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A Rare Case of Necrotizing Fasciitis and Cellulitis of the Breast

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ABSTRACT

Background. Necrotizing soft tissue infections is a formidable disease either presenting on its own or because of various manipulations. It is a potentially fatal condition that usually affects the soft tissues of the extremities, abdominal wall, and perineum. However, the condition can also manifest in other parts of the body. Predisposing factors include the presence of comorbidities, advanced age, and chronic alcoholism. The mammary gland is rarely affected, and, in most cases, it is a consequence of various manipulations, in particular puncture methods of treatment, inadequate conservative therapy, or trauma.

The paper presents a clinical case of necrotizing fasciitis of the breast in a 29-year-old female patient with no identified risk factor and provides a therapeutic and diagnostic concept in relation to necrotizing infection.

Keywords: necrotizing infection, necrotizing fasciitis, myonecrosis, mastitis, necrotizing cellulitis.

INTRODUCTIONS

Necrotizing soft tissue infections (NSTI) are rapidly progressive skin and soft tissue infections that cause widespread tissue necrosis and associated systemic disease [1]. The term "NSTI" is increasingly being used in place of the term "necrotizing fasciitis", originally coined by B. L. Wilson in 1952 to encompass cases where necrosis extends beyond the fascia and may involve muscle, skin and surrounding tissues [2].

Depending on the depth of tissue infection and necrosis, necrotizing soft tissue infection can be divided into three forms, which include dermis and subcutaneous tissue for necrotizing cellulitis, fascia for necrotizing fasciitis, and muscle layer with intact overlying skin for necrotizing myositis [3].

The incidence and prevalence have no definite trend related to season, location and patient population.

Diagnosis of these conditions is difficult as studies show a high rate of misdiagnosis on admission [4], mainly because the initial clinical manifestations may be underestimated and the treatment tactics chosen accordingly. This is confirmed by the presented clinical case.

PRESENTATION OF THE CASE

Patient D., born in 1992, was admitted to the department of purulent surgery and surgical complications of diabetes mellitus at the multi-

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disciplinary clinic of the Tashkent Medical Academy. On admission, the patient complained of pain in the left mammary gland, the presence of painful thickening and cyanosis in the left mammary gland, with thickening with transition to the lateral surface of the neck and sternum, increased body temperature up to 38^0C, lack of appetite, weakness.

Ten days prior to admission, the patient sustained a blunt trauma to the left breast (a fall from a ladder). After the injury, the patient goes to a medical facility, where the patient is examined and a posttraumatic hematoma is detected. The patient undergoes a diagnostic puncture in which the blood is aspirated in a small amount and conservative therapy in the form of compresses is prescribed. In four days, the patient's condition did not improve, and the patient turned to folk healers who performed punctures with subsequent injections of drugs (she does not remember the name of the drugs).

No history of diabetes mellitus, hypertension, HIV infection, smoking or any other chronic diseases.

On examination: the patient's condition is moderately severe. Body temperature 37.8°C, blood pressure 120/70 mm Hg, tachycardia with pulse rate 118/min.

Locally: on examination, there is a slight asymmetry of mammary glands due to enlargement of the left mammary gland.

Skin cyanosis is detected in the left breast starting from the areola and moving to the inner-upper quadrant. Foci of cyanosis were also detected in the projection of the lower third of the sternum (Fig. 1).

Fig. 1. The patient's appearance on the day of admission.

Palpation revealed tissue thickening, with moderate painfulness, and the borders of the thickening went beyond the visible altered part (Fig. 2).

Fig. 2. Boundaries of identified altered tissues (highlighted with marker).

The borders of the thickening cover the tissues of the sternum and pass to the lateral surface of the neck on the left side. The tissues are visually unchanged. No characteristic signs of inflammation were detected. There was an increase in cervical and axillary lymph nodes on the left side. The right breast was unremarkable.

On admission, the laboratory revealed leukocytosis ($12x10^9$/l) with a left shift (78% neutrophils) and anaemia (91g/l). Biochemical blood test: blood sugar 7.2 mmol/l; bilirubin 19.2 mmol/l, direct 0.8, indirect 1.9; ALT 0.3; AST 0.6; total protein 63 g/l; fibrinogen 6 g/l; CRP 2.1mg/l.

Breast ultrasound showed a diffusely swollen and enlarged breast with a twisted echogenic fatty component and a hypoechogenic edematous glandular component, without cavitary masses and a normal contralateral breast. In the area of the sternum and neck there is a fluid layer.

To diagnose surgical soft tissue infection, we applied an early diagnosis scale, which allows us to identify areas of altered tissues. According to this scale, there are certain clinical signs of the development of surgical soft tissue infection, which together allow us to determine the purulent process in the soft tissues accurately enough, with the determination of indications for surgical intervention.

Empirical antibacterial therapy with intravenous administration of piperacilin+tazabactam 4.5 x 3 times,

clindamycin 600 mg x 2 times, and amikacin sulfate 500 mg x 2 times was started in the patient. The mandatory component was the inclusion of fluconazole 200 mg x 1 times. Infusion therapy included the administration of rheosorbilact 200,0 x 1 times, glucose 5% 400,0 x 1 times, and Infusol 500,0 x 1 times.

Against this background, the patient was taken for surgery. The operation was performed under intravenous anaesthesia. The patient underwent dissection of foci in the area of sternum, breast, supraclavicular region on the left side and neck (Fig. 3).

Fig. 3. Necrosis of superficial fascia with thrombosis of breast tissue and subcutaneous fatty tissue.

Incision showed that there was a cloudy discharge in the fibers and a necrotic process was dominant, which was loose in the supraclavicular region and in the neck (Fig. 4).

Fig. 4. Necrosis of the superficial fascia with extension to the neck.

The operation involved the excision of necrotic tissue within relatively healthy tissue, thorough washing of the wound with hydrogen peroxide, and Decasan, taking a sample for culture and sensitivity, and histopathologic analysis. The wound was left open for daily follow-up sanation.

Histologic examination of the sample by hematoxylin and eosin staining showed the presence of diffuse inflammatory infiltration with segmented neutrophilic leukocytes and lobular destruction (Fig. 5).

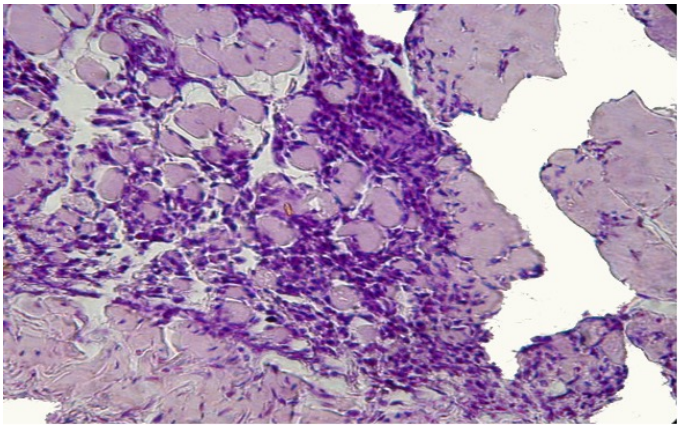

Fig. 5. Diffuse inflammatory infiltration by segmented neutrophilic leukocytes.

The microbial landscape showed preservation of polymorphism of the detected pathogens. Thus, the aerobes isolated were *Staphylococcus spp*. - 12%, *E.coli* - 18%, *Proteus spp*. - 15%, *Streptococcus pyogenus* - 12%, *Staphylococcus fecalis spp*. - 3%. Anaerobic microflora was represented by *Peptostreptococcus spp*. - 6%. Fungal flora was detected on the 1st day of treatment in 3% and was represented by fungi of the Candida genus.

Against the background of conservative therapy locally sanation with FarGALS.

In dynamics, the necrotic process remains in the wound, tissues are ischemic. There is no active purulent discharge, the process is delimited (Fig. 6). The patient underwent staged necrectomy with excision of all changed tissues (Fig. 7).

Local sanation was continued with the use of Oflomelid ointment, twice a day. On the 10th day, the patient was discharged for outpatient treatment in a satisfactory condition, with a sluggish granulating wound and recommendations on further management of the wound process.

At the next check-up the patient was found to have a painful thickening in the right mammary gland and the patient was repeatedly hospitalized at the department and

underwent autopsy and necrectomy of the nidus in the right mammary gland. Active granulation appeared in the dynamics (Fig. 8).

Fig. 6. Process delineation with preservation of necrotic process.

Fig. 7. View of the wound process on the 6th day after necrectomy.

On the 30th day, at the next examination, the wound is completely epithelialized, but there is a rough postoperative scar (Fig. 9). The patient subsequently needs to undergo plastic surgery, which is a planned process. The main goal of saving the patient's life was fulfilled.

Fig. 8. The wound is clean, and there is active granulation.

Fig. 9. View of the wound process on the 30th day, there is a postoperative scar.

DISCUSSION

Necrotizing fasciitis is an aggressive, rapidly spreading infection of the skin and subcutaneous tissue. Its occurrence in the breast is extremely rare, especially after routine procedures. Its appearance in the breast is uncommon in patients without risk factors, and so far, only seven cases have been reported in the literature in non-breastfeeding women [10].

In cases of necrotizing fasciitis of the breast, cutaneous manifestations may not be noticeable due to the thicker tissue between the deep fascia and the skin. By

the time cutaneous signs are noticed, the lesion is extensive and may require mastectomy [8].

The diagnosis of necrotizing soft tissue infection remains predominantly clinical and is based on clinical examination showing signs of inflammation with skin discolouration and pain disproportionate to local manifestations, along with systemic toxicity and subcutaneous crepitation. However, due to the paucity of cutaneous manifestations in the early stages of the disease, diagnosis can be extremely difficult and requires a high degree of vigilance. Sometimes, a definitive diagnosis can only be made intraoperatively when characteristic signs of inflammation are not detected [7, 13].

Delay in diagnosis can lead to sepsis, septic shock and death [8].

Necrotizing fasciitis can cause disturbance of various biochemical and hematologic parameters, based on which the LINEC scale was developed, which includes blood glucose level, total leukocyte count, haemoglobin level, serum sodium, C-reactive protein, and serum creatinine [11].

However, this scale is applicable in advanced necrotic processes when the process spreads to several anatomical structures.

According to M. V. Grinev et al. [5, 6], morphologic changes in fascial formations in necrotizing fasciitis initially have the character of wet gangrene, and its spread occurs according to the scale of regional (zonal) disturbance of microhemodynamics of fasciae. A characteristic feature of local manifestations is the discrepancy between visually determined relatively limited local necrosis of the skin and extensive putrefactive-necrotic lesion of subcutaneous fatty tissue and fascia (the phenomenon of the "tip of the iceberg"). This explains the underestimation of the severity of the patient's condition, associated with the well-known symptom of "clinical scissors" - the discrepancy between the severity of the general condition and the insignificant area of necrotic changes in the fascia of soft tissue structures. The main necrotic process develops under the skin, often necrotically unchanged or little changed, and remains unrecognized [6].

This fact allows us to state that it is not always possible to verify the diagnosis based on external manifestations alone, which is the reason for untimely diagnosis and delayed complex treatment.

The main concepts of treatment of necrotizing soft tissue infections are early diagnosis and differentiation; early initiation of empirical antibacterial coverage (broad-spectrum) and surgical management; adequate control of sources of infection; identification of infectious agents and appropriate adjustment of antimicrobial treatment [12, 15].

CONCLUSION

The presented clinical cases clearly demonstrate the peculiarities of the manifestation of the clinical picture of necrotizing infections of soft tissues and, accordingly, the difficulties of their diagnosis. They are prone to progression, accompanied by marked intoxication and high lethality. The results of treatment are largely determined by timely clinical diagnosis, which allows one to suspect the presence of necrotic lesions at early stages and, accordingly, to properly conduct timely surgical tactics, supplemented by an adequate complex of conservative therapeutic measures.

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Consent for publication - the study is valid. and recognition by the organization is not required. The authors agreed to open the publication.

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SUT BEZINING KAMDAN KAM XOLLARDA UCHRAYDIGAN NEKROZLANGAN FASTSIITI VA TSELLYULITI

Qosimov U.Q., Sultonova D.U., Qosimova M.S.
Toshkent tibbiyot akademiyasi

ABSTRAKT

Yumshoq to'qimalarning nekrotik infektsiyalari mustaqil ravishda yoki turli xil manipulyatsiyalar natijasida o'zini namoyon qiladigan xavfli kasallikdir. Bu odatda qo'l oyoqlar, qorin devori va oraliq soxaning yumshoq to'qimalariga ta'sir qiladigan potentsial o'limga olib keladigan holat. Biroq, bu kasallik tananing boshqa qismlarida ham o'zini namoyon qilishi mumkin. Olib keluvchi moyil omillar - yondosh kasalliklar, qarilik va surunkali alkogolizmning mavjudligi. Sut bezlari juda kamdan-kam hollarda kasallanadi va ko'p hollarda bu turli xil manipulyatsiyalar va punksion davolash usullaridan so'ng, travma yoki etarli darajada konservativ terapiya olib borilmaganligi natijasidir. Maqolada 29 yoshli bemor ayolda hech qanday xavf omili bo'lmagan sut bezi nekrotik fastsiiti klinik holati keltirilgan hamda davolash va diagnostika kontseptsiyasini taqdim etadi .

Tayanch iboralar: nekrotik infektsiya, nekrotik fasstiit, miyonekroz, mastit, nekrotizatsialangan tselülit.

РЕДКИЙ СЛУЧАЙ НЕКРОТИЗИРУЮЩЕГО ФАСЦИИТА И ЦЕЛЛЮЛИТА МОЛОЧНОЙ ЖЕЛЕЗЫ

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АБСТРАКТ

Некротизирующие инфекции мягких тканей - грозное заболевание, возникающее как само по себе, так и в результате различных манипуляций. Это потенциально смертельное заболевание, которое обычно поражает мягкие ткани конечностей, брюшной стенки и промежности. Однако заболевание может проявляться и в других частях тела. Предрасполагающими факторами являются наличие сопутствующих заболеваний, пожилой возраст, хронический алкоголизм. Молочная железа поражается редко, и в большинстве случаев это является следствием различных манипуляций, в частности пункционных методов лечения, неадекватной консервативной терапии или травмы. В статье представлен клинический случай некротизирующего фасциита молочной железы у 29-летней пациентки без выявленного фактора риска и дана лечебно-диагностическая концепция в отношении некротизирующей инфекции.

Ключевые слова: некротизирующая инфекция, некротизирующий фасциит, мионекроз, мастит, некротизирующий целлюлит.