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Letter to Editor

Necrotising fasciitis of breast

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Sir,

Necrotising fasciitis of the breast is a rare condition. It may result in extensive necrosis, systemic toxicity and fatality. It is known to occur following trauma, surgery, needle biopsy/aspiration, use of anticoagulants, and is associated with pregnancy, puerperal sepsis, lactation, diabetes mellitus and HIV infection.

A 26 years old breast-feeding mother with no comorbid conditions, reported with complaints of painful enlargement of the left breast and fever of 4 days duration. An ulcer in the nipple region with foul-smelling discharge had developed since the previous day. On examination, she was febrile (101ºF) with tachycardia (130/minute). Diffuse, tender swelling of the entire left breast with an ulcer destroying nipple-areolar complex was seen. (**Figure 1**). Foul-smelling discharge and slough were seen and the surrounding skin showed blebs and patchy discolouration (**Figure 2**). The right breast was normal. Blood examination revealed polymorphonuclear leucocytosis (16,000/cumm, neutrophils- 85%) but culture was sterile. Chest X-ray was normal. The patient was placed on Inj. Ampicillin – Cloxacillin, Inj. Metronidazole and Inj. Gentamicin empirically, and emergency debridement was done. All the necrotic tissue was excised till healthy bleeding margins were seen (**Figure 3**). Gram staining and culture of the pus showed evidence of polymicrobial infection consisting of *Staphylococcus aureus* and *Streptococcus pyogenes* sensitive to Ampicillin – Cloxacillin. Histopathology of the excised tissue revealed extensive acute pyogenic inflammatory infiltrate with abscess formation and extensive necrosis. The residual defect was resurfaced with split skin grafting and the nipple reconstructed after 23 days of regular dressings and antibiotics.

Necrotising fasciitis is common in lactating mothers[1] as was the history in our case. Cutaneous signs may not be apparent until late although in our case the patient presented with florid clinical picture of necrotising fasciitis. Nipple areola complex is spared in most cases[1] whereas it was completely destroyed in our case.

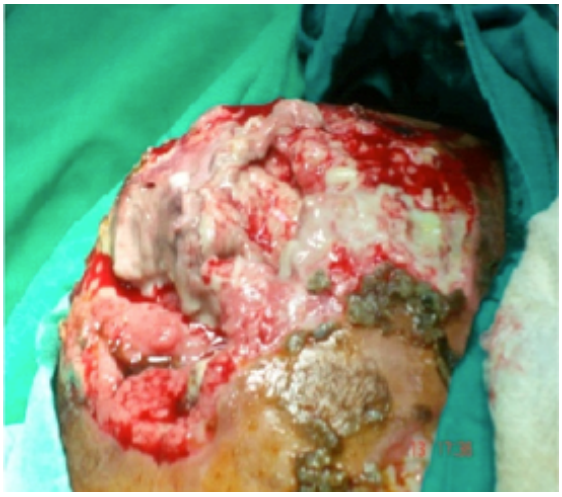

Figure 1: Necrotizing fasciitis of breast

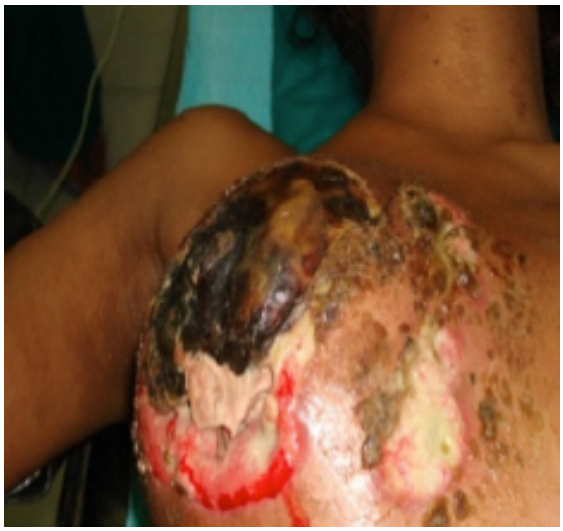

Figure 2: Vesicle and bulla formation

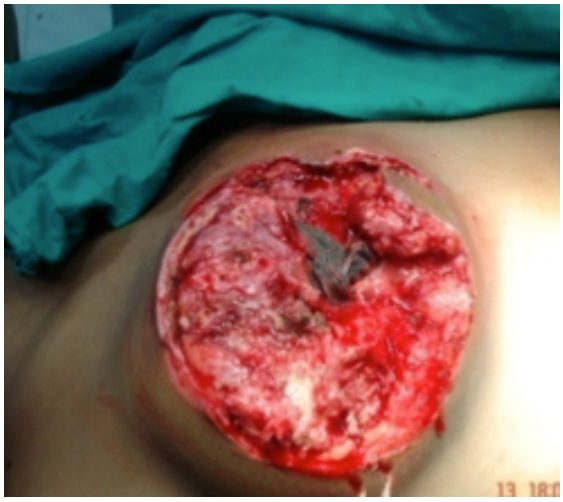

Figure 3: Clean wound after debridement

Administration of broad spectrum antibiotics and meticulous debridement, at repeated sittings if necessary, is essential for successful outcome. Debridement is essential and needs to be extensive enough to ensure healthy bleeding tissue in all directions[2]. However, the aim of surgery should be the complete removal of all infected tissue at the first debridement[3] as was done in our case.

Necrotising fasciitis of breast usually necessitates mastectomy because of delayed diagnosis[4] whereas necrotising fasciitis can result following mastectomy[2].

Combination of Penicllin with aminoglycosides and Metronidazole should not be ignored as an empirical choice and can be as effective as higher antibiotics[5] resorted to only if clinical condition and culture report so merits.

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