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Commentary

Management of continuous wound leakageThe Discussion of Skull crack intense subdural hematoma (ASDH) and Skull Injuries

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Introduction

FChronic wound leakage has been identified as one of the most significant risk factors for periprosthetic joint infection (PJI). There is currently no consensus on how to treat patients who develop wound leakage after total joint replacement (TJA). The goal of this study was to develop and evaluate a multimodal regimen for managing draining wounds after TJA. One of the most feared consequences after total joint arthroplasty is periprosthetic joint infection. Although periprosthetic joint infection is not the most prevalent complication, it is the most common reason for total knee arthroplasty revision within two years. The goal of innumerable studies spanning from preoperative protocol to intraoperative and postoperative procedures has been to reduce the likelihood of acquiring a Periprosthetic joint infection after total joint arthroplasty. Persistent wound leakage is a major risk factor for periprosthetic joint infection.

Draining wounds are a common and difficult complication, occurring in up to 14% of total hip arthroplasty (THA) and total knee arthroplasty (TKA) surgeries. After repeatedly draining wounds, the rate of PJI has ranged from 1.3 percent to 50 percent. Despite the significant risk of infection, there is no standardised approach for treating these wounds. Identifying PWD risk factors may also lead to proactive interventions that can be taken to avoid this issue.

Persistent drainage following THA and TKA has been defined in a variety of ways, the majority of which differ in terms of length and volume of drainage. PWD was defined at the 2013 International Consensus Meeting on PJI. Significant drainage (more than 2 2 cm area of gauze) from a wound after 72 hours, according to the work group, should be deemed abnormal. Local wound therapies are usually successful in stopping the discharge. However, it has been noted that wounds that are draining are unlikely to stop flowing beyond 5-7 days. As a result, the general view has been that drainage lasting longer than 5-7 days necessitates surgical intervention. Diabetes was found to have a 21.2 OR for PWD, while morbid obesity had a 17.3 OR.Morbid obesity increased the incidence of wound drainage in THA but not TKA, which is likely due to the presence of more subcutaneous adipose tissue around the hip than around the knee in these patients.

The decrease in the risk of PWD after switching from warfarin to aspirin for deep vein thrombosis prophylaxis for most patients was a noteworthy finding of this study. The unemployment rate fell from 6.3 percent to 3.1 percent. This is in line with other recent studies that suggest aspirin therapy has similar efficacy to standard warfarin medication and has fewer side effects. In comparison to warfarin, aspirin has not been demonstrated to enhance the risk of deep vein thrombosis or pulmonary embolism after a TJA.

Because wound drainage following TJA is a major risk factor for recurrent PJI, careful management of these patients is critical.With only local wound care procedures, drainage stopped spontaneously in 65 percent of the patients, according to our findings. Wounds with chronic leakage were shown to have a much higher incidence of PJI than wounds that healed normally.

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Conflict of Interest

We have no conflict of interests to disclose and the manuscript has been read and approved by all named authors.