worsening of respiratory status compared to the preoperative period. Therefore, study performers did not determine the patient with a SpO_2 value of 90% as respiratory failure whose SpO_2 was 90% before the surgery. Hence, there is no inclusion bias which may affect the outcome of the study. Thank the authors for giving us the opportunity for a better interpretation of the study results.

By the help of their critics, we realized that the follow-up parameters were not given in detail in our study. As given in the text, the postoperative complications were observed at 0.61 ± 1.41 days after surgery (0–14 days), and the mean hospitalization duration was 6.97 ± 7.81 (0–90 days) during the postoperative period. Postoperative mean intensive care hospitalization duration was 1.62 ± 5.51 (0–85) days. The patients were followed during their hospitalization period. We had previously stated this situation as a limitation in the study (Page 35).

We totally agree with their comments about the need for a prospective study including intraoperative management such as duration of anesthesia and colloid use to determine the causes of POPC more effectively, however; it is difficult and sometimes impossible to reach those data in retrospectively designed studies. We hope to work together in future projects aiming for better predicting POPCs.

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Nil.

Conflicts of interest

There are no conflicts of interest.

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