Closed incision negative pressure therapy: international multidisciplinary consensus recommendations

Christian Willy1, Animesh Agarwal2, Charles A Andersen3, Giorgio De Santis4, Allen Gabriel5, Onnen Grauhan6, Omar M Guerra7, Benjamin A Lipsky8, Mahmoud B Malas9, Lars L Mathiesen10, Devinder P Singh11 & V Sreenath Reddy12

1 Department of Traumatology and Orthopaedic, Septic and Reconstructive Surgery, Research and Treatment Center for Complex Combat Injuries, Wound Centre Berlin, Bundeswehr Hospital Berlin, Berlin, Germany
2 Division of Orthopaedic Traumatology, University of Texas Health Science Center at San Antonio, San Antonio, TX, USA
3 Vascular/Endovascular/Limb Preservation Surgery Service, Madigan Army Medical Center, Tacoma, WA, USA
4 Plastic, Reconstructive, Microvascular and Aesthetic Surgery, University of Modena and Reggio Emilia, Modena, Italy
5 Plastic Surgery, PeaceHealth Medical Group, Vancouver, WA, USA
6 Department of Cardiothoracic and Vascular Surgery, Deutsches Herzzentrum Berlin, Berlin, Germany
7 Surgery, Suburban Surgical Associates, St. Louis, MO, USA
8 Division of Medical Sciences, University of Oxford, Oxford, UK
9 Department of Surgery, Johns Hopkins University School of Medicine, Baltimore, MD, USA
10 Department of Orthopaedic Surgery, Aalborg University Hospital, Aalborg, Denmark
11 Division of Plastic Surgery, Anne Arundel Medical Center, Annapolis, MD, USA
12 TriStar CV Surgery, Centennial Heart and Vascular Center, Nashville, TN, USA

Key words
Consensus recommendation; Negative pressure therapy; Surgical incision management; Surgical site infection

Correspondence to
C Willy, MD, PhD
Professor of Surgery, Colonel, Head of Department
Department of Traumatology and Orthopaedics, Septic and Reconstructive Surgery
Bundeswehrkrankenhaus Berlin
Scharnhorststr. 13
10115 Berlin
Germany
E-mail: ChristianWilly@bundeswehr.org
doi: 10.1111/iwj.12612

Abstract
Surgical site occurrences (SSOs) affect up to or over 25% of patients undergoing operative procedures, with the subset of surgical site infections (SSIs) being the most common. Commercially available closed incision negative pressure therapy (ciNPT) may offer surgeons an additional option to manage clean, closed surgical incisions. We conducted an extensive literature search for studies describing ciNPT use and assembled a diverse panel of experts to create consensus recommendations for when using ciNPT may be appropriate. A literature search of MEDLINE, EMBASE and the Cochrane Central Register of Controlled Trials using key words ‘prevention’, ‘negative pressure wound therapy (NPWT)’, ‘active incisional management’, ‘incisional vacuum therapy’, ‘incisional NPWT’, ‘incisional wound VAC’, ‘closed incisional NPWT’, ‘wound infection’, and ‘SSIs’ identified peer-reviewed studies published from 2000 to 2015. During a multidisciplinary consensus meeting, the 12 experts reviewed the literature, presented their own ciNPT experiences, identified risk factors for SSOs and developed comprehensive consensus recommendations. A total of 100 publications satisfied the search requirements for ciNPT use. A majority presented data supporting ciNPT use. Numerous publications reported SSI risk factors, with the most common including obesity (body mass index ≥30 kg/m2); diabetes mellitus; tobacco use; or prolonged surgical time. We recommend that the surgeon assess the individual patient’s risk factors and surgical risks. Surgeons should consider using ciNPT for patients at high risk for developing SSOs or who are undergoing a high-risk procedure or a procedure that would have highly morbid consequences if an SSI occurred.
Introduction
The World Health Organization estimated that surgeons performed over 234 million major surgeries (i.e., operative procedures involving significant risks to the patient) globally each year (1). In industrialised countries, major complications (i.e. those that are potentially life-threatening and require hospitalisation and therapeutic intervention) occur in over 25% of inpatient surgical procedures (1). In the United States (US) alone, surgical site infections (SSIs) account for 36% of all health care-associated infections, which are a major cause of morbidity, putting 8 million US patients at risk for developing an SSI annually (2,3). Current standards of care for preventing SSI include preoperative prophylactic systemic antibiotics (for selected surgical procedures); preoperative antiseptic shower/bath; aseptic incision site surgical preparation; and sterile and meticulous surgical technique (4). Yet, the continued high SSI rates demonstrate the need for new preventative methods.

Traditionally, surgeons have closed surgical incisions with primary intention using sutures, staples, tissue adhesives, paper tape or a combination of these methods. However, negative pressure wound therapy (NPWT) has become a viable wound care option since its introduction two decades ago. For many different operative procedures, especially in the plastic surgery field, NPWT plays an integral adjunct treatment to enhance different interventions in the reconstructive pathway. Commercial negative pressure dressings are increasingly used in various clinical settings and for many types of acute and chronic open wounds.

Surgeons have recently discovered that foam-based negative pressure dressings applied over closed incisions can also be beneficial in preventing incision complications. The term ‘closed incision negative pressure therapy’ (ciNPT) refers to any type of NPWT using foam-based dressings over closed incisions.

Our goals were to investigate how ciNPT is beneficial in preventing wound incision complications and then to formulate recommendations for potential indications for its use. In December 2014, a multidisciplinary group of surgical and infectious disease experts met to discuss the following questions:

- Is there evidence-based data in the literature that reports any benefits from using ciNPT?
- Which types of patients and closed surgical incisions are at greatest risk for postoperative complications in the different surgical specialty fields?
- Can evidence-based recommendations be formulated for ciNPT use?

Materials and methods
Search of literature and selection of studies
A review of the literature was performed searching computerised versions of MEDLINE (PubMed), EMBASE and the Cochrane library. We further expanded the potential evidence base using a ‘snowball’ system (i.e. continued searches in the references of the self-researched publications). Search criteria included (i) publications in all languages, (ii) various study types [e.g. randomised clinical and experimental studies, systematic and non-systematic reviews, meta-analyses, expert opinions, case reports, experimental papers (animal and human studies)] and (iii) consensus conference reports. The authors received access to all publications in their full-published versions.

Articles published in a peer-reviewed journal that was considered relevant for the development and dissemination of medical knowledge [i.e. an Abridged Index Medicus (AIM) journal], supported the CONSORT statement, and a citation impact factor of >0.5 were used.

Search period and search keywords


Criteria of evidence-based medicine
More than 50 different evidence level scales exist worldwide. For the purpose of this study, we selected the 2009 Oxford Centre for Evidence-Based Medicine (EbM) classification system (5).

Multidisciplinary consensus meeting
To formulate consensus guidelines, peer-reviewed published literature focusing on ciNPT was used as the foundation for
discussion and as evidence to support guideline statements. Using a modified consensus process, described below, panelists agreed on which patient risk factors and closed surgical incisions were at the highest risk of SSIs and created an algorithm for the use of ciNPT.

Selection of panellists

Leaders at Acelity (San Antonio, TX, USA), in conjunction with the academic lead authors (CW, VSR), selected the 12 panellists based on their peer-reviewed publications on NPWT; clinical experience with negative pressure for incision management; and reputation for scholarly activity in their respective fields. To create a heterogeneous expert panel, we selected physicians who were from various geographic locations (US, Italy, Germany and Denmark), had diverse practice experience and represented different surgical specialties (general, orthopaedic, trauma, plastic, cardiac, podiatric and vascular surgery) as well as clinical microbiology and infectious disease.

Developing the consensus recommendations

Before the meeting convened, all panellists reviewed the publications retrieved by the systematic literature review and were briefed on the process for consensus building. The one-and-a-half day meeting was divided into four sections: (i) presentations (15–20 min) by each panellist reporting clinical experience with ciNPT; (ii) collection of comments to all distributed literature and evaluation/rating of the available literature on ciNPT; (iii) review of definitions of closed incisions at risk for complications and of patient-related risks; and (iv) open discussion regarding appropriate use of ciNPT (i.e. algorithm). By digitally recording all comments, the lead authors ensured that all viewpoints were adequately captured and reviewed. Participants did not reach conclusive recommendations at this meeting; rather, they elected to reflect on definitions of closed incisions at risk in various fields of surgery and to participate in follow-up discussions via electronic mail and a follow-up teleconference 12 weeks following the meeting. The panellists received follow-up documents, including a general manuscript outline and an assessment of ciNPT risk factors by surgical specialty, for review (i.e. agree or disagree) and comment via electronic mail. All participants reviewed comments made by other participants with the goal of reaching unanimous agreement, when possible, or consensus. The lead authors drafted a manuscript that was reviewed and commented on by all panellists. All panellists agreed upon the final manuscript prior to submission for publication.

Identifying risk factors and developing an algorithm

During the meeting, each panellist presented a list of risk factors considered to be important when assessing patients for ciNPT use. Each panellist also reviewed the resulting comprehensive list of risk factors and provided relevant supporting EbM literature, when available. Panel members recommended ciNPT use for risk factors with a reported odds ratio (OR) > 2 or if the risk factor was present in multiple surgical fields. Once the panelists reached a consensus on risk factors, they created an algorithm to identify at-risk scenarios in which ciNPT usage might be beneficial for incision management. All panellists reviewed and approved the algorithm.

Results

Type of ciNPT studies

A limited number of robust, prospective, randomised, comparative, controlled studies on ciNPT use over closed surgical incisions that might most benefit from this therapy exist. The literature search identified 100 publications that fulfilled the above mentioned criteria. Of these, 60 articles describe outcomes in a total of 2402 ciNPT-treated patients following surgical procedures, including orthopaedic (n = 21 articles, n = 852 patients), general (n = 22 articles, n = 869 patients), cardiothoracic (n = 8 articles, n = 505 patients), plastic (n = 6 articles, n = 133 patients) or vascular (n = 6 articles, n = 95 patients). Three articles have more than one surgical specialty and patient population; thus, some patients and articles are counted twice. The remaining 40 publications were literature reviews including meta-analyses, editorials, research articles or experimental model descriptions. Three articles were solely devoted to a health economic analysis (6–8), and three articles describe study protocols of future studies (9–11). A majority of the 100 publications reported data based on one manufacturer’s system: n = 91, KCI, an Acelity company, San Antonio, TX, USA; n = 8, Smith and Nephew, plc, London, UK; n = 1, Daewoong Pharmaceutical, Co, Ltd., Seoul, South Korea.

Of the 100 publications, 51 (51.0%) had authors based in the US; 15 (15.0%) in Germany; 8 (8.0%) in Australia; 6 (6.0%) in Italy; 4 (4.0%) in UK/Ireland; 3 (3.0%) each in Canada, China and Spain; 2 (2.0%) in Turkey; and 1 (1.0%) each in Denmark, Poland, South Korea, South Africa and the United Arab Emirates.

Using the Oxford Centre for EbM evidence levels (Table 1) (5), 51 (51.0%) included papers received a level 4 or 5 (reviews, comparative historical studies, case series, case reports, economic studies) and 39 (39.0%) received an evidence level of 3 or higher (comparative studies, meta-analyses). An additional 10 (10.0%) had no evidence level (research reports, technical information, editorials, study protocol, experimental study, etc.).

Main results of ciNPT studies

Preclinical studies evaluating ciNPT compared with standard wound care reported reduced scar thickness and narrower scar width, increased collagen at the incision site, increased mechanical properties and increased tensile strength in the ciNPT groups (12,13). In addition, using Laser Doppler flowmetry, the peristernal perfusion after cardiac surgery was increased among the patients who underwent negative pressure therapy and decreased among the controls significantly (14). Mammary artery harvesting reduced peristernal perfusion by 25-7% in the controls, but negative pressure increased perfusion by 100% after mammary harvesting (P = 0.04). Thus, ciNPT increased perfusion relative to controls and compensated for reduced perfusion rendered by mammary artery harvesting, providing additional support in high-risk patients (14).
Our review found a number of case studies, case series and non-randomised controlled trials that described ciNPT use. These studies included high-risk patients with one or more comorbidities who underwent various surgical procedures, including vascular bypass, sternotomy and caesarean section (14–63). In 2013, Condé-Green et al. reported that patients undergoing abdominal hernia repairs treated with ciNPT had a lower surgical site occurrence (SSO) rates (22% versus 63%, \( P = 0.02 \)) and dehiscence (9% versus 38%, \( P = 0.014 \)) compared with patients treated with wound dressings (17). In a retrospective study with a historical cohort by Gibbs et al., (34) after controlling for body mass index (BMI) and diabetes, wound complication rates in the ciNPT group (\( n = 103 \)) were found to be equivalent to those in the standard dressing group (\( n = 867 \)). Three other retrospective studies with a historical control group observed lower rates of SSI, SSOs, wound morbidity and re-operation in the ciNPT group compared with the historical controls (16,51,63). Overall, a majority of these studies reported that ciNPT use was associated with decreases in wound complications, wound dehiscence, SSIs, haematoma/seroma formation and incisional drainage.

Since 2004, numerous randomised controlled trials and individual cohort studies have described ciNPT use (see Table 2). These studies encompass various wound types and surgical interventions, including traumatic injury repair, cardiothoracic surgery, lower extremity amputations, arthroplasty, hernioplasty and vascular surgery (44,63–76). Enrolled patients often had comorbidities, including obesity (BMI ≥ 30 kg/m²), diabetes mellitus, peripheral vascular disease or chronic obstructive pulmonary disease (15,67–69,77). Two studies reported no differences in SSI rates or dehiscence between ciNPT and control (silver-impregnated wound dressings or sterile gauze dressings) groups (69,77). One study was stopped prematurely because of blister formation in a majority of ciNPT group patients (77). This adverse effect was most likely because of improper dressing configuration and too high tension when using the dressing as no other study reported adverse effects.

The majority of randomised controlled trials reported uniformly decreased SSI incidence, wound dehiscence and seroma development in the ciNPT-treated group versus the control groups (44,63–68,71,72,78). Stannard et al. examined outcomes in 249 patients undergoing an orthopaedic procedure for blunt trauma, resulting in 263 tibial plateau, pin or calcaneus fractures (66). Fractures randomised to receive ciNPT (\( n = 141 \)), compared with standard of care (\( n = 122 \)), had lower SSI rates (\( P = 0.049 \)) and wound dehiscence (\( P = 0.044 \)). Grauhan et al. reported a 4.5-fold decrease in wound infection rates in the ciNPT group (\( n = 75 \)) compared with the standard wound dressing group (\( n = 75 \); OR = 4.57; 95% confidence interval = 1.23–16.94; \( P = 0.0266 \)) in obese patients (BMI ≥ 30 kg/m²) following cardiac surgery (67).

Eight systematic reviews and meta-analyses were identified in the literature search (58,79–83). These studies have examined the potential effects of ciNPT in reducing SSI, seroma/haematoma formation and dehiscence as reported in the literature. Each systematic review used different methods for data comparisons; however, four reviews indicated that ciNPT use may help reduce rates of SSI (58,79,82,83). ciNPT effects on seroma/haematoma formation and dehiscence rate were inconclusive because of inconsistent data reporting. Two reviews stated that while evidence is mounting, no definitive claims can be made as reported evidence is inconsistent (80,81). A recent meta-analysis evaluated the effectiveness of ciNPT in lowering the incidence of surgical-site infections compared with standard incisional care (84). This study used a fixed-effects model to assess between-study and between-incision location subgroup heterogeneity and effect size. The authors demonstrated reduced overall weighted average rates of SSI in the ciNPT (6-61% versus 9-36%). The relative reduction of SSI rate was 29-4%, with the odds of SSI rate decrease equalling 0-496 (\( P < 0.00001 \)). Overall rates of dehiscence were also reduced in ciNPT versus control groups (5.32% and 10-68%, respectively). These results suggest that ciNPT can be a potentially effective method for reducing SSI and may be associated with decreased incidence of dehiscence.
### Table 2: Overview of published randomised controlled trials

<table>
<thead>
<tr>
<th>Year</th>
<th>References</th>
<th>EbM level*</th>
<th>Number of patients</th>
<th>Type of wounds</th>
<th>Results</th>
<th>Conclusion</th>
</tr>
</thead>
</table>
| 2015 | Nordmeyer et al. (75) | RCT level 1b | 20 (10 ciNPT, 10 control) | Internal fixation of spinal fractures | Seroma day 5  
ciNPT: 0 ml  
Control: 1.9 ml  
Seroma day 10  
ciNPT: 0.5 ml  
Control: 1.6 ml  
Wound care time  
ciNPT: 13.8 ± 6 min  
Control: 31 ± 10 min  
Number of compresses  
ciNPT: 11 ± 3  
Control: 35 ± 15 | ciNPT significantly reduced the development of seroma (day 5  
\( P = 0.0007 \); day 10  
\( P < 0.024 \)), required wound care time (\( P = 0.005 \)), and number of compresses (\( P = 0.0376 \)) |
| 2015 | Gillespie et al. (74) | RCT level 2b | 75 (35 ciNPT; 35 standard dressings) | Elective primary hip arthroplasty | SSI  
ciNPT = 2/35  
Control = 3/35  
(risk ratio = 0.67; 95% CI = 0.12-3.7;  
\( P = 0.65 \))  
Wound complications  
ciNPT experience more postoperative wound complications (risk ratio = 1.6;  
95% CI = 1.0-2.5;  
\( P = 0.04 \))  
Wound infections  
ciNPT: 3 (4%)  
Control: 12 (16%)  
Wound infections with Gram-positive skin flora  
ciNPT: 1 (1.3%)  
Control: 10 (13.3%) | Reduction of SSI suggests that a large RCT requires 900 patients per group.  
There is uncertainty in the benefit of ciNPT use following elective hip arthroplasty. |
| 2014 | Pauser et al. (71) | RCT level 2b | 21 (11 ciNPT (Group A); 10 control (Group B)) | Femoral neck fracture patients scheduled for hip hemiarthroplasty | Developed a seroma at 5 days  
Group A 0.257 ± 0.75 cm³  
Group B 3.955 ± 5.01 cm³  
Duration of secretion  
Group A 0.9 ± 1.0 days  
Group B 4.3 ± 2.45 days  
Total time for dressing changes  
Group A 14.8 ± 3.9 minutes  
Group B 42.9 ± 11.0 minutes | Significant decrease in development of postoperative seroma, total wound secretion days, and time for dressing changes in ciNPT group (Group A,  
\( P < 0.05 \)). |
| 2013 | Grauhan et al. (67) | RCT level 2b | 150 (75 ciNPT; 75 control) | Cardiac surgery in obese patients (BMI ≥30) | Wound infections  
ciNPT: 3 (4%)  
Control: 12 (16%)  
Wound infections with Gram-positive skin flora  
ciNPT: 1 (1.3%)  
Control: 10 (13.3%) | Significantly reduced incidence of wound infection in ciNPT group (\( P = 0.0266 \); OR = 4.57; 95% CI = 1.23-16.94).  
Significantly lower incidence of wound infections with Gram-positive skin flora in ciNPT group (\( P = 0.009 \); OR = 11.39; 95% CI = 1.42-91.36). |
| 2012 | Stannard et al. (66) | RCT level 1b | 249 patients, 263 fractures (141 ciNPT; 122 control) | Blunt trauma with one of three high-risk fracture types (tibial plateau, pilon, calcaneus) | Infection results  
ciNPT: 1 (0.7%) acute 13 (8%) delayed  
Control: 5 (4%) acute 18 (15%) late | Significantly lower rates of infection in ciNPT group (\( P = 0.049 \)). |
<table>
<thead>
<tr>
<th>Year</th>
<th>References</th>
<th>EbM level*</th>
<th>Number of patients</th>
<th>Type of wounds</th>
<th>Results</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>Masden <em>et al.</em> (69)</td>
<td>RCT level 2b</td>
<td>81 (44 ciNPT; 37 control)</td>
<td>Multiple wounds in high risk patients</td>
<td>Dehiscence results in ciNPT fractures: 12 (8.6%)</td>
<td>Significantly lower rates of total wound dehiscence in ciNPT fractures ($P = 0.044$). No significant difference in time to discharge.</td>
</tr>
<tr>
<td>2012</td>
<td>Pachowsky <em>et al.</em> (70)</td>
<td>RCT level 2b</td>
<td>19 (9 ciNPT; 10 control)</td>
<td>Total hip arthroplasty</td>
<td>Wound infections</td>
<td>No significant difference between ciNPT group and controls in wound infections ($P = 0.48$) or dehiscence ($P = 0.54$).</td>
</tr>
<tr>
<td>2011</td>
<td>Howell <em>et al.</em> (77)</td>
<td>RCT level 2b</td>
<td>51 patients, 60 total knee arthroplasties (24 ciNPT; 36 control)</td>
<td>Primary total knee arthroplasty in obese (BMI $\geq 30$) patients</td>
<td>Time to dry wound</td>
<td>No significant difference in days to a dry wound or number of postoperative infections. The study was stopped prematurely when 15 knees (63%) treated with the ciNPT developed skin blisters.</td>
</tr>
<tr>
<td>2011</td>
<td>Atkins <em>et al.</em> (14)</td>
<td>CC level 3b</td>
<td>20 (10 ciNPT; 10 standard dressing)</td>
<td>Sternotomy</td>
<td>Postoperative infections</td>
<td>ciNPT increased perfusion relative to controls and compensated for reduced perfusion resulting from mammary artery harvesting.</td>
</tr>
<tr>
<td>2006</td>
<td>Stannard <em>et al.</em> (64)</td>
<td>RCT level 2b</td>
<td>Study A 44 (13 ciNPT; 31 control) Study B 44 (20 ciNPT; 24 control)</td>
<td>Traumatic injury with subsequent surgical incision</td>
<td>Wound drainage</td>
<td>Significantly reduced time of wound drainage in ciNPT group ($P = 0.03$). No significant difference for infection or wound breakdown.</td>
</tr>
</tbody>
</table>

BMI, body mass index; ciNPT, closed incision negative pressure therapy; CI, confidence interval; OR, odds ratio; RCT, randomised controlled trial.

*Classification produced by Bob Phillips, Chris Ball, Dave Sackett, Doug Badenoch, Sharon Straus, Brian Haynes, Martin Dawes (March 2009) (5).
In total, despite the wide variety of surgical procedures and patient comorbidities included in the 35 comparative studies and analysed in eight systematic reviews, the majority reported that patients treated with ciNPT showed reduced SSI rates with the caveat that more large, randomised controlled trials are necessary.

Risk factors in different surgical fields

Based on the EbM literature review and panel member experience, the panel generated a list of risk factors for the development of SSI shown in Table 3. Among comorbidities, the most frequently cited are diabetes mellitus, American Society of Anesthesiologists (ASA) physical classification system score ≥ 3, advanced age, obesity (BMI ≥ 30 kg/m²), tobacco use, hypoalbuminaemia and corticosteroid use (85–99). Most cited surgical incision risk factors for SSI development included incisions after prolonged surgical time, re-operation or re-exploration and emergency operation. In addition, incisions in the presence of ischaemia (91), high perioperative blood loss or high surgical tension also have an increased SSI risk. Panel members also designated high tension, open groin or sternotomy incisions as high-risk incisions where ciNPT use is recommended.

Algorithm to use ciNPT

Based on the literature review and panel member experience, we developed an algorithm for when a surgeon might consider using ciNPT (Figure 1). In addition to the patient and surgical incision risk factors listed above, ciNPT use may also be appropriate for incisions where infection can cause high morbidity, such as sternotomy, open reduction and internal fixation of fractures: Acetabulum, pilon, calcaneous, tibial plateau. Fasciotomy, above knee amputation, below knee amputation. The group of authors decided against developing a score. Rather, the relevant risk factors for SSI are presented and must be considered in the light of each individual patient’s situation.

Discussion

In open wounds, negative pressure therapy helps promote a wound-healing environment by reducing oedema, removing infectious materials and promoting perfusion and granulation tissue formation (100–102). Recently, surgeons are using negative pressure therapy over closed incisions (ciNPT) in a variety of clinical settings. ciNPT appears to manage the surgical incision by reducing incision line tension, decreasing oedema and
<table>
<thead>
<tr>
<th>Risk factors</th>
<th>Number of articles</th>
<th>Number of patients</th>
<th>Supporting article(s)</th>
<th>Surgical field (GEN, PLA, CAR, ORT, VAS)</th>
<th>cNPT recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mellitus</td>
<td>19</td>
<td>223,336</td>
<td>Imai et al. (85)</td>
<td>GEN, CAR, ORT, VAS</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Xue et al. (86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harrington et al. (103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pull ter Gunne et al. (114)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Martin et al. (99)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ASA score ≥3</td>
<td>9</td>
<td>265,783</td>
<td>Berger et al. (88)</td>
<td>GEN, PLA, CAR, ORT, VAS</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Xue et al. (86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Si et al. (89)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ridgway et al. (90)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advanced age</td>
<td>8</td>
<td>231,813</td>
<td>Fahrner et al. (104)</td>
<td>GEN, PLA, CAR, ORT, VAS</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Baumeister et al. (105)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harrington et al. (103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ridgway et al. (90)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI &gt; 30 kg/m²</td>
<td>12</td>
<td>151,935</td>
<td>Imai et al. (85)</td>
<td>GEN, PLA, CAR, ORT, VAS</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Xue et al. (86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Harrington et al. (103)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pull ter Gunne et al. (114)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Turtaiinen et al. (91)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prolonged surgical operation time</td>
<td>13</td>
<td>142,957</td>
<td>Imai et al. (85)</td>
<td>GEN, PLA, CAR, ORT</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Barber et al. (115)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Simsek Yavuz et al. (106)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Urquhart et al. (92)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active tobacco use</td>
<td>4</td>
<td>178,532</td>
<td>Neumayer et al. (87)</td>
<td>GEN, PLA, ORT, VAS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Edmonston et al. (116)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypoalbuminaemia</td>
<td>4</td>
<td>200,037</td>
<td>Shanmugam et al. (93)</td>
<td>GEN, VAS</td>
<td></td>
</tr>
<tr>
<td>Corticosteroid usage</td>
<td>2</td>
<td>166,026</td>
<td>Neumayer et al. (87)</td>
<td>GEN, CAR, VAS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Neumayer et al. (87)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active alcoholism</td>
<td>2</td>
<td>163,624</td>
<td>Neumayer et al. (87)</td>
<td>GEN, ORT, VAS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aggarwal et al. (95)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-operation</td>
<td>9</td>
<td>23,825</td>
<td>Fahrner et al. (104)</td>
<td>GEN, PLA, CAR, ORT</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Xue et al. (86)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bryan et al. (96)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Aggarwal et al. (95)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>5</td>
<td>77,984</td>
<td>Imai et al. (85)</td>
<td>GEN, ORT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Namba et al. (107)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal disease/renal dialysis</td>
<td>4</td>
<td>85,004</td>
<td>Centofanti et al. (108)</td>
<td>CAR, ORT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bozic et al. (109)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk factors</td>
<td>Number of articles</td>
<td>Number of patients</td>
<td>Supporting article(s)</td>
<td>Surgical field (GEN, PLA, CAR, ORT, VAS)</td>
<td>ciNPT recommended</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Local arterial insufficiency</td>
<td>2</td>
<td>83,081</td>
<td>Baumeister et al. (105)</td>
<td>PLA, ORT</td>
<td></td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>3</td>
<td>37,589</td>
<td>Shanmugam et al. (93)</td>
<td>GEN, CAR</td>
<td></td>
</tr>
<tr>
<td>Haematoma</td>
<td>2</td>
<td>38,177</td>
<td>Fahrner et al. (104)</td>
<td>GEN, PLA</td>
<td>X</td>
</tr>
<tr>
<td>Haematoma</td>
<td>2</td>
<td>38,177</td>
<td>Xue et al. (86)</td>
<td>GEN, PLA</td>
<td></td>
</tr>
<tr>
<td>Pedicled harvest using both internal thoracic arteries</td>
<td>1</td>
<td>126,235</td>
<td>Deo et al. (117)</td>
<td>CAR</td>
<td></td>
</tr>
<tr>
<td>Hyperglycaemia</td>
<td>2</td>
<td>2351</td>
<td>Ata et al. (118)</td>
<td>GEN, ORT</td>
<td>X</td>
</tr>
<tr>
<td>Preoperative chemoradiation</td>
<td>2</td>
<td>3070</td>
<td>Xue et al. (86)</td>
<td>PLA</td>
<td>X</td>
</tr>
<tr>
<td>Postoperative drainage</td>
<td>2</td>
<td>7463</td>
<td>Pessaux et al. (120)</td>
<td>GEN, PLA</td>
<td>X</td>
</tr>
<tr>
<td>High perioperative blood loss</td>
<td>1</td>
<td>4855</td>
<td>Sorensen et al. (98)</td>
<td>GEN</td>
<td>X</td>
</tr>
<tr>
<td>Hypertension (blood pressure)</td>
<td>1</td>
<td>2745</td>
<td>Xue et al. (86)</td>
<td>PLA</td>
<td></td>
</tr>
<tr>
<td>Malnutrition</td>
<td>2</td>
<td>64</td>
<td>Shinkawa et al. (121)</td>
<td>GEN, ORT</td>
<td>X</td>
</tr>
<tr>
<td>Venous insufficiency</td>
<td>1</td>
<td>70</td>
<td>Baumeister et al. (105)</td>
<td>PLA</td>
<td></td>
</tr>
<tr>
<td>High surgical incision tension</td>
<td>N/A</td>
<td>N/A</td>
<td>Panel experience</td>
<td>PLA</td>
<td>X</td>
</tr>
<tr>
<td>Thickness of lipodermis</td>
<td>N/A</td>
<td>N/A</td>
<td>Panel experience</td>
<td>PLA</td>
<td></td>
</tr>
</tbody>
</table>

ASA, American Society of Anesthesiologists physical classification system; BMI, body mass index; CAR, cardiothoracic surgery; COPD, chronic obstructive pulmonary disease; GEN, general surgery; N/A, not applicable; ORT, orthopaedic surgery; PLA, plastic surgery; VAS, vascular surgery.

* Risk factor ranking was obtained by multiplying the number of articles, the number of patients and the number of surgical fields.
†Based on odds ratio >2 or presence in multiple surgical fields.
providing an air tight seal. Using the results of the literature search and panel member experiences, we summarised potential evidence-based benefits of ciNPT usage, identified both patients and incisions that could potentially benefit from ciNPT and created recommendations for the most appropriate use of this treatment.

Every surgical procedure has its own set of risks for SSIs. While many SSIs can be treated with antibiotics and/or superficial wound debridement, there are certain scenarios in which wound infection has disastrous consequences, such as in a lower extremity prosthetic bypass or joint replacement surgery. As with specific procedures, patients with certain comorbidities are at increased risk of developing SSIs. The most common patient and surgical operation risk factors identified by EbM and panel member experience were: obesity (BMI ≥30 kg/m²), diabetes mellitus (e.g. 50% higher risk of developing SSI following cardiac surgery), tobacco use, prolonged surgical time, ASA score ≥3 and corticosteroid use (Table 3) (85,88,92,93,95,96,103–110). High-risk incisions included those with specific characteristics (e.g. incisions that were re-opened or under high tension) as well as those associated with specific surgical procedures (e.g. pelvic surgery incisions, sternotomy, extremity fractures, open reduction and internal fixation and vascular groin surgery in which synthetic grafts were used).

Using the above information, we created consensus recommendations for the most appropriate use of ciNPT (i.e. in patients with one or more comorbidities or in patients with a surgical incision that is historically at high risk for developing SSIs) (Figure 1).

Despite the small number of ciNPT studies, in comparison to the large number on NPWT, current literature supports its benefit in high-risk patients and incisions. A majority of the 100 publications reported decreased rates of SSIs, dehiscence and haematoma/seroma formation (14–17,22–25,27–32,44,58,59,63–68,70,71,111–113). A recent meta-analysis reported a 50% reduction in the rate of SSIs in the ciNPT group compared with the control group (OR 0.564; P < 0.00001) (84). Groin incisions were excluded from the analysis. Nevertheless, this study further supports our consensus recommendation. Adverse effects with ciNPT use were only noted in one study (Howell et al.) (77), which was stopped prematurely because of skin blistering development at the skin/dressing interface in 63% of the ciNPT group. This adverse effect was most likely because of improper dressing configuration (e.g. a lack of a non-adherent film dressing or drape used to protect the skin from the foam dressing and too high tension when using the dressing). It is noteworthy that in this study, ciNPT was used for only 48 hours instead of the recommended 7 days. No other study reported any skin blistering or other adverse effects.

Treatment costs are an important issue in patient care. To date, three studies examined the cost of ciNPT use (6–8) and compared SSO rates and cost savings of ciNPT to routine incision care. Lewis et al. concluded that ciNPT may be a cost-effective treatment for closed laparotomy incisions following removal of gynaecological cancers if it reduces SSO rates (6). Tuffaha et al. examined use of ciNPT in obese women following caesarean section. Here, ciNPT appeared to be cost-effective compared with standard wound dressings, although the authors note the high uncertainty surrounding the decision to use ciNPT (7). Lastly, Echebiri and colleagues used a computer model to evaluate the potential economic benefit for prophylactic ciNPT after a caesarean section (8). The authors provided evidence suggesting that ciNPT in high-risk patients following caesarean section could be cost-beneficial (8). While these results are encouraging, large cohort studies examining cost savings in various surgical fields are needed.

Limitations exist in this study. The robustness of the consensus recommendations is highly dependent upon the knowledge experience, and objectivity of our panel members. These members were carefully selected based on their personal familiarity with the ciNPT system and their publications in the field. Each reviewed the full literature available on the topic. During the in-person meeting, any potential panel members’ biases were considered based on available evidence and vigorous debates of our medical practices. An additional limitation was the small number of prospective, randomised comparative studies included in the literature search. Thus, the evidence-based level of the available articles could skew the consensus guidelines because of a restricted evidence pool. Furthermore, we acknowledge the potential bias introduced by the meeting sponsor (the manufacturer of the PREVENATM Incision Management System (KCI, an Acelity company, San Antonio, TX), one ciNPT device).

To our knowledge, this is the first consensus document attempting to better define the potential use of ciNPT to reduce the incidence of SSIs. The panel believes that data in the available literature, while limited, allows the surgeon to determine a patient’s risk for a particular operative procedure. In high-risk patients and high-risk surgical procedures, ciNPT appears to have the potential to reduce surgical incision complications and surgical cost per patient up to $9000 (15,66,67), depending on the type of incision and patient risk factors. With an estimated 8.7–58.2 million patients globally developing an SSI, use of ciNPT may substantially reduce these rates. As additional high-level, peer-reviewed publications become available, these consensus recommendations can be updated.

Acknowledgements

The authors thank Ricardo Martinez, MS (Acelity), and Julie M Robertson, PhD (Acelity) for assistance with the preparation and editing of this manuscript. No external funding support was received for this work. CW, AA, CAA, GDS, OG, OMG, MBM, LLM and VSR are consultants to KCI, an Acelity company. BAL has served as a consultant and advisory board member for KCI, an Acelity company. AG is a consultant to KCI, an Acelity company and Allergan. DS is a consultant to KCI, an Acelity company and Novadaq.

References


60. Matsumoto T, Parekh SG. Use of negative pressure wound therapy on closed surgical incision after total ankle arthroplasty. Foot Ankle Int 2015;36:787–94.


64. Pellino G, Sciaudone G, Candiseo G, Campitiello F, Selvaggi F, Canonicco S. Effects of a new pocket device for negative pressure


