Case Report

Patient:	Herr F. G.
Age:	83 Jahre
Inpatient stay:	Mai bis Juli 2019

Anamnese:

On 13.05.2019, the 83-year-old patient presented in our clinic, with 3 days existing pain and feeling of cold in the left lower leg. As secondary illnesses the patient had a kidney insufficiency with GFR of 48.4 ml / min, an atropical eczema as well as a pollen allergy.

Findings:

At admission, the picture of incomplete left ischemia was seen. The inguinal pulses were palpable on both sides. In the popliteal fossa on the left and on the lower leg vessels on the left, pulses were not palpable with an extension of the popliteal aneurysm on the left with no contrast of the left lower leg vessels.

The duplex sonography showed on the left a biphasic signal down to the perfused area of the popliteal aneurysm.

On the left lower leg there were minimal flow signals in the A. tibialis posterio 10 cm / sec. The A. tibialis anterior and A. fiubularis were closed distally.

There was a suspicion of a peripheral embolization in the lower leg vessels.



The patient had no blood-thinning medication or antiplatelet medication.



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Therapy:

The indication for the attachment of a femoro-crural venous bypass with thrombectomy of the lower leg vessels was made.

The surgical treatment with thrombectomy of the fibular artery, in chronic occlusion of the anterior tibial artery, the posterior aortic artery and a femoro-crural venous bypass on the fibular artery were performed the following day (saphenous vein - same side).

Course:

On the 1st postoperative day there was a rebleeding in the operating area on the left lower leg.

A second wound revision with hematoma removal was performed immediately postoperative day.

Circulation via the fibular artery was sufficient for the left foot.

The leg was still clearly swollen after the operation with increasing necrosis of the skin under tension.



On the 20th postoperative day, after removal of the skin clips, wound dehiscence on the left lower leg occurred.

On the 22nd postoperative day (05.06.2019), the transversal wound revision was performed with necrectomy of the necrotic skin parts and the subcutaneous tissue. It V.A.C. ULTRA Therapy System installed. The rinsing was carried out with Serasept (polihexanide) from Serag Wiessner every 2 hours with 30 ml and the suction was set to 75 mmHg.

On the second day (07.06.2019) after the installation of VAC-Vera-flo, we performed a new wound revision with cross-sectional soft tissue revision and partial resection of the gastrocnemius muscle.

On June 11, 2019 the drainage was changed with a clear cleansing of the wound base with good granulation.



On 14.06.2019, the drainage with flushing took place. Good granulation of the wound cavity due to V.A.C. VERAFLO Cleanse CHOICE Dressing M kit.



On 18.06.2019, 1 day after the VAC-vera-flo drainage was applied, the wound was so infectious that a normal vacuum drainage was used. The negative pressure was now 125 mmHg dressing V.A.C. GranuFoam.





Further changes of the vacuum treatment took place on the 19th day, 21st day and on the 34th day.





The wound was now completely granulated, so that on the 38th day of treatment, the vacuum therapy was completed and wound closure by split-skin grafting could be done. Due to the dehiscent wound edges, a secondary suture was not possible. On the split skin also a VAC drainage with GRANUFOAM dressing was applied with a suction of 100 mmHg.





After 5 days, V.A.C. finally removed.



Conclusion:

The early onset of VAC-vera-flo therapy quickly reduced the infection. Subsequent VAC therapy results in good granulation with the possibility of leg preservation and subsequent closure of the wound.

The patient is mobile and can walk independently after the physiotherapy without help (for the VAC therapy antibiosis).

After 68 days, the patient left the hospital on his own, walking and with his left lower leg.

Image: Image:

In a later control after 2 months at home it was this picture.