We present a case of necrotizing infection of the lower extremity. Following serial surgical debridement and negative culture growth, the likelihood and rate of healing in chronic diabetic foot ulcers: A prospective, randomized, multi-centre clinical trial in 80 patients. Wound J. 2018; 15: 950-959.

66yo male with h/o DVT presented with left lower extremity complex wounds with full thickness necrosis after episode of cellulitis. Findings were consistent with a deep tissue necrotizing infection. Past medical history included obesity and DVT. Admitted treatment included hospital admission with IV antibiotics for persistent infection with full thickness necrosis. Intravenous antibiotics were given, followed by surgical debridement of non-viable tissue. Negative Pressure Wound Therapy with instillation and dwell time (NPWTi) was initiated to cleanse the wound bed using a hypofatetative irrigant solution with a 20-minute dwell time, followed by 2 hours of continuous NPWT at -125 mmHg. Dressings were changed every 3 days. After NPWTi, patients either underwent surgical closure or surgical debridement followed by 3 days of NPWTi and surgical closure with split thickness skin graft placement or placement of meshed HD ADM.

METHODS

• Patient presented with necrotizing infection with full thickness necrosis of left lower extremity.
• Intravenous antibiotics were given, followed by surgical debridement of non-viable tissue.
• Negative Pressure Wound Therapy with instillation and dwell time. NPWTi was initiated to cleanse the wound bed using a hypofatetative irrigant solution with a 20-minute dwell time, followed by 2 hours of continuous NPWT at -125 mmHg. Dressings were changed every 3 days.
• After NPWTi, patients either underwent surgical closure or surgical debridement followed by 3 days of NPWTi and surgical closure with split thickness skin graft placement or placement of meshed HD ADM.

RESULTS

• Patient presented with necrotizing infection with full thickness necrosis of left lower extremity (Figure 1A).
• Past medical history: Obesity, DVT.
• Following 2 surgical debridements and NPWTi (Figures 1B-1E), meshed HR ADM was placed (Figure 1F).
• After 6 weeks of continued NPWT, the meshed HR ADM was completely incorporated (Figure 1G).
• Following autologous split thickness skin graft and NPWT (Figure 1D), the contingent wound healed completely. At 3 months, the graft matured and the contour deficit was minimal (Figure 1I).

REFERENCES

5. *SomaGen® (HTX Biologics, Edison, NJ)

BACKGROUND

• Necrotizing infection carries a high mortality. If the patient survives, they typically have undergone multiple surgical debridement to assist in cleaning the infection and necrotic tissue.
• As a result of excision of non-viable tissue, the patient is typically left with a significant tissue defect. Cellular tissue products have become increasingly popular to assist with wound healing in chronic diabetic foot ulcers.
• Aseptically processed meshed human reticular dermal matrix (HR-ADM®) is unique in that it is an acellular dermal matrix that comes from the reticular dermis.

METHODS

• Aseptically processed meshed reticular dermal matrix (HR-ADM®) is unique in that it is an acellular dermal matrix that comes from the reticular dermis.
• The reticular dermal layer allows for a more open network structure to better support cellular infiltration and tissue ingrowth.
• Patients who have wounds with a major tissue deficit may benefit from aseptically processed meshed allograft to help restore tissue and optimize the wound bed, prior to autologous skin grafting.

CASE STUDY

The reticular dermal layer allows for a more open network structure to better support cellular infiltration and tissue ingrowth. Aseptically processed meshed human reticular acellular dermal matrix (HR-ADM) is unique in that it is an acellular dermal matrix that comes from the reticular dermis.

We present a case of necrotizing infection of the lower extremity. Following serial surgical debridement and negative culture growth.

RESULTS

The reticular dermal layer allows for a more open network structure to better support cellular infiltration and tissue ingrowth.

• Patients who have wounds with a major tissue deficit may benefit from aseptically processed meshed allograft to help restore tissue and optimize the wound bed, prior to autologous skin grafting.

• Patient presented with necrotizing infection with full thickness necrosis of left lower extremity.
• Intravenous antibiotics were given, followed by surgical debridement of non-viable tissue.
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REFERENCES

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