MANAGEMENT OF SUSPECTED NECROTISING FASCIITIS

Royal Alexandra Hospital – Consensus Document

Issue: Review:	Senior Clinicians:	Emergency Medicine – Nayak Raghavendra Orthopaedics – Andrew Ker General Surgery – Andrew Renwick

FEATURES

- Spreading cellulitis with skin colour changes from red to bluish grey
- Pain out of proportion to physical signs
- Systemic features/sepsis
- Predisposing condition or immunocompromised – though may occur in previously healthy individuals
- Rapid progression

PRINCIPLES

- If diagnosis raised by senior ED physician: **this is a surgical emergency: PATIENT TO THEATRE IN 2 HOURS or alternative diagnosis made**
- Early surgery saves lives. Delays must not occur. Avoid interspeciality discussions about responsibility. If asked, attend
- Consultants MUST be informed early and involved in care, even when diagnosis not clear
- Take blood cultures and give immediately IV Flucloxacillin 2mg 6hrly, IV Benzylpenicillin 2.4g 6hrly, IV Metronidazole 500mg 8hrly, IV Clindamycin 1.2g 6hrly and IV Gentamicin
- If MRSA suspected or if true Penicillin / Beta-lactam allergy, replace Flucloxacillin and Benzylpenicillin with IV Vancomycin

Diagnosis Necrotising Fasciitis possible, refer to:

- Trunk – General Surgery Registrar
- Upper or lower limb – Orthopaedic Registrar
- Junctional area (upper or lower) – Orthopaedic and General Surgery Registrar for joint involvement/decision making
- Genitalia involvement – Early Urology involvement
- Neck – Early ENT involvement

*All cases should have ICU/Anaesthetics involved at early stage*

Registrar not immediately available – **DIRECT REFERRAL TO CONSULTANT**

IMMEDIATE PATIENT ASSESSMENT

If surgery required **Surgeon** will:

- Contact Consultant oncall
- Arrange for theatre. **Aim for < 2 hours**