SUBACUTE NECROTISING FASCIITIS

I vividly remember my first case of acute necrotising fasciitis. A young man with a gunshot wound had been sent to Groote Schuur Hospital from the platteland for further treatment. The bullet had entered through the abdomen, passed through the large bowel and exited through the back. We had cleaned him up in theatre and thought everything was fine, until I was called by one of the sisters to look at something on his back. I had never seen necrotising fasciitis before, but it was unmistakeable and by the time we got him to theatre that evening, the registrar and I effectively carried out a full dissection of the tissues of the back down to the offending fascia. So, when I saw this report of subacute necrotising fasciitis I was intrigued.

The authors report that an 82-year-old woman presented to a hospital in Singapore in March 2004. She complained of pain and swelling in her right hand for the past 6 days. There was no history of trauma and no other medical history of note. Two general practitioners had attributed the swelling to disuse and fluid overload and prescribed symptomatic treatment. The woman described her hand as gradually becoming dusky with fixed discolouration that started from her middle finger and migrated proximally, eventually involving the entire hand. Her family brought her to hospital when she complained of persistent pain, developed a slight fever and the skin on the hand started to peel with gentle pressure. On admission her right hand was necrotic and foul smelling. She was febrile, with a raised leucocyte count and C-reactive protein. There was no gas in the soft-tissue planes on X-ray.

The differential diagnosis included cellulitis or gangrene secondary to peripheral vascular disease. However, she was admitted with a presumptive diagnosis of necrotising fasciitis. The woman was started on high-dose intravenous penicillin, cloxacillin and clindamycin. The authors noted the rapid migration of the margin of tenderness and erythema from her wrist up her forearm. An emergency debridement was carried out 8 hours after admission. They dissected down to the necrotic fascia and found 'dish water' pus. The arm was amputated through the elbow. Cultures of the debrided tissue grew *Proteus mirabilis* and *Enterococcus* species. Blood cultures were sterile. Histological examination confirmed necrotising fasciitis. By May 2004 the patient was doing well and adjusting to her amputation.

There are two forms of necrotising fasciitis — type 1 is polymicrobial and type 2 is caused by group A streptococcus. The condition usually presents with the sudden onset of severe pain and runs a fulminating course, with a high fever developing rapidly, hypotension and multi-organ failure. However, the subacute form presents as above, as a slowly progressive soft-tissue infection over a period of days to weeks, with minimal pain and often no constitutional symptoms. Failure to consider the diagnosis in a patient who appears 'too well' could lead to delay, with catastrophic outcome, as these authors point out.

Wong Chin-Ho and Tan Soo-Heong. *Lancet* 2004; **364:** 1376.

Bridget Farham

SINGLE SUTURE

CONTINUING RISK OF DEATH

A review of 430 510 patients with breast cancer reaches the sad conclusion that in both black women and white women the probability of death from breast cancer exceeded the probability of death from all other causes for 28 years after the initial diagnosis. This will not surprise oncologists, but many women who have been treated for breast cancer have the impression that if there are no signs of recurrence after 5 years then they can assume they have been cured.

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