Images in Medicine

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Dentistry Section

Prompt Diagnosis and Management of Cervical Necrotizing Fascitis

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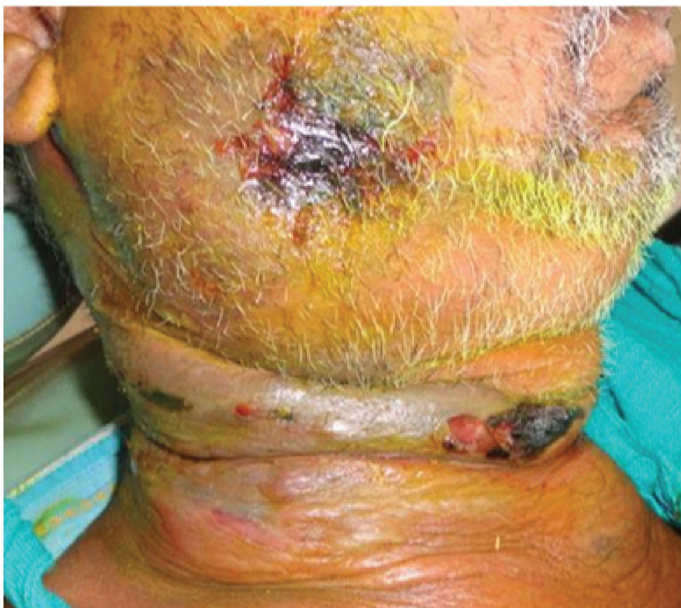
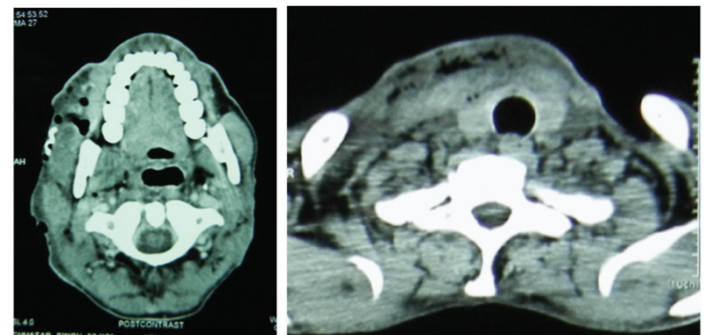
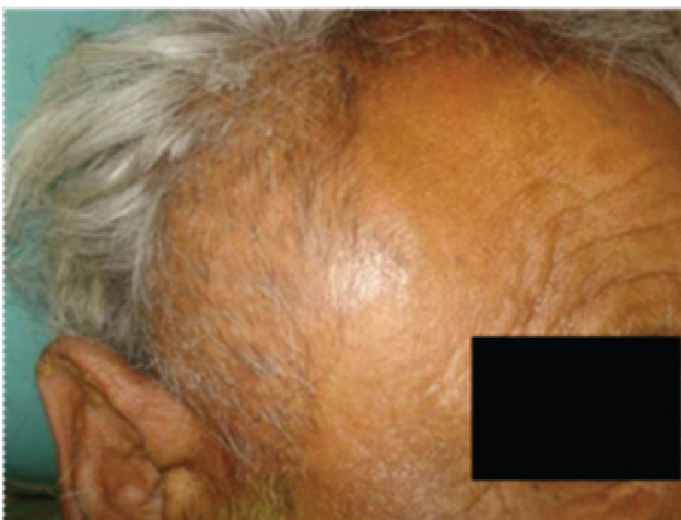
Necrotizing fasciitis is a rapidly progressing inflammatory infection of the fascia, with secondary necrosis of the subcutaneous tissue. It is uncommon and difficult to diagnose, and it causes progressive morbidity until the infectious process is diagnosed and treated medically and surgically [1]. Smith et al., stated that the mortality rate of necrotizing fasciitis can be upto 34%. Monomicrobial necrotizing fasciitis is caused by the betahemolytic *streptococcus* normally seen in healthy persons with the previous history of wound infection [2]. Necrotizing fasciitis is also known as Flesh eating disease, Gangrenous erysipelas, Hospital gangrene, Non-closteroidal crepitant cellulitis, Streptococcal gangrene, Meleney's cellulitis [3]. A 50-year-old male was admitted with history of pain and swelling of cervical and temporal region since four days. The patient presented with cervical and temporal abscess upon physical examination [Table/Fig-1]. The overlying skin showed multiple haemorrhagic areas [Table/Fig-2] varying in size from 2 cm to 4 cm. Computerized Tomography (CT scan) of the head and neck region [Table/Fig-3] showed collection of air in the pretracheal, retrotracheal regions. A diagnosis of cervical necotizing fasciitis along with temporal abscess secondary to grossly decayed 48 was made. The following differential diagnoses were considered, Necrotizing fasciitis, Ludwig's angina, Erysipelas, Progressive bacterial gangrene. Microbiolgical analysis of the pus revealed *staphylococcus aureus*. Intravenous antibiotic therapy consisted of Injection cefotaxime with salbactum (1.5 gm eight hourly) and Injection levofloxacin 100 ml 24 hourly. Incision and drainage of the cervical and temporal abscess was done followed by vigorous debridement of fascia, subcutaneous tissue and necrotic skin [Table/Fig-4]. Neomycin and cutacill dressing was done [Table/Fig-5]. Reconstruction was done after three weeks using split thickness graft from the thigh region [Table/Fig-6,7].



[Table/Fig-1]: Swelling of cervical region with multiple haemorrhagic areas

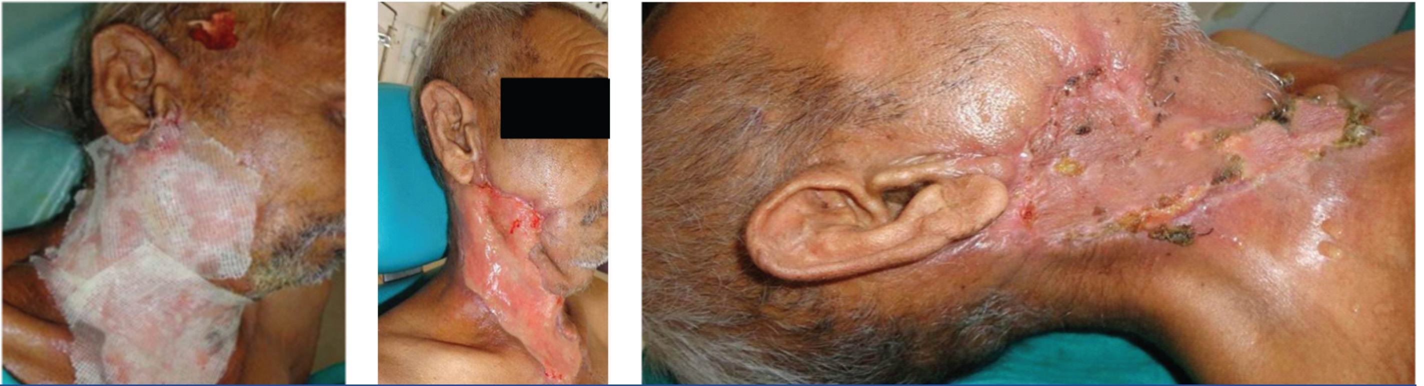


[Table/Fig-3]: CT scan showing air spaces



[Table/Fig-2]: Swelling of the temporal region,

[Table/Fig-4]: Debridement of fascia & subcutaneous tissue



[Table/Fig-5]: Neomycin and cutacill dressing **[Table/Fig-6]:** Healing after three weeks **[Table/Fig-7]:** Healing one month after the graft placement

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