To the Editor,

We read the case report published in the Medical Ultrasonography [1], on “Fournier’s Gangrene” by Matilsky et al with academic interest. It is appreciable that the authors have presented this rare case of necrotizing fasciitis using bedside ultrasound. However, CT scan of the abdomen and pelvis should be considered next for planned surgical management. We agree to the fact that the diagnosis of Fournier’s gangrene can be made with bedside ultrasound with a very high sensitivity [2,3]; however CT can be more specific not only in confirming the diagnosis, but also in evaluating the disease extent [4,5]. CT scan of the abdomen and pelvis can also unfold the underlying cause, as it is rare for Fournier’s gangrene to be idiopathic [4-6]. We came across a 52 year-old male diabetic patient, who presented with a 4 day history of left scrotal pain and heaviness in the ED, and was diagnosed as Fournier’s gangrene on bedside sonography (fig 1). The patient immediately underwent a CT scan of the abdomen and pelvis, which revealed subcutaneous air in the left scrotal sac, extending to the left inguinal canal, without any other focus of infection (fig 2). The CT scan solidified the plan of surgeons to perform isolated left scrotectomy, thus decreasing the overall surgical morbidity. At surgery, approximately 50 ml of foul smelling fluid was drained. Currently, the patient is planned for another debridement, before scrotal skin reconstruction can be performed.

The authors have very rightly described the fact, that the Fournier’s gangrene can be diagnosed using bedside ultrasound, with a very high sensitivity, showing rever-
beration artifact due to subcutaneous air in the non-de-pendent part of the scrotal wall [2,3,7]. However, CT can unleash the underlying pathology causing Fournier’s gangrene, as well as can delineate the pathways of its spread, and thus can be of help in surgical planning, preventing another trip to the operating room for any unforeseen underlying pathology causing Fournier’s gangrene. Timing is very important in the management of Fournier’s gangrene and a planned protocol can benefit the patient.

We do recommend a bedside sonography to rule out Fournier’s gangrene, due to its high sensitivity, and if sonography points to Fournier’s gangrene, the patient should immediately undergo a CT scan of the abdomen and pelvis, to look for any primary focus of infection. CT should also be considered in a patient with extreme tenderness, due to the direct pressure on the scrotum, limiting complete evaluation. Scrotal ultrasound is a very sensitive modality in diagnosing and evaluating acute scrotum, however further evaluation with CT scan should especially be considered in case of Fournier’s gangrene, to evaluate the underlying etiology and surgical planning.

This letter is written with the aim that readers of Medical Ultrasonography can appreciate the proposed plan for the patients with scrotal pain and swelling, with the concern for Fournier’s gangrene.

References