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Subcutaneous Fat Thickness on Erect Radiographs Is a Predictor of Infection Following Elective Posterior Lumbar Fusion

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ABSTRACT

Background: Posterior lumbar fusions are a common and successful procedure, yet surgical site infection (SSI) is still prevalent and causes significant morbidity. Obesity is a well-established risk factor for SSI. Still, the accuracy of the body mass index (BMI) caused some to suggest other metrics that are more representative of the thickness of the soft-tissue envelope in the surgical site.

Methods: A retrospective review of all cases that developed SSI following posterior lumbar fusion over the past 5 years was done. An age and gender-matched control group was formed from the lumbar fusion cases that did not develop SSI. Demographic and clinical data were collected, and morphometric measurements of the soft-tissue envelope were performed at the level of L4 for all cases on standing x-ray imaging and magnetic resonance imaging (MRI).

Results: A total of 366 patients underwent posterior lumbar fusion, 26 of whom developed SSI. BMI and skin to spinous process measurements on x-ray imaging—not MRI—were found to be significantly associated with SSI. Regression analysis further confirmed the strength of the association.

Conclusion: While BMI and MRI measurements are useful, wound depth measurements on x-ray imaging can be predictive of SSI in lumbar fusion cases.

Clinical Relevance: Wound depth measurements are predictive of lumbar wound infection. The information within this study can help surgeons better predict and manage infections of posterior lumbar wounds.

Level of Evidence: 3.

Lumbar Spine

Keywords: surgical site infection, spine fusion, lumbar spine

INTRODUCTION

Surgical site infection (SSI) is a global issue, placing a significant burden on the health care systems of all countries.¹ SSI following instrumented spine surgery is prevalent, with rates from 2% to over 20% in the current literature.^{2–5} It is the most common complication after elective spine surgery in most series and is responsible for a significant number of readmissions and reoperations.^{6–8} The morbidity and increased cost are substantial, up to 4 times the cost of an uninfected patient.^{9–11} Multiple risk factors have been associated with SSI following instrumented spine surgery. Smoking, diabetes mellitus (DM), increased blood loss, the number of levels fused, prolonged operative time, and obesity have all been implicated.¹² Obesity is a global pandemic, rising in prevalence at an alarming rate.¹³ The association of obesity with

worse outcomes in spine surgery has been reported on extensively.^{14–19} A significant portion of the morbidity comes from its proven status as a risk factor for SSI in spine surgery.^{14,15,17,20} Body mass index (BMI) alone is helpful, but studies have looked at the lumbar wound soft-tissue envelope thickness as a more accurate predictor of SSI.^{21–24} The correlation was found but was also disputed.²⁵ All these studies have taken measurements from magnetic resonance imaging (MRI) or computed tomography in the standard, supine position. We have had concerns that these measurements are not very accurate, as it is well established that supine MRI can underestimate the findings as compared with standing MRI.^{26,27} Standing MRI scanners are not widely available, yet a standing radiograph is universally available and can provide the “skin to spinous process (SP)” measurement needed with accuracy and ease for all cases. In

this study, we aim to take the erect lumbar radiograph measurements from cases of lumbar SSI and compare them to a control group. We hypothesize that standing lumbar radiographs are a more accurate measure of the subcutaneous layer thickness and a better predictor of postoperative lumbar SSI than MRI measurement.

MATERIALS AND METHODS

All adult patients who underwent primary instrumented posterior lumbar spine fusion surgery in the past 5 years in our institution (from January 2015 to December 2020) were included in the primary review. The surgeries were done by 4 spine surgeons. An institutional SSI prevention protocol has been in place since 2012. It includes evidence-based antibiotic prophylaxis and wound care measures. These wound care measures included the release of retractors on an hourly basis, debridement of any necrotic tissue at the end of the procedure, soaking with a diluted (0.3%) povidone-iodine solution for 30 seconds, followed by irrigation with a standard 2 L of warmed

normal saline. An amount of 1 g of vancomycin powder was added to the deep layer prior to closure. Wound closure was done using interrupted sutures for the deep facial layer and continuous sutures for the subcutaneous and skin layers.

Patients' who developed SSI were defined as those who underwent either reoperation or readmission within 30 days of the initial surgery for infection and had positive tissue cultures proving the diagnosis. Data-points to be collected included demographics, BMI, number of levels fused, estimated blood loss, length of anesthesia, glycemic control, use of drains, skin to SP on standing x-ray imaging, skin to SP on sagittal MRI, skin to SP on axial MRI, and skin to lamina on axial MRI. X-ray imaging was performed using a standard technique, with the elbows flexed and hands on the clavicles. All the measurements were taken at the level of L4 (Figure 1) using the standard imaging viewer software. An orthopedic spine surgeon (AA) took all the measurements and repeated them twice, 1 month apart. Intraobserver reliability using the kappa statistic was performed, and the data found to be very

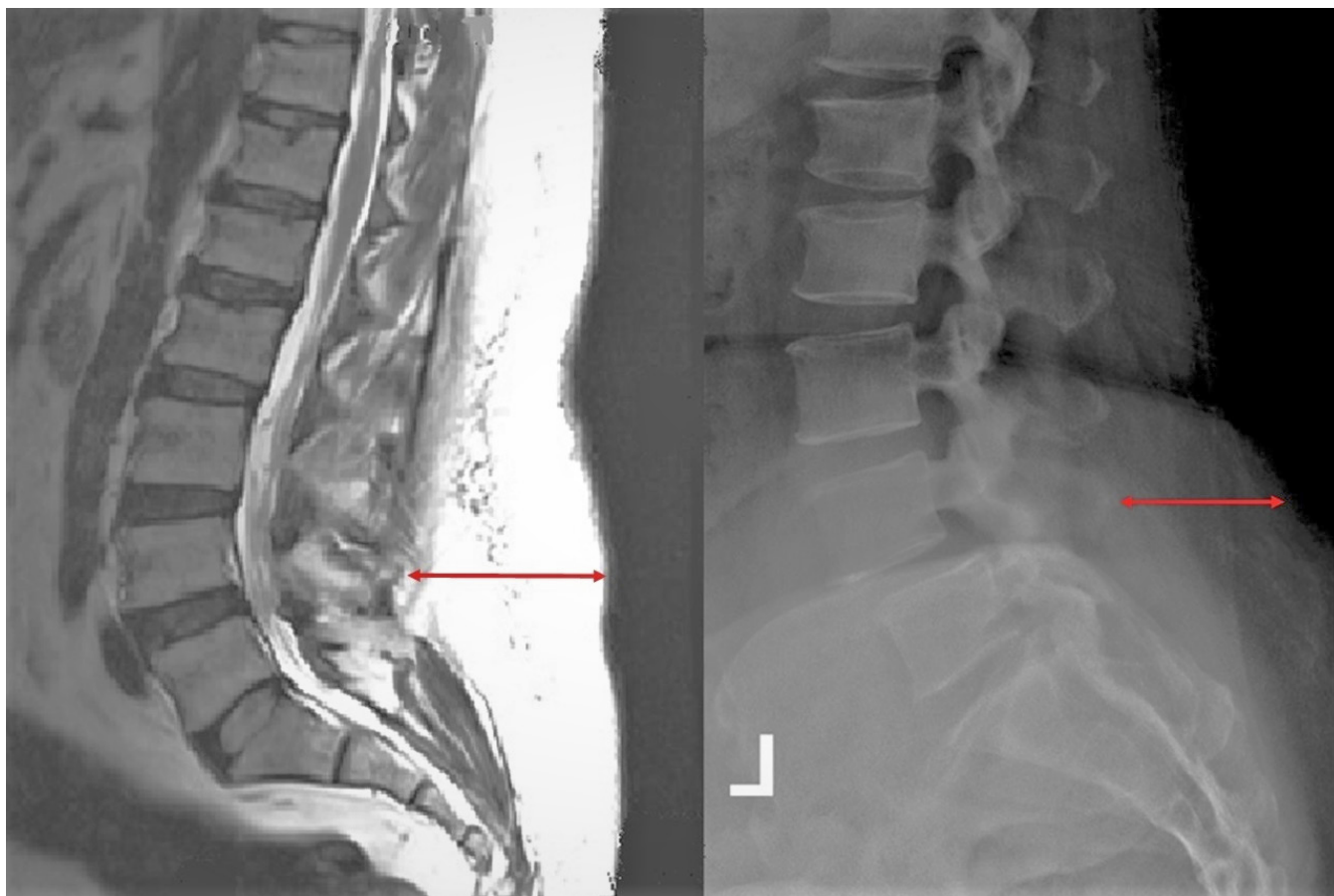


Figure 1. Skin to spinous process measurements at L4 on x-ray imaging and magnetic resonance imaging.

reliable. The means of measurements were used for the final analysis. Any patients who lacked any data-points were excluded from the study cohort. Patients who underwent surgery for infection or neoplasia were also excluded. An age and sex-matched control group was chosen randomly from the cases that did not develop SSI. The research ethics board approval was obtained (21/5777/IRB [institutional review board]) prior to the collection of the data. All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation (institutional and national) and with the Helsinki declaration of 1975, as revised in 2000. The *t* test and the Mann-Whitney *U* test were used for continuous variables, whereas the χ^2 test was used for categorical variables. When a significant association was found, binary logistic regression was utilized to determine the strength of the correlation. A *P* value of less than 0.05 was used to assess significance. All analyses were performed using SPSS version 27 software (IBM Corp, Armonk, NY, USA).

RESULTS

A total of 366 patients were included in the primary data collection, of whom 26 (7.1%) developed SSI as per the study definition. The cases were evenly distributed among the 4 surgeons. The demographic and clinical data are presented in Table 1, which shows the control group was well matched to the study group for age and sex. All the patients' cultures were positive for *Staphylococcus aureus* except for 2 patients: one was positive for *Pseudomonas aeruginosa*, and the other was infected with methicillin-resistant *S aureus*.

BMI was found to be significantly associated with SSI (*P* = 0.049). The average infected case was obese, while the average noninfected case was overweight

(33 vs 29). A linear relation between BMI and skin to SP on x-ray imaging was found with an increase of 0.23 mm with each unit increase in BMI (Helsinki) (Figure 2).

The skin to SP measurement was also found to be significantly associated with SSI (*P* = 0.017). A difference of 10 mm was found between the 2 groups, while MRI measurements showed only an 8.5 mm difference on the sagittal views, going down to 5 mm in the axial cuts. Multivariate regression is displayed in Table 2. The odds of SSI were higher with a higher BMI, thicker fat envelope on sagittal x-ray imaging and sagittal MRI. When the cases were divided into quartiles based on the skin to SP measurements, the patients with thickness above the 50% mark (44.5 mm) had a 6-fold increase in the odds of SSI (OR = 6.112, 95% CI = 1.479–25.259) compared with those less than 44.5 mm (*P* = 0.012).

DISCUSSION

The rates of postoperative infection following instrumented thoracolumbar spine surgery have been reported to be 4.4% to 13% in a recent systematic review.²⁸ The rate in this series is within that range but higher than the average of other series.^{2,4,5} The factors identified in the literature as risk factors for SSI following spine surgery are many, so much so that a web-based calculator has been designed to predict the risk.²⁹ DM has been identified by many as a risk factor.^{7,30} In our study, it did not correlate with the risk of SSI. The explanation might be that our perioperative protocols exclude patients with uncontrolled diabetes from having elective spine surgery. Others have reported that controlled DM should have no impact on the incidence of complications following spine surgery.^{31,32} Multiple operative factors have been implicated as risk factors for spinal SSI. Operative time, the number of levels fused, intraoperative blood loss, and the use of drains are

Table 1. Demographics and clinical data (*N* = 366).

| Risk Factor | Surgical Site Infection Cohort | Control Group | <i>P</i> Value |
|---|--------------------------------|---------------|----------------|
| Age, y, mean (SD) | 48.2 (19.0) | 50.1 (19.7) | 0.722 |
| Female sex, n (%) | 21 (81) | 21 (81) | 1.00 |
| Body mass index, mean (SD) | 33.4 (9.1) | 28.9 (6.9) | 0.049 |
| No. of levels, mean (SD) | 4.1 (4.4) | 3.5 (4.3) | 0.632 |
| Length of anesthesia, min, mean (SD) | 334 (119) | 354 (124) | 0.552 |
| Estimated blood loss, mL, mean (SD) | 571 (459) | 400 (265) | 0.106 |
| Serum glucose on day 3, mmol/L, mean (SD) | 8.58 (3.5) | 7.49 (1.9) | 0.168 |
| Drain use, n (%) | 13 (50) | 14 (54) | 0.781 |
| Days from initial procedure to reoperation, mean (SD) | 21.7 (14.6) | N/A | N/A |
| Skin to SP on x-ray, mm, mean (SD) | 47.9 (14.9) | 37.7 (17.1) | 0.017 |
| Skin to SP on sagittal MRI, mm, mean (SD) | 43.5 (14.9) | 35.0 (17.1) | 0.062 |
| Skin to SP on axial MRI, mm, mean (SD) | 39.3 (14.2) | 34.3 (16.1) | 0.248 |
| Skin to lamina on MRI, mm, mean (SD) | 61.2 (16.7) | 55.4 (16.5) | 0.213 |

Abbreviations: MRI, magnetic resonance imaging; SP, spinous process.

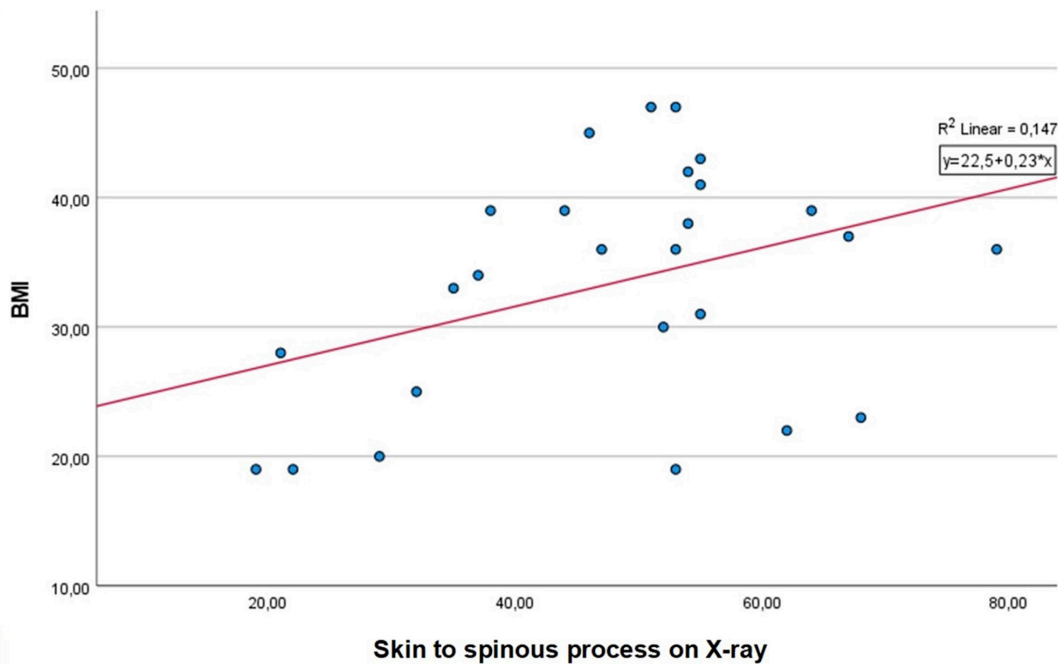


Figure 2. Scatter plot showing linear relationship between BMI and “skin to spinous process” measurements. BMI, body mass index.

commonly investigated.^{33–36} In this study, these factors were not associated with the development of SSI.

Obesity—commonly measured using BMI—is a well-established risk factor for spinal SSI.^{14,16,19,37,38} A recent meta-analysis found it to be responsible for worse clinical outcomes and higher complication rates—notably thromboembolic events and SSI.¹⁸ The correlation in this study is robust and confirms the findings of other studies. The concern that BMI might not be the best indicator of wound complications stems from being a general assessment that doesn’t consider fat distribution throughout the body. The subcutaneous layer is subjected to retraction during the procedure. Given its limited vascularity, this could result in tissue ischemia and fat necrosis.^{39–41} The thicker the subcutaneous layer is, the more dead space will result and infection could follow.⁴²

The first study to report on linear wound measurements—specifically skin to lamina and fat layer thickness—was by Mehta et al.²¹ The series of 24 patients who developed SSI were compared to an unmatched control group. While BMI was not correlated with SSI,

obesity (BMI >30 kg/m²) was significantly associated with SSI. As for the wound measurements, Mehta et al reported on the skin to lamina, fat, and muscle layer thickness. The fat layer thickness was significantly predictive of SSI (OR = 1.037, 95% CI = 1.007–1.068), and the muscle layer thickness was not. Lee et al published a similar case-control study, again noting that obesity is a significant risk factor. Still, it was the subcutaneous fat thickness that was strongly predictive of SSI with an OR of 1.06 (95% CI = 1.02–1.10) on regression analysis. Two more studies were published in the past year having similar objectives to Mehta et al and Lee et al and arriving at similar conclusions.^{22,24} In the aforementioned studies, measurements were taken from MRI or CT. Most took the measurements from the skin to the SP, while some added “skin to lamina.” The measurement from the skin to the SP was more correlated with SSI in these studies than the “fat layer thickness” that can only be evaluated on MRI.^{21,24,43} As such, it was used as the primary measurement in our study albeit from erect radiographs rather than MRI or CT. Our results confirm the findings of the previous studies.

Our study was limited by its retrospective design and its small sample size. Nevertheless, our results confirm the association of SSI with a higher BMI and a thicker soft-tissue envelope. Future larger, prospective studies that add more risk factors to the analysis are needed.

Table 2. Multiple regression analysis of risk factors for surgical site infection.

| Risk Factor | OR | 95% CI | P Value |
|---|-------|-------------|---------|
| Body mass index | 1.114 | 1.020–1.217 | 0.016 |
| Skin to SP on x-ray imaging | 1.077 | 1.021–1.135 | 0.006 |
| Skin to SP on sagittal magnetic resonance imaging | 1.057 | 1.009–1.107 | 0.020 |

Abbreviation: SP, spinous process.

CONCLUSION

This study describes a simple and readily available measurement that can serve as a predictor of SSI following lumbar spine fusion surgery.

REFERENCES

- World Health Organisation. Global guidelines for the prevention of surgical site infection. 2018.
- Lee NJ, Shin JI, Kothari P, et al. Incidence, impact, and risk factors for 30-day wound complications following elective adult spinal deformity surgery. *Global Spine J.* 2017;7(5):417–424. doi:10.1177/2192568217699378
- Ramo BA, Roberts DW, Tuason D, et al. Surgical site infections after posterior spinal fusion for neuromuscular scoliosis: a thirty-year experience at a single institution. *J Bone Joint Surg Am.* 2014;96(24):2038–2048. doi:10.2106/JBJS.N.00277
- Sato S, Yagi M, Machida M, et al. Reoperation rate and risk factors of elective spinal surgery for degenerative spondylolisthesis: minimum 5-year follow-up. *Spine J.* 2015;15(7):1536–1544. doi:10.1016/j.spinee.2015.02.009
- Rao SB, Vasquez G, Harrop J, et al. Risk factors for surgical site infections following spinal fusion procedures: a case-control study. *Clin Infect Dis.* 2011;53(7):686–692. doi:10.1093/cid/cir506
- Blumberg TJ, Woelber E, Bellabarba C, Bransford R, Spina N. Predictors of increased cost and length of stay in the treatment of postoperative spine surgical site infection. *Spine J.* 2018;18(2):300–306. doi:10.1016/j.spinee.2017.07.173
- Olsen MA, Nepple JJ, Riew KD, et al. Risk factors for surgical site infection following orthopaedic spinal operations. *J Bone Joint Surg Am.* 2008;90(1):62–69. doi:10.2106/JBJS.F.01515
- Gu W, Tu L, Liang Z, et al. Incidence and risk factors for infection in spine surgery: a prospective multicenter study of 1764 instrumented spinal procedures. *Am J Infect Control.* 2018;46(1):8–13. doi:10.1016/j.ajic.2017.09.025
- Calderone RR, Garland DE, Capen DA, Oster H. Cost of medical care for postoperative spinal infections. *Orthop Clin North Am.* 1996;27(1):171–182.
- Fang A, Hu SS, Endres N, Bradford DS. Risk factors for infection after spinal surgery. *Spine (Phila Pa 1976).* 2005;30(12):1460–1465. doi:10.1097/01.brs.0000166532.58227.4f
- Browne JA, Cook C, Pietrobon R, Bethel MA, Richardson WJ. Diabetes and early postoperative outcomes following lumbar fusion. *Spine (Phila Pa 1976).* 2007;32(20):2214–2219. doi:10.1097/BRS.0b013e31814b1bc0
- Fei Q, Li J, Lin J, et al. Risk factors for surgical site infection after spinal surgery: a meta-analysis. *World Neurosurg.* 2016;95:507–515. doi:10.1016/j.wneu.2015.05.059
- Blüher M. Obesity: global epidemiology and pathogenesis. *Nat Rev Endocrinol.* 2019;15(5):288–298. doi:10.1038/s41574-019-0176-8
- Marquez-Lara A, Nandyala SV, Sankaranarayanan S, Noureldin M, Singh K. Body mass index as a predictor of complications and mortality after lumbar spine surgery. *Spine (Phila Pa 1976).* 2014;39(10):798–804. doi:10.1097/BRS.0000000000000232
- Rihn JA, Kurd M, Hilibrand AS, et al. The influence of obesity on the outcome of treatment of lumbar disc herniation: analysis of the Spine Patient Outcomes Research Trial (SPORT). *J Bone Joint Surg Am.* 2013;95(1):1–8. doi:10.2106/JBJS.K.01558
- Soroceanu A, Burton DC, Diebo BG, et al. Impact of obesity on complications, infection, and patient-reported outcomes in adult spinal deformity surgery. *J Neurosurg Spine.* 2015;23(5):656–664. doi:10.3171/2015.3.SPINE14743
- Vaidya R, Carp J, Bartol S, Ouellette N, Lee S, Sethi A. Lumbar spine fusion in obese and morbidly obese patients. *Spine (Phila Pa 1976).* 2009;34(5):495–500. doi:10.1097/BRS.0b013e318198c5f2
- Devine JG, Jackson KL. The effects of obesity on spine surgery: a systematic review of the literature. *Global Spine J.* 2016;6(4):394–400. doi:10.1055/s-0035-1570750
- Buerba RA, MC F, Gruskay JA, Long WD, Grauer JN. Obese Class III patients at significantly greater risk of multiple complications after lumbar surgery: an analysis of 10,387 patients in the ACS NSQIP database. *Spine J.* 2014;14(9):2008–2018. doi:10.1016/j.spinee.2013.11.047
- Abdallah DY, Jadaan MM, McCabe JP. Body mass index and risk of surgical site infection following spine surgery: a meta-analysis. *Eur Spine J.* 2013;22(12):2800–2809. doi:10.1007/s00586-013-2890-6
- Mehta AI, Babu R, Karikari IO, et al. 2012 Young investigator award winner: the distribution of body mass as a significant risk factor for lumbar spinal fusion postoperative infections. *Spine (Phila Pa 1976).* 2012;37(19):1652–1656. doi:10.1097/BRS.0b013e318241b186
- Sang C, Chen X, Ren H, Meng Z, Jiang J, Qin Y. Correlation between lumbar multifidus fat infiltration and lumbar postoperative infection: a retrospective case-control study. *BMC Surg.* 2020;20(1):35:1–7. doi:10.1186/s12893-019-0655-9
- Li Z, Liu P, Zhang C, et al. Incidence, prevalence, and analysis of risk factors for surgical site infection after lumbar fusion surgery: ≥2-year follow-up retrospective study. *World Neurosurg.* 2019;131:e460–e467. doi:10.1016/j.wneu.2019.07.207
- Güleç İ, Güzey FK. The importance of subcutaneous tissue thickness for the occurrence of surgical site infection after lumbar disc surgery. 2020.
- Osterhoff G, Burla L, Werner CML, et al. Role of preoperative blood transfusion and subcutaneous fat thickness as risk factors for surgical site infection after posterior thoracic spine Stabilization. *Surg Infect (Larchmt).* 2015;16(3):333–337. doi:10.1089/sur.2014.081
- Guglielmi G, Boesen MM. Weight-bearing MRI of the lumbar spine: technical aspects. In: *Seminars in Musculoskeletal Radiology 2019.* Publisher unknown.
- Kubosch D, Vicari M, Siller A, et al. The lumbar spine as a dynamic structure depicted in Upright MRI. *Medicine (Baltimore).* 2015;94(32). doi:10.1097/MD.0000000000001299
- Zhou J, Wang R, Huo X, Xiong W, Kang L, Xue Y. Incidence of surgical site infection after spine surgery: a systematic review and metaanalysis. *Spine (Phila Pa 1976).* 2020;45(3):208–216. doi:10.1097/BRS.0000000000003218
- Lubelski D, Feghali J, Ehresmainfectionn J, et al. Web-based calculator predicts surgical-site infection after thoracolumbar spine surgery. *World Neurosurg.* 2021;151:571–578. doi:10.1016/j.wneu.2021.04.086
- Liu J-M, Deng H-L, Chen X-Y, et al. Risk factors for surgical site infection after posterior lumbar spinal surgery. *Spine (Phila Pa 1976).* 2018;43(10):732–737. doi:10.1097/BRS.0000000000002419
- Guzman JZ, Iatridis JC, Skovrlj B, et al. Outcomes and complications of diabetes mellitus on patients undergoing degenerative

lumbar spine surgery. *Spine (Phila Pa 1976)*. 2014;39(19):1596–1604. doi:10.1097/BRS.0000000000000482

32. Kim CH, Chung CK, Shin S, et al. The relationship between diabetes and the reoperation rate after lumbar spinal surgery: a nationwide cohort study. *Spine J*. 2015;15(5):866–874. doi:10.1016/j.spinee.2015.01.029

33. Boston KM, Baraniuk S, O'Heron S, Murray KO. Risk factors for spinal surgical site infection, Houston, Texas. *Infect Control Hosp Epidemiol*. 2009;30(9):884–889. doi:10.1086/605323

34. Pull ter Gunne AF, van Laarhoven CJHM, Cohen DB. Incidence of surgical site infection following adult spinal deformity surgery: an analysis of patient risk. *Eur Spine J*. 2010;19(6):982–988. doi:10.1007/s00586-009-1269-1

35. Abdul-Jabbar A, Takemoto S, Weber MH, et al. Surgical site infection in spinal surgery: description of surgical and patient-based risk factors for postoperative infection using administrative claims data. *Spine (Phila Pa 1976)*. 2012;37(15):1340–1345. doi:10.1097/BRS.0b013e318246a53a

36. Pennington Z, Lubelski D, Molina C, Westbroek EM, Ahmed AK, Sciubba DM. Prolonged post-surgical drain retention increases risk for deep wound infection after spine surgery. *World Neurosurg*. 2019;130:846–853. doi:10.1016/j.wneu.2019.07.013

37. Haleem A, Chiang H-Y, Vodela R, et al. Risk factors for surgical site infections following adult spine operations. *Infect Control Hosp Epidemiol*. 2016;37(12):1458–1467. doi:10.1017/ice.2016.193

38. Yuan K, Chen H-L. Obesity and surgical site infections risk in orthopedics: a meta-analysis. *Int J Surg*. 2013;11(5):383–388. doi:10.1016/j.ijssu.2013.02.018

39. Mangram AJ, Horan TC, Pearson ML, Silver LC, Jarvis WR, HICPA C. Guideline for prevention of surgical site infection. *Am J Infect Control*. 1999;27(2):97–134. doi:10.1016/S0196-6553(99)70088-X

40. Hopf HW, Hunt TK, West JM, et al. Wound tissue oxygen tension predicts the risk of wound infection in surgical patients. *Arch Surg*. 1997;132(9):997–1004. doi:10.1001/archsurg.1997.01430330063010

41. Kabon B, Nagele A, Reddy D, et al. Obesity decreases perioperative tissue oxygenation. *Anesthesiology*. 2004;100(2):274–280. doi:10.1097/00000542-200402000-00015

42. Baroudi R, Ferreira CAA. Seroma: how to avoid it and how to treat it. *Aesthet Surg J*. 1998;18(6):439–441. doi:10.1016/s1090-820x(98)70073-1

43. Lee JJ, Odeh KI, Holcombe SA, et al. Fat thickness as a risk factor for infection in lumbar spine surgery. *Orthopedics*. 2016;39(6):1124–1128. doi:10.3928/01477447-20160819-05

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