

Necrotising fasciitis

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This is a severe, rapidly progressing infection of the soft tissue and fascia associated with significant morbidity and mortality (Figure 3.14). Reported mortality rates vary widely but a Danish nationwide cohort study including over 1500 patients found 30-day and 1-year mortality rates of up to 26% and 10 40%, respectively . The infection is commonly polymicrobial but monomicrobial presentation with *Streptococcus pyogenes* (group A streptococcus) is also frequent. Examples of other organisms include *Staphylococcus aureus* , *Escherichia coli* , *Pseudomonas* , *Clostridium* and *Bacteroides* . There is usually a history of trauma or surgery with wound contamination. Diabetes mellitus is the most common comorbidity , although up to 30% of patients may not have any 10,11 comorbidities. Clinical features are shown in Summary box 3.6 . A scoring system to aid clinical decision making has been developed, but its performance remains questionable. remains primarily a clinical diagnosis and surgical treatment should not be delayed if suspicion is high. Treatment consists of appropriate intravenous antibiotics with urgent radical surgical debridement. A second look operation is usually planned in 24–48 hours depending on clinical response. Multiple debridements may be required. Summary box 3.6 Signs and symptoms of necrotising fasciitis

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Figure 3.14 Necrotising fasciitis of the anterior abdominal wall. Local Unusual pain Erythema, oedema, warmth Crepitus Blisters, bullae Greyish drainage ('dishwater pus') Fixed staining Necrosis, gangrene Systemic Fever, tachycardia, tachypnoea Shock Coagulopathy Multiorgan failure

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