January 7, 2011

IrriSept: A MRSA axillary abscess treated without antibiotics in a 26 year-old male: A Case Report

Case # 26110

By Paul J. Rucinski, M.D.

Introduction: A case report of IrriSept use on a 26 year-old male that presents with a right axillary methicillin-resistant *Staphylococcus aureus* (MRSA) abscess without antibiotics.

Case Presentation: A 26-year-old white male presents with the chief complaint of "low back soreness." On physical examination he had a low-grade fever (100.8 F), mild tachycardia (110 BPM) and a 20 cm x 12 cm, well-demarcated area of erythema in the right axilla that was tender and irritated with approximately 6 cm x 4 cm of central fluctuance. The patient's back exam was unremarkable. When questioned, he noted that this area rapidly progressed from the size of a "zit" in just three days. He put a "drying salve" on it without improvement. He stated that several months prior, in this same area, he had minor swelling that cropped up as a "very small zit" but it went away once he "popped" it. He denied any other associated symptoms. His past medical history is unremarkable.

Treatment Plan: Incision and Drainage (I&D) of the right axilla abscess was performed. The site was cultured, cleansed with IrriSept wound cleansing and debridement system using the LT Splatter Guard, and followed with IrriRinse per manufacturer's instructions, packed with plain Iodoform gauze, and seen for follow-up at 24 hours, 48 hours, six days, and 7 weeks. The patient was only prescribed Tylenol with codeine for pain on the treatment day. The abscess resolved without further treatment, oral or intravenous antibiotics, nor the need for hospitalization. The patient has not required any further treatment.

Conclusion: In this case, the patient had a MRSA abscess that was successfully treated as an outpatient using IrriSept without antibiotics. The abscess pocket was cleansed and debrided with IrriSept using the LT SplatterGuard. This IrriSept case achieves MRSA abscess resolution without hospitalization, oral or intravenous antibiotics or the need for any further treatment.

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Introduction:

Traditionally, MRSA has been confined to clinical settings, however, healthcare professionals are now confronted with the growing prevalence of a new form of MRSA known as Community-Acquired MRSA (CA-MRSA). Abscesses are typically infected with *Staphylococcus aureus* or CA-MRSA. Skin abscesses may occur spontaneously or as a result of tissue injury in healthy individuals. Risk factors for CA-MRSA include populations that share close quarters or experience frequent skin-to-skin contact (for example: military recruits, athletes, prison inmates, and children in daycare facilities[1,2]). Patients that have been hospitalized or had surgery in the past year are at increased risk for Healthcare-Associated MRSA (HA-MRSA)[1].

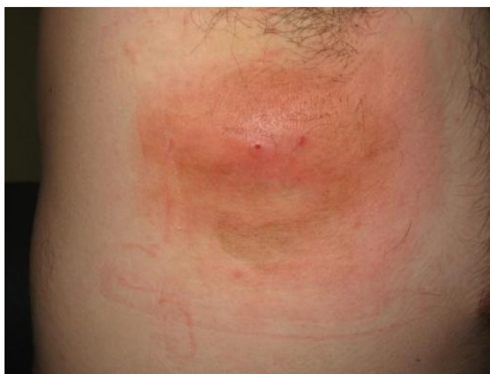
July 20, 2010- Treatment Day:

Patient: A 26-year old male presented with complaints of low back soreness, low-grade fever (100.8 F), and mild tachycardia (110 BPM). Physical exam revealed right axillary swelling. When questioned, the patient stated that the swelling had occurred months before as a "very small zit" that resolved once he "popped" it. In the past three days the area had become larger and more painful. Patient stated pain was a "10 plus" on a scale of 0-10. Patient had applied a drying salve without improvement and denies any other modifying factors or symptoms.

Physical Exam: A well-demarcated area of erythema in a somewhat circular pattern in the right axilla measured approximately 20 cm x 12 cm. The raised area of central fluctuance measured approximately 6 cm x 4 cm. The site is very tender upon palpation and without exudate. Erythema 4+, warm to touch 4+, edema 4+, cellulitis 3+, induration 1+, fluctuance 4+

Procedure: The patient's skin was prepped with Hibiclens and anesthetized with 1% lidocaine without epinephrine. The abscess was incised with a #11 blade. Copious amounts of purulent drainage were expressed, enough to saturate two packs of 4x4's. A culture was obtained and later reported heavy MRSA. The site was cleansed with IrriSept using the LT SplatterGuard, and followed with IrriRinse per manufacturer's instructions. The abscess pocket was packed with 12 inches of ¼-inch plain Iodoform gauze. The site was covered with 4x4's and Kling was used around patient's chest and over his shoulder.

Plan: The patient was prescribed Tylenol with codeine for pain and instructed to return for follow-up the next day. Antibiotics would be started if there were no signs of improvement at the 24 hour post IrriSept treatment.



Treatment Day (Pre IrriSept Irrigation)

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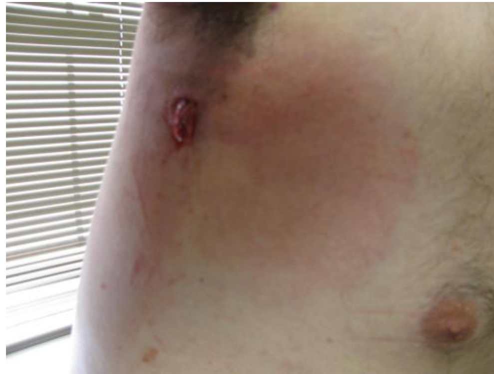
July 21, 2010- 24 hour Follow-Up:

The patient reports discomfort decreased by 50% with pain 5 on a 0-10 pain scale. He denies drainage, fever, or chills and is not using any pain medication.

Physical Exam: Examination of right axilla reveals resolution of well-demarcated erythema. The site is without fluctuance, induration, or purulent discharge. The patient denies tenderness. Motor, sensory, and vascular checks normal. Erythema improving, absence of warmth or cellulitis. 2 cm circular area of bloody drainage on 4x4.

Procedure: The packing was left in place and the wound was redressed in normal manner.

Plan: No antibiotics. Follow-up in 24 hours.



Day 1 (24 hours post IrriSept Irrigation)

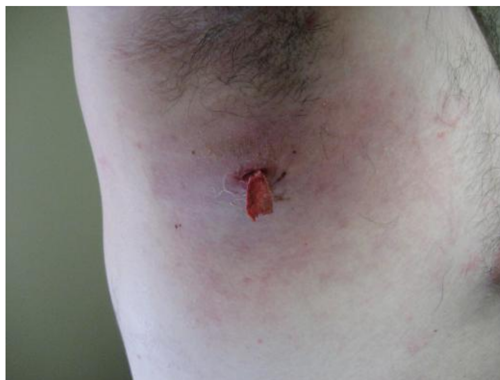
July 23, 2010- 48 hour Follow-Up:

The patient reports pain 1 on a 0-10 scale.

Physical Exam: Examination of right axilla reveals continued improvement in the site. The dressing is without drainage.

Procedure: The packing was removed and wound redressed in normal manner.

Plan: No antibiotics. Follow-up in 4 days.



Day 2 (48 hours post IrriSept Irrigation)

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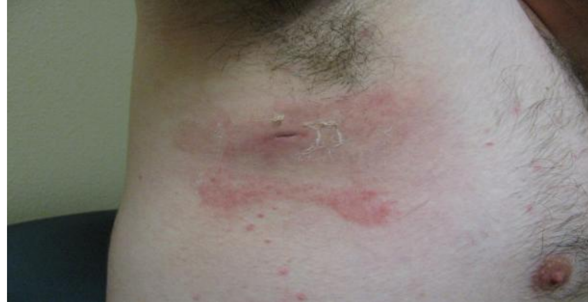
July 26, 2010- Six day Follow-Up:

The patient reports pain 0 on a 0-10 scale.

Physical Exam: Examination of right axilla reveals continued improvement in site and closure of I&D incision. Dressing is without drainage, irritation noted from bandage adhesive.

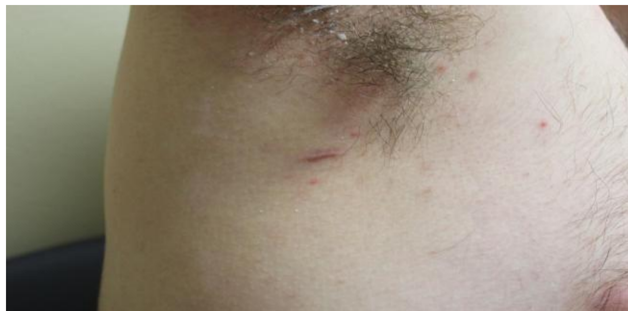
Plan: No antibiotics. Follow-up PRN.



Day 6 Post IrriSept Irrigation

September 8, 2010- Seven week Follow-Up:

The patient was being evaluated for unrelated complaint of back strain. No further treatment was required for the MRSA positive axillary abscess.



7 weeks, one day post IrriSept Irrigation

Conclusion: In this case, the patient had a MRSA abscess that was successfully treated as an outpatient using IrriSept without any prescribed antibiotics. The abscess pocket was only cleansed and debrided with IrriSept using the LT SplatterGuard. This IrriSept case achieves MRSA abscess resolution without hospitalization, oral or intravenous antibiotics nor the need for any further treatment.

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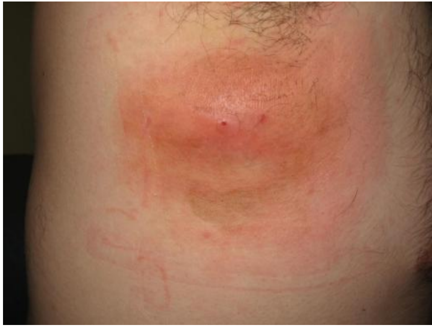
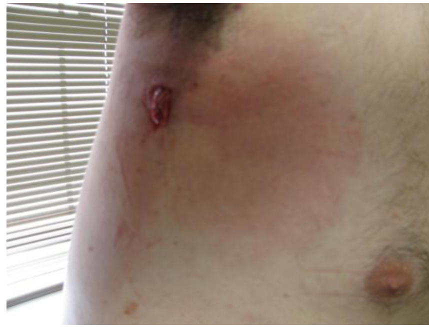
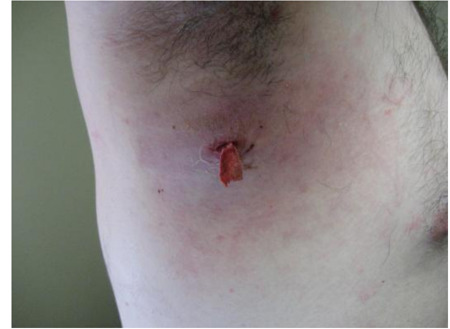
Pictorial Diary



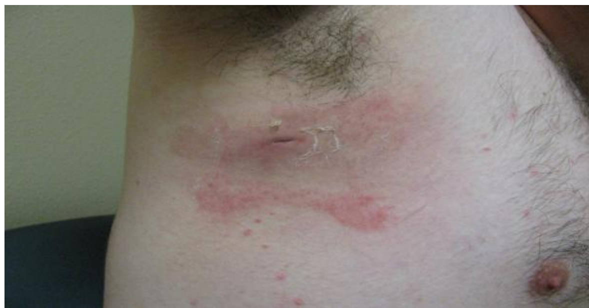
Treatment Day



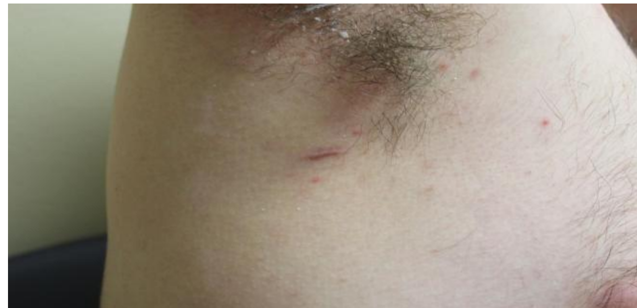
24 hours



48 hours



6 days



7 weeks

1. http:/www.nlm.nih.gov/medlinplus/ency/article/007261.htm
2. http://www.mayoclinic.com/health/mrsa/DS00735

Dr. Rucinski is a Board-Certified Emergency Medicine Physician. He is a shareholder of Innovation Technologies, Inc., the parent company of IRIIMAX Corporation, and serves as the Chief Medical Officer (CMO) for IRRIMAX Corporation.

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