

also inaccurate; IAH / ACS can be easily and accurately diagnosed with the use of inexpensive bedside IAP measurements such as those used by the authors. The medical literature is replete with studies demonstrating the efficacy and diagnostic accuracy of IAP measurements.<sup>3-5</sup> Such measurements can be used to diagnose IAH / ACS and to direct ongoing therapeutic interventions. Radiologic tests are unnecessary, expensive and time-consuming, and they have poor diagnostic sensitivity and specificity for IAH / ACS. Their routine application as a diagnostic tool only serves to delay and confuse the appropriate management of patients with IAH / ACS.

The WSACS has described a graded approach to the diagnosis and management of IAH / ACS (www.wsacs.org) that can be used to avoid the need for surgical decompression in many patients.<sup>2,3</sup> In this algorithm, percutaneous drainage is considered as a potential therapeutic option before proceeding with surgical decompression. If percutaneous drainage is unsuccessful in reducing IAP and restoring adequate visceral perfusion in the setting of ACS, surgical decompression should be immediately performed. The clinical situation in which “surgical decompression is not feasible” and percutaneous treatment would be an effective rescue therapy, as suggested by the authors, is exceedingly rare and unlikely.

**Michael L. Cheatham, MD**  
**Jan De Waele, MD, PhD**  
**Andrew Kirkpatrick, MD**  
**Michael Sugrue, MD**  
**Manu LN Malbrain, MD, PhD**  
**Rao R. Ivatury, MD**

**Zsolt Balogh, MD, PhD**  
**Scott D’Amours, MD**  
 Executive Committee of the World Society of the Abdominal Compartment Syndrome

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**THE AUTHORS REPLY**

**W**e thank Dr. Cheatham and colleagues for their interest in our article.<sup>1</sup> We regret the typographical error in the definition of abdominal compartment syndrome (ACS). This should have been “greater than 20 mm Hg.” The patient had sustained raised intra-abdominal pressure. This was recorded more than once. Diagnosis was not based on a single measurement of intra-abdominal pressure. He went into respiratory failure, a new organ dysfunction

that supports the diagnosis of ACS in our patient. We have not implied that radiological testing should be done to reach a diagnosis; however, with such imaging the large loculated fluid collections and oedematous bowel loops can be better differentiated, helping to plan the appropriate intervention.

Although the authors of the letter state that “the scenario of surgical decompression not being feasible and percutaneous treatment being an effective rescue therapy is exceedingly rare and unlikely,” there is a case report<sup>2</sup> of a patient with ACS who was initially unfit for surgery and was treated with percutaneous drainage. We document in our case report<sup>1</sup> another instance where percutaneous drainage helped in the recovery of a patient with ACS who was unfit for surgery.

**K.S. Amitha Vikrama, MD**  
**Shyamkumar Nidugala Keshava, DMRD, DNB**  
**Moses Vinu, MD**  
**Philip Joseph, MS**  
**Frederick Vyas, MS**  
**Sitaram Venkatramani, MS**  
 Department of Radiology  
 Surgery Unit IV  
 Christian Medical College  
 Vellore, India

**Competing interests:** None declared.

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