

Successful Salvage of Large Gluteal Abscess with Necrotising Fasciitis Spanning Gluteal to Mid Leg Region

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Abstract: A 40-year-old female with diabetes presented with left gluteal abscess and massive ulcer extending from the gluteal region to mid-leg, complicated by necrotizing fasciitis. She underwent multiple surgical debridements, aggressive supportive management, long duration of antibiotics, glycemic control, and subsequent secondary wound closure- including split-skin grafting. This staged care enabled wound healing and limb salvage.

Keywords: necrotizing fasciitis, diabetic wound infection, gluteal abscess, surgical debridement, split skin grafting

1. Introduction

Necrotizing fasciitis is a rapidly progressive soft-tissue infection characterized by widespread fascial necrosis and high mortality. Prompt recognition, emergency surgical intervention, and multimodal care are essential for limb salvage and survival in patients with large ulcers complicated by this condition.

2. Case Report

A 40-year-old female, presented with complaints of swelling and pain in the left buttock extending up to the left mid leg, persisting for one week. Associated symptoms included fever, tachycardia, and anemia. On clinical examination, a large left gluteal abscess was noted, with evidence of necrotizing fasciitis.

3. Clinical Findings

Ulcer of size 7*4*2 cm with marked swelling, overlying skin necrosis, induration and tenderness with signs of systemic infection and anemia were noted.

Diagnosis: Necrotizing fasciitis complicating the left gluteal abscess with diabetes mellitus and sepsis.

Management:

Surgical Debridement:

Under spinal anaesthesia,

- Thorough **radical emergency surgical debridement**.
- **7 maintenance debridements** to remove the recurrent necrotic tissue formation due to residual or super added infection.
- **Secondary suturing and 1st SSG** to minimise the raw area and to reduce the demand of the wound.

Post - Wound Debridement



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Blood Transfusion: For correction of anemia and stabilization, **14 packed cells** were transfused.

Broad-Spectrum Antibiotics: Initiated empirically and adjusted per culture and sensitivity results.

Supportive Measures: Glycemic control with insulin, intensive monitoring, and nutritional support and physiotherapy.

Definitive Wound Closure: After infection was controlled and healthy granulation tissue was achieved, **2nd SSG** was done under spinal anaesthesia.

Post SSG And Secondary Suturing



Challenges we Dealt with:

- Repeated surgeries -7 debridements
- 7 spinal anaesthesia.
- 14 packed cell transfusions
- Long duration of wound care and hospital stay
- Superadded, iatrogenic and nosocomial infections.

4. Discussion

PERSEVERANCE in wound management is a cornerstone quality of the operating surgeon and his team. This case underscores the need for consistent and determined wound care, especially when faced with superadded, iatrogenic, or nosocomial complications in a diabetic immunopathy.

The successful management is just a reflection of the surgeon's qualities which include

- Surgical skills
- A positive attitude, even in the face of slow progress
- Perseverance in delivering good wound care even if warrants repeated debridements despite frequent setbacks.
- Empathy to address the patient's anxieties
- And winning the patient's confidence through clear communication and compassionate care.

So, **STAY TIGHT TO GET IT HEALED.**