Necrotizing Fasciitis after Cesarean Delivery

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This 27-yr-old patient (preoperative body mass index, 32 kg/m²) presented 12 days after a repeat cesarean delivery. The patient complained of pain, swelling, and a 6 × 4-cm complex mass of blood-filled bullae on her abdominal panniculus, 7 cm from her well-healed incision. She was afebrile and not diabetic. Her hemoglobin concentration was 8.3 g/dl; leukocyte count, 23,200/ml; and creatinine concentration, 3.9 mg/dl. Bleeding, not infection, was suspected; necrotizing fasciitis was not diagnosed until the computed tomographic scan was examined (fig.). Surgical debridement required removal of 75% of the panniculus. The patient went to intensive care intubated, on a phenylephrine infusion, with her open wound packed. She was discharged home with negative-pressure wound therapy. The wound healed completely, and the patient’s renal function normalized.

Necrotizing fasciitis is a rapidly progressing, usually polymicrobial, infection of subcutaneous tissue. The infection can spread up to 2.5 cm/h, with minimal change in the overlying skin.1 Erythema, swelling, and severe pain are generally seen at presentation.1 Bullae and soft tissue gas (fig.) are late signs.1 Anemia, hyponatremia, hypoglycemia, and increased creatinine, C-reactive protein, and leukocyte count are laboratory risk indicators for necrotizing fasciitis.1 Magnetic resonance imaging or computed tomography can establish the diagnosis and guide the extensive surgical debridement.1 Obesity is a risk factor for postcesarean necrotizing fasciitis, which has an incidence of 2 per 1,000 cesarean deliveries.2 Because necrotizing fasciitis–associated mortality increases as the time to intervention lengthens, anesthesiologists can improve care for these patients by facilitating prompt surgical debridement.1

References

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