Dear colleagues and friends!

Doctor Faris Al-Aswad has earnestly drawn attention to important problem of emergency surgery – stabbed abdominal wounds. I and my colleagues encourage his good intention. We support author's accent on clinical criteria which turned out to be the grounds of optimal surgical tactics. Indications for urgent laparotomy remain the most difficult and significant aspect standing before surgeons. On the whole we share author's view-point that concerns about negative laparotomy. Indeed, we have to admit clinical symptoms leadership, which are always pretend to be the keystone and must be taken into account in a surgery choice. On our opinion it is desirable to widespread the non-invasive (ultrasonography, computerized tomography, X-ray, etc.) and invasive (instrumental and finger inspection of wound) investigation. It is quite true, negative laparotomy is evidence of pre-operation diagnostic mistake. But frankly speaking in some cases it is more dangerous to refuse immediate laparotomy because of risk to miss serious intra-abdominal complications like peritonitis and bleeding than to perform negative laparotomy under such circumstances. We declare that in doubtful and unclearly cases it is necessary to use very deliberated and weighted approach. There are two sides of the problem. In surgical practice we often have met both false-negative and false-positive clinical signs of acute abdomen pathology such as peritonitis and bleeding. Thus according to our own experience, we consider evaluating data of other objective diagnostic methods along with clinical features. We suggest to begin stabbed wounds management with the thorough inspection under local or intravenous anesthesia by finger or "soft" (anatomical) instrument (i.e. clasp with gauze or so) which might be converted to laparocenthesis or searching (wandering) intra-abdominal catheter. In certain cases we offer to implement video-endoscopic technologies, in particular laparoscopy, during which surgeon can survey abdominal cavity and even perform adequate procedure removing the causative source and rescuing patient's life. Otherwise surgeons have to proceed to explorative laparotomy which could be the last point when other diagnostic possibilities are exhausted. In emergency is the most important to eliminate quickly threatening to life damages. In a matter of fact, it's better to perform negative laparotomy than to deny the urgent intervention when it's necessary and in this way to miss the development of severe and dangerous complications. Nonetheless there were used all the possible methods to avoid negative laparotomy and set correct diagnosis making right decision to say about surgical tactics. Of course, at the absence of "bad" and dangerous clinical signs and other objective criteria it is mainly preferable to limit surgery by careful inspection and perfect primary wound debridment.

But we must reveal very weighty and convincing results of complex investigation which could persuade us to do the certain procedures for patient's benefit. We have to point out one more question that is worth for further discussion – the wound infection prevention and peculiarities of post-operation sequels prophylaxis. In the modern world surgeons might be cooperated and thanks to ESS initiation we have good opportunity to express our standpoints, accept useful interesting information and exchange experience effectively.

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