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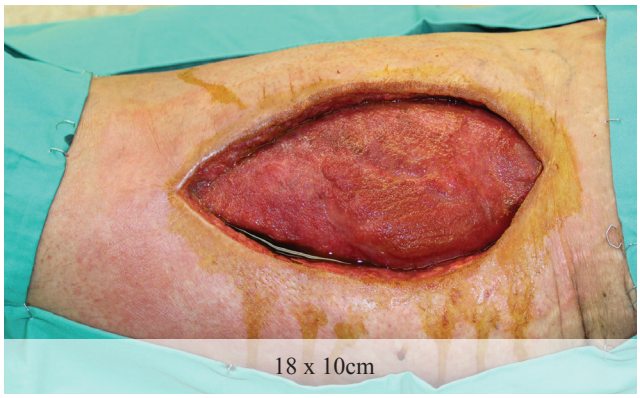
This 53 yo male was in his usual state of good health until 4-5 weeks ago when he noticed increasing buttock pain, fevers and eventual Left leg swelling and pain. He reports no trauma to the leg, denies any breaks in the skin or IV drug use. He is otherwise healthy, has no major medical issues. He presented to the Emergency Room for an evaluation. He denies any rectal trauma and gives no ideas as to the etiology of the leg infection and pain. A CT scan of the leg, abdomen and pelvis was obtained which notes an ischio-rectal abscess that tracks down the posterior thigh to the adductor hiatus with extensive soft tissue abscess which involves the upper posterior left thigh extends into the lower left pelvis at the level of the left ischial fossa with mixed gas and fluid consistent with abscess as described above.

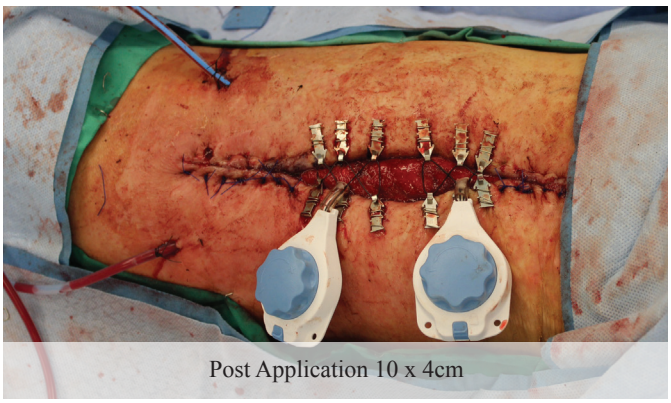
The patient was brought to the operating room the evening of presentation for evacuation of the extensive abscess, washout and placement of a wound VAC. He was brought back to the Operating Room 48 hours later for a second washout where there was no additional necrotic tissue or purulence. The patient was managed with a wound VAC on the floor with every other day changes for 11 days.

The resulting 18 x 10cm wound could not be closed primarily and treatment options included prolonged VAC treatment with subsequent split thickness skin graft. The patient was brought back to the OR after we were confident the source was controlled and underwent a partial wound closure and placement of the DermaClose RC external tissue expander. Xeroform gauze was placed over the open wound under the DermaClose device and the patient was brought back to the OR 4 days later for definitive closure of the wound with removal of the DermaClose device. The wound was closed with ease.

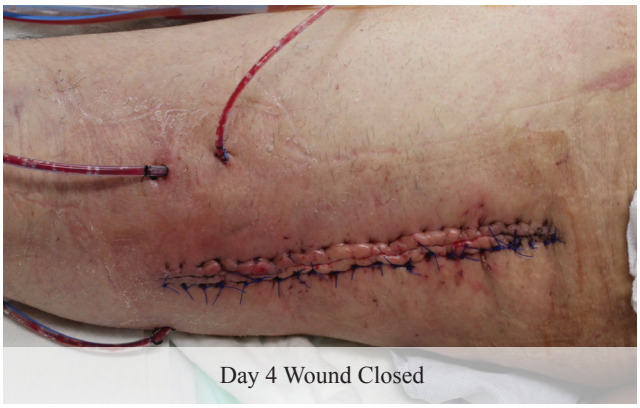
Follow up at six weeks from definitive closure shows the wound healing nicely with no complications.



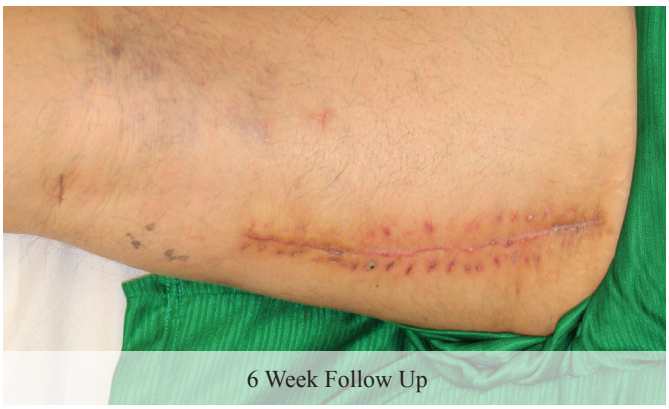
18 x 10cm



Post Application 10 x 4cm



Day 4 Wound Closed



6 Week Follow Up

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