Postoperative Pulmonary Complications after Surgery in Patients with Interstitial Lung Disease

Sun Mi Choi, Jinwoo Lee, Young Sik Park, Young-Jae Cho, Chang-Hoon Lee, Sang-Min Lee, Ho Il Yoon, Jae-Joon Yim, Jae Ho Lee, Chul-Gyu Yoo, Choon-Taek Lee, Young Whan Kim, Jong Sun Park

Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, Seoul National University College of Medicine, Seoul National University Hospital, Seoul, and Division of Pulmonary and Critical Care Medicine, Department of Internal Medicine, Seoul National University Bundang Hospital, Seongnam, Republic of Korea

Introduction

Postoperative pulmonary complications (PPCs) are frequent and an important cause of perioperative morbidity and mortality. They contribute to the risk of surgery and anesthesia, and are associated with increased length of hospital stay. A rate of PPCs of 6.8% was reported alone in ILD patients. Lower BMI, emergency surgery, lung surgery, and longer anesthesia time were risk factors. Operative conditions as well as lung function should be considered in preoperative planning and management for ILD patients undergoing major surgery.

Methods

We included 336 patients with ILD who underwent major surgery between January 2005 and December 2010 at two tertiary hospitals in Korea. All types of surgery that had been performed under general anesthesia were included. Demographic characteristics, preoperative lung function, and operative conditions including anesthesia time and estimated blood loss were compared between patients with and without PPCs.

Results

PPCs occurred in 37 patients (11%). Thirteen patients developed pneumonia, the most common PPC, and 11 had acute exacerbation of ILD. In multivariable analysis, BMI <23 (OR = 2.488, 95% CI: 1.084–5.710, p = 0.031), emergency surgery (OR = 23.992, 95% CI: 2.629–218.949, p = 0.005), lung surgery (OR = 5.090, 95% CI: 1.391–18.628, p = 0.014), and longer anesthesia time (OR = 1.595, 95% CI: 1.143–2.227, p = 0.006) were statistically significant risk factors.

Conclusions

The incidence of PPCs detected over all surgeries was not as high as that reported for lung surgery alone in ILD patients. Lower BMI, emergency surgery, lung surgery, and longer anesthesia time were risk factors. Operative conditions as well as lung function should be considered in preoperative planning and management for ILD patients undergoing major surgery.
Structural pulmonary disease has been reported at 6–26% [5–7]. On the other hand, the incidence, morbidity, mortality, and risk factors for PPCs after surgery in patients with interstitial lung diseases (ILDs) have not been well described.

The most common ILD is idiopathic pulmonary fibrosis (IPF). Patients with IPF have shown markedly higher rates of postoperative pulmonary morbidity (26%) and mortality (8%) after surgical resection for lung cancer as compared to those without IPF [8, 9]. Several studies have shown that other types of ILD also influence PPCs and mortality after lung surgery [10], and the patients with ILD had a higher incidence of these complications compared to those without ILD after lung resection. Among all types of PPCs, acute respiratory distress syndrome was reported at a significantly higher percentage in ILD patients versus those without ILD (13.5 vs. 2.3%), and mortality was also higher in the patients with ILD (8.1 vs. 1.4%) [11]. However, there is little published data focusing on the incidence and characteristics of PPCs after surgery other than lung surgery in patients with ILD.

The aim of this study was to examine the characteristics and predictors of PPCs after major surgery in patients with ILD.

Materials and Methods

Patients with ILD who underwent surgery under general anesthesia at two tertiary hospitals, Seoul National University Hospital and Seoul National University Bundang Hospital, between January 2005 and December 2010 were retrospectively reviewed. Using the patients’ operation code (general anesthesia) and ILD diagnostic code, we selected 566 ILD patients who had undergone any kind of surgery under general anesthesia. After review of medical records, we excluded 230 patients who did not have real ILD at the time of surgery or had been intubated before the surgery. Finally, 336 patients were included in the analysis.

The surgeries included all types of surgery that had been performed under general anesthesia: head and neck, thoracic, abdominal, pelvic surgeries, etc. The ILDs included IPF, nonspecific interstitial pneumonia (NSIP), cryptogenic organizing pneumonia, connective tissue disease-related ILD (CTD-ILD), respiratory bronchiolitis-ILD, and other unclassified interstitial fibrosis.

IPF was diagnosed by lung biopsy (in 98 patients) or clinically (in 92 patients). All NSIPs and cryptogenic organizing pneumonias were confirmed by surgical lung biopsies. Patients who did not meet any of the ILD subtype criteria after surgical lung biopsies were classified as ‘unclassified interstitial fibrosis’. Patients with interstitial fibrosis, as revealed by CT imaging, but who did not undergo surgical lung biopsy were classified as ‘others’. In patients diagnosed clinically, a multidisciplinary discussion was carried out between two pulmonologists and two radiologists according to the guideline [12].

Data collected included demographic characteristics, preoperative lung function, operative conditions such as anesthesia time and estimated blood loss (EBL), type of PPC, and follow-up data including mortality. We defined EBL as ‘the blood collected in suction bottles during the operation period’.

PPCs were defined as any of the following: (1) pneumonia, diagnosed by new radiologic infiltrates with clinical findings such as fever, purulent sputum, and laboratory abnormalities suggestive of infection; (2) acute exacerbation (AE) of underlying ILD, defined as an increase of bilateral lung infiltrates if infection and cardiac problem had been excluded; (3) prolonged air leakage via chest tube (≥7 days) after thoracotomy, and (4) others, which were hemotherax, pulmonary infarction, and spontaneous pneumothorax. We also reviewed in-hospital mortality after surgery.

Statistical analyses were done with SPSS 17.0 (Chicago, Ill., USA). Variables were compared between patients with and without PPC with Student’s t test or a Mann-Whitney U test for continuous variables and a χ² test or Fisher’s exact test for categorical variables in univariable analyses. Multivariable logistic regression analysis was performed to evaluate predictors of PPCs. A p value <0.05 was regarded as statistically significant.

This study was approved by the Seoul National University Hospital and Seoul National University Bundang Hospital Institutional Review Boards for Clinical Research (IRB No.: B-1105/128-401) and the informed consent requirement was waived due to the retrospective study design.

Results

Baseline Characteristics of Study Patients

The records of a total of 336 patients with ILD who underwent surgery under general anesthesia were reviewed. The median age was 64 years. The most common ILD was IPF (56.5%). Rates of NSIP and CTD-ILD were 15.5 and 14.5%, respectively (table 1).

Comparison between Patients with and without PPCs

PPCs were reported in 37 patients (11%). Comparison of baseline characteristics of patients with and without these complications is shown in table 1. Underlying comorbidities such as hypertension and diabetes mellitus were similar in both groups. The PPC group tended to have more male patients (70.3 vs. 55.2%), more patients with a history of smoking (62.2 vs. 46%), and more patients with a BMI <23 (62.2 vs. 44.8%) compared to the group without PPCs. There were more patients with concurrent malignant diseases (40.5 vs. 22.7%) and lung cancer in the PPC group (18.9 vs. 5.7%). The patients with PPCs tended to have lower preoperative forced expiratory volume in 1 s % predicted (FEV₁%,) and forced vital capacity % predicted (FVC%), while the FEV₁/FVC ratio and diffusing capacity for carbon monoxide % predicted (DLCO%) were similar in both groups.
Symptoms on admission for surgery were different between the groups. More respiratory symptoms such as sputum and dyspnea were described in the patients who developed PPCs than in those who did not (45.9 vs. 24%, p = 0.004, and 67.6 vs. 45.3%, p = 0.011, respectively). Among several procedure-related variables, greater EBL (p = 0.020) and longer anesthesia time (p = 0.056) were noted in the patients with PPCs (table 2).

There were more patients who underwent thoracotomy in the PPC group, and more patients with lung surgery in the PPC group (p = 0.004 and p = 0.07, respectively). There were no patients who underwent head and neck surgery in the PPC group, and 24 (8%) in the no-PPC group (p = 0.091). We also found more patients with emergency operation in the PPC group (8.1 vs. 1.7%, p = 0.047; table 2).

### Incidence and Characteristics of PPCs

Table 3 shows the incidence and types of PPCs. These complications were defined as severe if the patient developed respiratory failure requiring mechanical ventilation, or if the patient died, regardless of application of mechanical ventilation. PPCs were reported in a total of 37 (11.0%) patients. Pneumonia, in 13 patients, was the most common, and 30.8% of the cases were severe. There were 11 cases of AE of underlying ILD after surgery, and 81.8% of these cases were considered severe. There were several cases with subsegmental atelectasis; however, no case with clinically significant atelectasis (lobar or whole lung atelectasis evidenced on a chest radiograph or requiring bronchoscopic toileting) was observed. In addition, we did not encounter any case of pulmonary embo-
which is not an unusual finding because the incidence of postoperative pulmonary embolism in Asian countries is far lower than in Western countries [13].

The overall postoperative mortality was approximately 3% (10/336), and most of the deaths was associated with pulmonary complications (9/10; 3 patients with pneumonia and 6 with aggravation of the underlying ILD). The remaining patient died from myocardial infarction after a surgery (table 4). Clinical characteristics of the 10 patients who died are shown in table 5. Three of the 10 fatal complications developed after nonpulmonary surgery. There was 1 patient with IPF and prostate cancer who died of aggravation of the underlying ILD after prostatectomy who had normal preoperative FVC% and no preoperative respiratory symptoms.

### Risk Factors for PPCs

Risk factors were analyzed (table 6) and BMI <23 (OR = 2.488, 95% CI: 1.084–5.710, p = 0.031), emergency surgery (OR = 23.992, 95% CI: 2.629–218.3949, p = 0.005), lung surgery (OR = 5.090, 95% CI: 1.391–18.628, p = 0.014), and longer anesthesia time (OR = 1.595, 95% CI: 1.143–2.227, p = 0.006) were statistically significant risk factors for PPCs in multivariable analysis.

### Subgroup Analysis

Of the 336 patients, 179 underwent diagnostic video-assisted thoracoscopic surgery (VATS) or mediastinoscopy. To evaluate the outcome of other types of major therapeutic surgery in patients with ILD, we did a sub-

---

**Table 2. Perioperative variables between patients with or without PPCs**

<table>
<thead>
<tr>
<th></th>
<th>Total (n = 336)</th>
<th>PPC group (n = 37)</th>
<th>No-PPC group (n = 299)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia time, h</td>
<td>1.83 (1.4–3.2)</td>
<td>2.1 (1.5–4.3)</td>
<td>1.8 (1.4–3.1)</td>
<td>0.056</td>
</tr>
<tr>
<td>EBL, ml</td>
<td>20 (0–100)</td>
<td>100 (0–300)</td>
<td>10 (0–100)</td>
<td>0.020</td>
</tr>
<tr>
<td>Surgery site</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head and neck</td>
<td>24 (7.1)</td>
<td>0 (0)</td>
<td>24 (8.0)</td>
<td>0.091</td>
</tr>
<tr>
<td>Thoracic (lung)</td>
<td>209 (62.2)</td>
<td>28 (75.7)</td>
<td>181 (60.3)</td>
<td>0.07</td>
</tr>
<tr>
<td>Thoracic (extrapulmonary)</td>
<td>12 (3.6)</td>
<td>2 (5.4)</td>
<td>10 (3.3)</td>
<td>0.629</td>
</tr>
<tr>
<td>Abdominal-pelvis</td>
<td>69 (20.5)</td>
<td>6 (16.2)</td>
<td>63 (21.0)</td>
<td>0.491</td>
</tr>
<tr>
<td>Spine</td>
<td>13 (3.9)</td>
<td>0 (0)</td>
<td>13 (4.3)</td>
<td>0.375</td>
</tr>
<tr>
<td>Extremities</td>
<td>9 (2.7)</td>
<td>1 (2.7)</td>
<td>8 (2.7)</td>
<td>&gt;0.999</td>
</tr>
<tr>
<td>Surgical modality of thoracic surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open thoracotomy</td>
<td>26 (7.7)</td>
<td>8 (21.6)</td>
<td>18 (6.0)</td>
<td>0.004</td>
</tr>
<tr>
<td>VATS</td>
<td>193 (57.4)</td>
<td>22 (59.5)</td>
<td>171 (57.0)</td>
<td>0.775</td>
</tr>
<tr>
<td>Mediastinoscopy</td>
<td>2 (0.5)</td>
<td>0 (0)</td>
<td>2 (0.7)</td>
<td>&gt;0.999</td>
</tr>
<tr>
<td>Transfusion during surgery</td>
<td>25 (7.4)</td>
<td>4 (10.8)</td>
<td>21 (7)</td>
<td>0.500</td>
</tr>
<tr>
<td>Emergent surgery</td>
<td>8 (2.4)</td>
<td>3 (8.1)</td>
<td>5 (1.7)</td>
<td>0.047</td>
</tr>
</tbody>
</table>

Data are presented as n (%) or median (interquartile range).

**Table 3. Types of PPCs**

<table>
<thead>
<tr>
<th>PPC</th>
<th>Severea</th>
<th>Not severe</th>
<th>n (%)b</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>4</td>
<td>9</td>
<td>13 (3.9)</td>
</tr>
<tr>
<td>Exacerbation of underlying ILDc</td>
<td>9</td>
<td>2</td>
<td>11 (3.3)</td>
</tr>
<tr>
<td>Prolonged air leakage via chest tube</td>
<td>0</td>
<td>10</td>
<td>10 (3.0)</td>
</tr>
<tr>
<td>Othersd</td>
<td>0</td>
<td>3</td>
<td>3 (0.9)</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>24</td>
<td>37 (11.0)</td>
</tr>
</tbody>
</table>

a Needed mechanical ventilation or dead. b Percentage of the total patients (total = 336). c Defined as increase of bilateral lung infiltrates if infection and cardiac problem had been excluded. d Hemotherax, pulmonary infarction, pneumothorax after coronary artery bypass surgery.

**Table 4. Mortality and cause of death**

<table>
<thead>
<tr>
<th>Cause of death</th>
<th>n (%)a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary complication</td>
<td></td>
</tr>
<tr>
<td>Pneumonia</td>
<td>3 (0.9)</td>
</tr>
<tr>
<td>Aggravation of underlying ILD</td>
<td>6 (1.8)</td>
</tr>
<tr>
<td>Nonpulmonary complication</td>
<td></td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>1 (0.3)</td>
</tr>
<tr>
<td>Total</td>
<td>10 (3.0)</td>
</tr>
</tbody>
</table>

a Percentage of the total patients (total = 336).
group analysis that excluded the patients who underwent diagnostic VATS lung biopsy and mediastinoscopy. A total of 157 patients were included in the subgroup analysis and PPCs were reported in 18 (11.5%). Comparison of baseline characteristics and perioperative variables for patients with and without PPCs is shown in online supplementary tables 1 and 2 (for all online suppl. material, see www.karger.com/doi/10.1159/000357046). Risk factors for PPCs in these patients were analyzed by multivariable analysis (online suppl. table 3). Higher DLCO% (OR = 0.946, 95% CI: 0.900–0.994, p = 0.027) seemed to reduce the risk for PPCs while longer anesthesia time (OR = 1.965, 95% CI: 1.182–3.266, p = 0.009) and lung surgeries (OR = 5.786, 95% CI: 1.129–29.644, p = 0.035) were identified as risk factors.

**Discussion**

The association between ILD and PPCs after pulmonary resection is well known, and the influence of ILD on postoperative complications, morbidity, and survival in lung cancer patients is well documented [8, 10, 14, 15]. Preexisting comorbidities and decreased preoperative DLCO have also recently been suggested as risk factors for the development of acute pulmonary complications after pulmonary resection in patients with lung cancer and ILD [16]. However, there is as yet no consensus guideline for perioperative management in patients with ILD, and there is little published data focusing on the incidence and characteristics of PPCs after surgery other than lung surgery in patients with ILD.
In our study, PPCs were reported across all types of surgery in 37 out of 336 patients (11%) with ILDs, and the overall postoperative mortality rate was approximately 3% (10/336) in patients with ILD. Nine patients died due to postoperative pneumonia or aggravation of the underlying ILD. A recent study in a population-based surgical cohort showed a 5% incidence of PPCs [17], and the incidence of PPCs in ILD patients was higher than in the general population.

Previous studies have reported that the incidence of PPCs was 42–53% after lung resection surgery in ILD patients [10, 16]. In the present study, the incidence of PPCs reported over all surgery, including lung surgery, was not as high as that reported for lung surgery alone in ILD patients.

We found that lower BMI (<23), emergency surgery, lung surgery, and longer anesthesia time were independent risk factors for PPCs in ILD patients, and our results suggest that operation-related factors had greater influence on the development of PPCs than patient-related factors such as lung function or preoperative respiratory symptoms. Our results also differed from the other studies that included only lung resection surgeries and reported lower preoperative FVC% and DLCO% in association with PPCs [11, 16]. Moreover, the results differed from those in chronic obstructive pulmonary disease patients that showed increased incidence of PPCs according to underlying pulmonary function [18–20].

To highlight the outcomes of major therapeutic surgery, we conducted a subgroup analysis including ILD patients who had therapeutic surgeries and excluded those who underwent diagnostic VATS or mediastinoscopy. In the subgroup analysis, the independent risk factors for PPCs were lower DLCO, lung surgery, and longer anesthesia time, and were not much different from the entire patient group.

Previous studies have reported that typical honeycombing or IPF itself was a potential risk factor for AE after pulmonary resection for lung cancer [21, 22]. Therefore, we expected a higher incidence of PPCs in patients with IPF compared to those with other type of ILD. However, this was not the case. Our study showed that the incidence of PPCs was similar in patients with IPF or with other types of ILD (11.1 and 11.2%, respectively). The prognostic value of different types of ILD after pulmonary or nonpulmonary surgery remains unknown. The prognosis of IPF/usual interstitial pneumonia is generally the worst among the ILDs, with a median survival of only 3–5 years from the diagnosis [23, 24]. We did not find any significant difference in the incidence of PPCs according to the type of ILD.

Surgical intervention of any form has been thought to be an inciting factor. However, there are few published data for AE of IPF or other ILDs following nonpulmonary surgery. One recent study reported 3 cases of AE in IPF in patients who underwent nonpulmonary surgery [25], and in our study 2 patients experienced AE of ILD after nonpulmonary surgery: 1 after prostatectomy and 1 after intestinal surgery. Although most of the PPCs occurred after lung surgery, there were fatal AEs of ILD after nonpulmonary surgeries.

This is the first study, to our knowledge, to evaluate the incidence and characteristics of PPCs in patients with ILD after variable types of surgical procedures, including nonpulmonary surgery. We also evaluated patient-related factors, such as underlying lung function, comorbidity, and respiratory symptoms, and procedure-related factors, including anesthesia time, EBL, type of surgery, and others. Pulmonologists are frequently called upon for preoperative consultations before major surgeries. ILD is problematic because there is still no consensus guideline for perioperative management of ILD patients. We have comprehensively reviewed the incidence and characteristics of PPCs in patients with ILD following various types of surgery, and our results may be useful to assist with perioperative management of ILD patients.

Our study has several limitations. First, it is a retrospective study. Second, we did not review chest CT scan results to evaluate the extent and severity of the ILDs. The patients in our study had several types of ILD and variable severity of fibrosis, which may have influenced the incidence and severity of the PPCs. Third, our study did not examine long-term survival data as we reviewed only in-hospital mortality.

In conclusion, the results suggest that the incidence of PPCs after all types of surgery is not as high as that after lung resection surgery alone in patients with underlying ILD, but the rate was higher than that reported in the general population. Lower BMI, emergency surgery, lung surgery, and longer anesthesia time were risk factors for PPCs in ILD patients. Our results emphasize that operation-related factors as well as lung function should be considered in preoperative planning and management for ILD patients undergoing major surgery.

### Financial Disclosure and Conflicts of Interest

All authors have no financial or other potential conflicts of interest to disclose.
References


