NECROTISING FASCIITIS

BD Sathyanarayana, B Leelavathy

A case of necrotising fasciitis is being reported. Due to delay in diagnosis and treatment, patient developed contracture leading to flexion deformity.

Key words: Necrotising fasciitis, Collagenase, Contracture, Deformity

Introduction

Necrotising fasciitis is a rare, serious, acute, rapidly progressive, toxic, often fatal, mixed bacterial infection, primarily involving the superficial fascia and later affecting the subcutaneous tissue and skin.[1]

A synergistic infection, it usually consists of a combination of aerobic and anaerobic or microaerophilic microorganisms which destroy the fascia causing necrosis and disruption of fasciocutaneous circulation.[2] Infection is associated with excessive collagenase production leading to dissolution of connective tissue.[3]

Blunt injury, minor rauma, malnutrition, diabetes, operative wound, break in continuity of skin etc., are common predisposing factors, It may be immediately fulminant or may remain dormant for 6 or more days before beginning to spread rapidly. Subcutaneous and fascial necrosis accompanies extensive undermining of the skin, resulting in gangrene.

Treatment is excision of the entire area of fascia affected and administration of large dose of penicillin and appropriate systemic support.

Case Report

A 33-year-old house-wife was admitted in Victoria Government Hospital after having taken treatment from a private hospital for contact dermatitis around the left knee-joint.

The patient had a fall and got a blunt injury over the left knee for which some native medicine mixed with warm oil was applied over and around the knee. Four days later few blebs with little erythema appeared on lateral surface of the left knee for which antibiotic and oral steroids were given after a diagnosis of contact dermatitis was made. Later blebs ruptured and led to ulcers.

Examination revealed an ulcer of 25cmx 8cm size, on the lateral aspect of the left knee joint with an undermined edge of bluish black

From the Department of Skin and STD, Bangalore Medical College, Bangalore, India

Address correspondence to:
DR BD Sathyanarayana

colour. The floor of the ulcer was covered with a dirty greyish-white slough (Fig.1) Patient had mild pain and tenderness. There were two blebs of 3x2cm in size filled with pus on the posteriomedial surface of the middle one third of the same leg.

Fig. 1. Necrotising fasciitis

We made a diagnosis of necrotising fascitis and referred the patient with antibiotic coverage to the plastic surgeon for debridement. When the ulcer became healthy, skin grafting was done and the ulcer healed completely, but due to the contracture the patient continued to limp.

Discussion

Necrotising fasciitis has been reported only once in this journal.[4] It may be difficult to recognise and requires a high index of suspicion, vigilance, and continued observation to minimise tissue destruction and morbidity.

The diagnosis is confirmed by incision through skin and subcutaneous tissue to the muscular fascia where grey necrotic fascia is seen rather than normal white glistening tissue.

As initial symptoms and signs are localised to the skin, the dermatologist is referred to at first. If an early diagnosis is made and appropriate treatment given the role of surgeon could be minimised.

References

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