Superficial wound infection

Management

1. culture the wound and/or any purulent drainage

2. start the patient empirically on vancomycin plus cefepime or meropenem

3. modify antibiotics appropriately when culture and sensitivity results available

4. Debridement of all necrotic and devascularized tissue and any visible suture material (foreign bodies). Superficial wound infections may be debrided in the office or treatment room, deep infections must be done in OR

5. shallow defects may be allowed to heal by secondary intention, and the following is one possible regimen

a) pack the wound defect with 1/4" Iodophor®gauze

b) dressing changes at least BID (for hospitalized patients, change q 8hrs), remove and trim≈ 0.5–1" of packing with each dressing change

● while the wound is purulent, utilize 1/2 strength Betadine® wet to dry dressings

● when purulence subsides, switch to normal saline wet to dry

c) antibiotics, may be useful as an adjunct to wound treatment initially, switch to oral antibiotics as early as possible, a duration of 10–14 days total is probably adequate if local wound care is being done

6. some prefer to close the wound by primary intention, it is critical that there be no tension on the wound for healing to occur. Some close over an irrigation system or antibiotic beads. Retention sutures may be helpful

7. with large defects or when bone and/or dura becomes exposed, the use of a muscle flap (often performed by a plastic surgeon) is probably required

8. CSF leakage requires exploration in the OR with watertight dural closure to prevent meningitis

From:
https://neurosurgerywiki.com/wiki/ - **Neurosurgery Wiki**

Permanent link:
https://neurosurgerywiki.com/wiki/doku.php?id=superficial_wound_infection

Last update: **2024/06/07 02:54**