Clinical Report

Systemic Inflammatory Response Syndrome and Postoperative Complications after Orthognathic Surgery

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Abstract

Symptoms of Systemic Inflammatory Response Syndrome (SIRS) presenting immediately after surgery have lately been regarded as potential warnings of impending postoperative complications and multiple organ failure. Reports discussing the relationship between operative stress and SIRS are found in the field of digestive surgery, but not in that of oral surgery. Sixty-five patients with jaw deformity who had undergone maxillary and mandibular orthognathic surgery (Le Fort I osteotomy and sagittal splitting ramus osteotomy) between September 2003 and October 2006 were involved in this study. A search based on the SIRS diagnostic criteria resulted in assignment of 33 cases to the SIRS group and 32 cases to the non-SIRS group. Postoperative complications occurred in 27.3% of the SIRS group and 0.0% of the non-SIRS group (p<0.01). In four cases, a postoperative fluctuation in IL-6 level evaluated. These results suggest the importance of careful management of postoperative SIRS patients in preventing complications.

Key words: Systemic Inflammatory Response Syndrome (SIRS) — Postoperative complication — Jaw deformity — Orthognathic surgery — Interleukin 6

Introduction

The American College of Chest Physicians and the Society of Critical Care Medicine co-hosted a consensus conference in 1991 (report published in 1992) to define sepsis and accompanying organ failure. At the conference, a new disease concept called systemic inflammatory response syndrome (SIRS) was proposed. SIRS represents a state in which an attack induces systemic inflammatory reactions. More concretely, patients are diagnosed with SIRS when meeting at least 2 of the diagnostic criteria (Table 1). Besides infection, SIRS is induced by various causes, including trauma, burn and surgical stress.

In recent years, due to the simple diagnostic standards, SIRS has been interpreted as a warning sign for the onset of postoperative complications and organ failure, and prevention is clinically important. Furthermore, to identify high-risk SIRS associated with organ injury, the relationship between SIRS duration and outcomes has also been investigated.

To date, the relationship between surgical stress and SIRS has been mostly reported in the field of gastrointestinal surgery. In the field of oral surgery, the relationship has not been investigated at all, even though the mouth is the starting point of the gastrointestinal tract. In 2000 and 2002, we first introduced the concept of SIRS in the head and neck region and investigated the relationship between surgical stress and postoperative complications in oral cancer patients who underwent neck dissection. The results clarified that postoperative SIRS also occurs in the field of oral surgery. The present study investigated SIRS and postoperative complications in orthognathic surgery, another form of oral surgery. Chronological changes in plasma interleukin (IL)-6 were also ascertained.

Patients and Methods

We selected 65 patients (13 men, 52 women) who underwent maxillary and mandibular orthognathic surgery (Le Fort I osteotomy and sagittal splitting ramus osteotomy) from among patients with jaw deformities undergoing surgery at Tokyo Dental College Chiba Hospital between September 2003 and October 2006. Mean patient age was 24.4 years (range, 16–45 years). All patients received intravenous steroid therapy a total of 3 times (8 mg during surgery and 4 mg each at 6 and 12 hr after surgery) to prevent facial edema.

Starting immediately after surgery, body temperature, heart rate and respiratory rate were monitored, and white blood cell count (WBC) was measured at different times. Patients who met ≥2 of the SIRS diagnostic criteria (Table 1) for ≥24 hr were classified as belonging to the SIRS group, while all other patients were classified as belonging to the non-SIRS group. Duration of SIRS was measured from return to the ward, and a duration ≥24 hr but <48 hr was considered as “2 days”. Among these patients, the relationship of SIRS to surgical techniques was investigated, and SIRS and non-SIRS groups were compared in terms of age, operating time, blood loss and incidence of postoperative complications. We considered infection due to wound suture

Table 1 SIRS diagnostic criteria

<table>
<thead>
<tr>
<th>Response is manifested by two or more of following conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body temperature</td>
</tr>
<tr>
<td>Heart rate</td>
</tr>
<tr>
<td>Respiratory rate</td>
</tr>
<tr>
<td>WBC</td>
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failure, suppurative inflammation secondary
to local infection, and viral infection due to
low immunity as postoperative complications.
The Mann-Whitney
\textit{U}-test and Fisher’s exact
probability test were used to determine statis-
tical significance on the SPSS Version 11 for
Windows.

Furthermore, based on the perspective that
SIRS represents hypercytokinemia, plasma
levels of IL-6 were measured before and
after surgery using chemiluminescent enzyme
immunoassay (CLEIA).

### Table 2 Characteristics of SIRS group (33 cases)

<table>
<thead>
<tr>
<th>case (No)</th>
<th>age</th>
<th>sex</th>
<th>operative procedures</th>
<th>time (min)</th>
<th>bleeding (g)</th>
<th>SIRS (days)</th>
<th>complications</th>
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<td>1</td>
<td>17</td>
<td>F</td>
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<td>857</td>
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<tr>
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<tr>
<td>4</td>
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<tr>
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<td>394</td>
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<td></td>
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<td>1</td>
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<td>2</td>
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<td>Le Fort I osteotomy + SSRO (+ Genioplasty)</td>
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<tr>
<td>20</td>
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<td>M</td>
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<td>2,647</td>
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<td>30</td>
<td>F</td>
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<td>497</td>
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<tr>
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<td>Le Fort I osteotomy + SSRO</td>
<td>304</td>
<td>278</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

SSRO: sagittal splitting ramus osteotomy

### Results

1. **Comparison between SIRS and non-SIRS groups**

The SIRS group comprised 33 patients (33/65, 50.8%; 7 men, 26 women) with a
mean age of 23.7 years (range, 16–39 years) (Table 2). Mean operating time was 5 hr 14 min
(range, 3 hr 4 min to 9 hr 29 min). Mean blood loss was 805.4 ml (range, 210–2,647 ml).

The non-SIRS group comprised 32 patients (32/65, 49.2%; 6 men, 26 women) with a
mean age of 25.1 years (range, 16–45 years) (Table 3). Mean operating time was 4 hr 29 min (range, 2 hr 46 min to 6 hr 27 min). Mean blood loss was 519.8 ml (range, 90–1,768 ml). Based on these data, age, operating time and blood loss were compared between the SIRS and non-SIRS groups. The results showed that although no significant difference in age was present, operating time was significantly longer and blood loss significantly greater in the SIRS group (Table 4).

For the 33 patients in the SIRS group, duration of SIRS was 1 day in 24 patients (72.7%), 2 days in 3 patients (9.0%), 3 days in 2 patients (6.1%), 4 days in 2 patients (6.1%) and 5 days in 2 patients (6.1%), with a mean of 1.6 days. In all patients, SIRS occurred from postoperative day 1, and in no cases did SIRS occur after a postoperative period of non-SIRS.

2. Correlation with postoperative complications (Fig. 1)

Postoperative complications were seen in 9 of the 65 patients.
Nine (27.3%) of the 33 patients in the SIRS group developed complications, comprising wound infection (n = 4), herpes labialis (n = 2), ununited wound (n = 1), pharyngitis (n = 1), and sinusitis (n = 1). In contrast, none of the 32 patients in the non-SIRS group experienced complications. The incidence of complications was significantly higher in the SIRS group than in the non-SIRS group.

The relationship between duration of SIRS and postoperative complications was investigated (Table 5). Mean duration of SIRS for patients who did not have postoperative complications was 1.7 days, compared to 1.6 days for patients with complications. No significant differences were identified between patients with and without complications.

Table 4  Comparison between SIRS group and non-SIRS group regarding age, operation time and bleeding

<table>
<thead>
<tr>
<th></th>
<th>SIRS</th>
<th>non-SIRS</th>
<th>M±SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>23.69±5.48</td>
<td>25.12±7.05</td>
<td>ns</td>
</tr>
<tr>
<td>Operation time (min)</td>
<td>314.18±73.51</td>
<td>268.55±62.13</td>
<td>p&lt;0.05</td>
</tr>
<tr>
<td>Amount of bleeding (g)</td>
<td>805.39±602.25</td>
<td>519.75±346.02</td>
<td>p&lt;0.05</td>
</tr>
</tbody>
</table>

ns: not significant

Table 5  SIRS duration and postoperative complications

<table>
<thead>
<tr>
<th></th>
<th>complication negative</th>
<th>complication positive</th>
<th>M±SE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIRS duration (days)</td>
<td>1.66±1.24</td>
<td>1.55±1.06</td>
<td>ns</td>
</tr>
</tbody>
</table>

ns: not significant

Fig. 1  Details of postoperative complications (SIRS: 9 cases)

SIRS  9 cases: 9/33=27.3%
Non-SIRS 0 cases : 0/32=0.0%

Fisher’s exact probability test
p<0.01 (significant difference positive)
3. Changes in inflammatory cytokine levels (Fig. 2)

In the present study, plasma IL-6 was measured in 4 of the 65 patients: 2 patients (Cases 1 and 32) in the SIRS group and 2 patients (Cases 64 and 65) in the non-SIRS group. In all cases, IL-6 peaked on postoperative day 1 and began to decrease after postoperative day 2. In only 1 of the 4 cases (Case 1), IL-6 did not decrease much from postoperative day 1 to 2 (14.3 and 14 pg/ml, respectively). Maximum IL-6 in all cases was <20 pg/ml.

Discussion

Most of the parameters required for a diagnosis of SIRS are routinely measured at the bedside after surgery. In the past, physicians intuitively assessed vital signs and predicted the risk for various postoperative complications, including infection, empirically. The introduction of SIRS is clinically very useful in systematically ascertaining the degree of surgical stress and predicting postoperative complications. Yajima et al. were the first to report SIRS in the field of oral surgery33). Here, we thoroughly investigated the relationship of SIRS to surgical stress and postoperative complications in different groups of subjects by comparing oral and gastrointestinal surgeries.

1. SIRS and non-SIRS groups

In the field of gastrointestinal surgery, the incidence of SIRS has been reported at 73.0% for gastrectomy, 67.0% for esophageal cancer resection, 54.1% for colon resection and 37.5% for cholelithiasis surgery32,34). In our study on maxillary and mandibular orthognathic surgery, incidence of SIRS was 50.1%. This suggests that the incidence of SIRS after orthognathic surgery is not necessarily low.

Mean duration of SIRS is 6.9 days for esophageal cancer surgery and 5.9 days for all gastrointestinal surgeries32). In the present study on orthognathic surgery, mean duration was 1.6 days. The duration of SIRS thus appears shorter for orthognathic surgery.

SIRS and non-SIRS groups were compared. Hagiwara et al.6) studied patients who underwent surgery for esophageal cancer and reported no significant differences in age, blood loss or nutritional state, but operating time for SIRS patients was significantly longer. Likewise, our study on orthognathic surgery revealed no significant difference in age, and operating time was significantly longer and blood loss significantly greater in the SIRS group. The incidence of postoperative SIRS thus seems to be substantially affected by operating time and blood loss. This is because orthognathic surgery is an osteotomy, so blood
loss increases with operating time.

2. SIRS and postoperative complications

In esophageal cancer surgery, the incidence of complications in the non-SIRS group was 31.0%, compared to 83.0% in the SIRS group\(^3\). In the present study on orthognathic surgery, complications were confirmed in 9 patients (27.3%) in the SIRS group and none in the non-SIRS group, representing a significantly higher incidence of complications in the SIRS group. Caution must, therefore, also be exercised regarding the onset of postoperative complications in SIRS patients in orthognathic surgery, and screening patients using the concept of postoperative SIRS appears clinically significant.

Studies have shown that longer duration of SIRS is associated with a higher incidence of organ damage and multiple organ failure\(^{1,6}\). Kitamura \(et\ al.\)^\(^{12}\) reported that the mean duration of SIRS in patients who did not have complications following gastrointestinal surgery was 3.3 days, compared to 8.5 days in patients with multiple organ failure. In our study, no significant correlation was seen between duration of SIRS and incidence of postoperative complications. This might have been because patients with SIRS lasting only 1 day accounted for 72.7% of the total, and the longest duration was a relatively short 5 days.

Hirasawa \(et\ al.\)^\(^{7}\) documented multiple organ failure in 11 (4.8%) of 231 patients who had SIRS following gastrointestinal surgery and in 4 (12.9%) of 31 patients who had SIRS following emergency surgery. In our study on orthognathic surgery, none of the patients developed multiple organ failure. These results thus suggest that the incidence of SIRS following orthognathic surgery is relatively high, but because of the short duration, severe complications are less likely. Another factor was that many patients with jaw deformities were otherwise healthy and young.

Besides the duration of SIRS, the number of SIRS-positive criteria influences the incidence of postoperative complications. A higher number of SIRS-positive criteria reportedly correlates with a higher incidence of complications\(^{25}\). Ogawa\(^{19}\) retrospectively investigated this point and reported that an increase in the number of positive criteria at the time of onset was also included. Furthermore, even when the number of SIRS-positive criteria was low, incidence of complications increased when duration was longer, and emphasis would thus be better placed on duration (a time factor indicating failure to remove SIRS). We agree with this perspective and did not investigate the relationship between number of SIRS-positive criteria and incidence of postoperative complications. Hirasawa\(^{6}\) also reported the following parameters for “dangerous SIRS”: 1) SIRS lasting ≥4 days; 2) plasma level of IL-6 ≥800–1,000 pg/ml on postoperative day 5; 3) damaged tissue oxygen metabolism; and 4) appearance of cytotoxicity. However, SIRS remains a warning sign that can be assessed using simple criteria. Instead of determining whether SIRS is dangerous, ascertaining whether a patient has SIRS and quickly eliminating the state represent the most important steps in avoiding postoperative complications. Ogawa proposed the second attack theory to clarify this point\(^{18}\). In other words, in the state of SIRS, cytokines that are induced due to a first attack (surgical stress) cause the adherence of neutrophils to vascular endothelial cells and aggregation of neutrophils to important organs. Under such circumstances, when cytokines are again released by a second attack (mainly infection), easily irritable neutrophils attack the organs, hindering organ function. Therefore, when preventing postoperative complications and organ failure, shortening the duration of SIRS as much as possible and quickly eliminating states in which a second attack could cause body injury is important.

3. Changes in cytokines

Surgical stress has been known to cause various changes in the endocrine and metabolic systems. Besides these neuroendocrine reactions, stress-induced cytokine induction reaction has been most closely examined in recent years and is thought to play a central role in inflammatory reactions. Stating that
hypercytokinemia is the essence of SIRS is thus no exaggeration\(^3,7,8,17,22\). When the body is subjected to surgical stress, levels of inflammatory cytokines such as TNF-\(\alpha\), IL-1\(\beta\), IL-6 and IL-8 are known to increase, while at the same time, levels of anti-inflammatory cytokines such as IL-4 and IL-10 are also elevated. From the perspective of measurement sensitivity, IL-6 in the plasma can be easily detected after surgery, and is frequently used as a SIRS marker\(^3,7,11,15–17,21–23,27,31\). Studies have shown that plasma levels of IL-6 are significantly higher in patients with postoperative SIRS\(^3,10,20,22\), remain high in deceased patients with SIRS\(^3,20\), and closely reflect degree of surgical stress\(^4\).

In the present study, changes in plasma IL-6 before and after surgery were only seen in 4 of the 65 patients. In our previous study on oral cancer surgery, the highest level of IL-6 was \(>100\) pg/ml\(^10\). However, the highest level of IL-6 was much lower with orthognathic surgery, at 17.9 pg/ml. In the present study, all patients who underwent orthognathic surgery received steroids to prevent postoperative edema, and this could have suppressed increases in plasma cytokines.

**Conclusion**

In 65 patients with jaw deformities who underwent maxillary and mandibular orthognathic surgery (Le Fort I osteotomy and sagittal splitting ramus osteotomy), SIRS and postoperative complications were investigated, and the following conclusions reached:

1. Incidence of SIRS was 50.8\%, and comparisons with non-SIRS showed no significant difference in age, but operating time and blood loss were significantly greater in the SIRS group.

2. Duration of postoperative SIRS was 1 day in 72.7\% of patients, 2 days in 9.0\%, 3 days in 6.1\%, 4 days in 6.1\% and 5 days in 6.1\%. Duration of SIRS was thus only 1 day in more than two-thirds of cases.

3. Incidence of postoperative complications was 27.3\% in the SIRS group, compared to 0.0\% in the non-SIRS group, representing a significant difference between groups.

4. Postoperative complications comprised wound infection (\(n = 4\)), herpes labialis (\(n = 2\)), ununited wound (\(n = 1\)), pharyngitis (\(n = 1\)), and sinusitis (\(n = 1\)) in the SIRS group.

5. No significant correlation was observed between duration of SIRS and incidence of postoperative complications.

6. Compared with oral cancer surgery, levels of inflammatory cytokine IL-6 were lower in orthognathic surgery.

7. Focus needs to be placed on identifying and carefully monitoring SIRS patients while taking into consideration the risk of postoperative complications.

**References**


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