

LETTERS**Rates of Readmission after Inpatient Plastic Surgery May Not Tell the Whole Story**

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Dear Editor,

Jain et al. [1] have offered a fascinating insight into rates of readmission after inpatient plastic surgery and predictors of such readmissions. The facts as they present them are inarguable, and clearly present opportunities for both clinical quality improvement and cost savings. However the story that they tell might not be the whole story—from a quality improvement perspective or a cost one.

Firstly the paper looks at readmission rates—but not all complications will result in a readmission. These complications that do not result in readmission will still by definition cause morbidity and are likely to be associated with some costs. Some of these complications might be as serious as those that result in readmission—not least because it is not always the seriousness of the illness itself that precipitates admission. In an elderly and vulnerable patient who lives alone, a minor complication might result in a readmission—however the opposite might be the case in a younger and more robust patient. The complications that result in readmission are quite simply not all the complications or even necessarily the most serious complications.

Secondly even though the analysis clearly demonstrates the factors that predict readmission that does not mean that anything can be done about these factors. Some of them (such as having a history of chronic obstructive pulmonary disease) certainly are not modifiable factors. For all the factors, there is undoubtedly a *prima facie* case to be made that targeted interventions to prevent complications might prevent readmissions. However this *prima facie* case is far from strong evidence that these targeted interventions will prevent complications and readmissions. In any case targeted interventions are

likely to be associated with at least some costs and the costs might actually outweigh the costs of readmissions.

Even though Jain et al. have come up with some interesting findings we should be cautious before reading too much into them or radically changing current practice in light of them.

Yours Sincerely,

Dr Kieran Walsh

Reference

1. Jain U, Salgado C, Mioton L, et al. Predictors of readmission after inpatient plastic surgery. Arch Plast Surg 2014;41:116-21.

Correction of a Misjudgment of Reference in *Grabb and Smith's Plastic Surgery Seventh Edition*

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To the Editor,

We have carefully read the 7th edition of Grabb and Smith's widely used textbook, *Plastic Surgery* [1]. We would like to thank the editors for their noble effort. It is an important textbook that contains all of the basic principles of plastic and reconstructive surgery. While reading through the book, we noticed a misjudgment of a reference on page 994, in the section on Sacral Defects. The text is as follows "Some groups have published that their first choice for reconstruction of ischial and sacral pressure sores is free tissue transfer with microvascular anastomosis to the gluteal vessels" with a citation of "Free

flaps for pressure sore coverage” by Lemaire et al. [2]. However, in the original article by Lemaire et al. [2], the researchers reported that they used free flaps with very limited indications and multiple or recurrent pressure ulcerations without any local flap options left. Only 6 of 88 patients were reconstructed with free flaps. The authors preferred free flap surgery as the last step of the reconstructive ladder, not as the first-line treatment. It is obvious that there is a misjudgment of the reference. We would like to point out this error for correction in the next edition. In our enthusiasm to assist the textbook editors in the ongoing development of an excellent text, we decided

to send this letter to the Editor of the *Archives of Plastic Surgery* journal, which is followed by plastic surgeons all around the world.

References

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2. Lemaire V, Boulanger K, Heymans O. Free flaps for pressure sore coverage. *Ann Plast Surg* 2008;60:631-4.