Original Research Article

Study of the effectiveness of laboratory risk indicator for necrotizing fasciitis scoring system in the diagnosis of necrotizing fasciitis among patients presenting with soft tissue infections

Shreeniketan Nayak, Prakash S. Kattimani*

Department of General Surgery, KIMS Hubli, Karnataka, India

Received: 06 June 2021
Revised: 16 June 2021
Accepted: 17 June 2021

*Correspondence:
Dr. Prakash S. Kattimani,
E-mail: pakyabims@gmail.com

Copyright: © the author(s), publisher and licensee Medip Academy. This is an open-access article distributed under the terms of the Creative Commons Attribution Non-Commercial License, which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original work is properly cited.

ABSTRACT

Background: Necrotizing soft tissue infection (NSTI) is an uncommon but life threatening disease with a high mortality rate. Delay in diagnoses and in surgery for debridement is associated with increased mortality rates. Hence here we would like to use this scoring system - laboratory risk indicator for necrotizing fasciitis (LRINEC) in patients presenting to our hospital with necrotizing soft tissue infection and if found to have good predictive values, it would be a boon to developing countries like India where the mortality of the disease is high (7% to 76%).

Methods: Patients presenting with symptoms suggestive of soft tissue infection underwent clinical examination and basic laboratory investigations. Following which, information collected using semi structured proforma cum observational checklist. LRINEC scoring system applied to each of the study subjects at admission. The confirmatory diagnosis of necrotizing fasciitis done on patients who undergo surgery vide histopathology, irrespective of the result of the LRINEC scoring system. Tissue cultures and sensitivity patterns analyzed.

Results: A total of 100 patients were enrolled. LRINEC score has an ability to diagnose necrotizing fasciitis from other soft tissue infections. High LRINEC score had more incidences of features of sepsis. Presence of the co morbidities tended to increase the LRINEC score. And defines patients with a high LRINEC score of > 8 had higher mortality rate.

Conclusions: LRINEC score is a simple clinical tool for the diagnosis of necrotizing fasciitis from other soft tissue infections. LRINEC scoring system and clinical assessment should be used concurrently for diagnosing necrotizing fasciitis from other soft tissue infections.

Keywords: LRINEC, Necrotizing fasciitis, Necrotizing soft tissue infection

INTRODUCTION

Necrotizing fasciitis (NF) is a rapidly progressing, inflammatory infection of the fascia with the secondary involvement of skin, subcutaneous tissues and muscle, associated with substantial morbidity and mortality. Various terminologies are used to describe NF such as hospital gangrene, streptococcal gangrene, acute dermal gangrene, Fournier’s gangrene, suppurative fasciitis, and synergistic necrotizing cellulitis.

Wilson in 1952 gave the term ‘necrotizing fasciitis’ to describe the disease and it is the preferred terminology in these days, as it describes the most consistent and key features of the disease; the fascial necrosis. Necrosis means death of a portion of the tissue and fascia is fibrous tissue that encloses muscle. It is a severe form of soft tissue infection and with no surgical treatment the mortality rate reaches up to 30-60 percent. High morbidity and mortality associated with NF makes it an emergency; early debridement will have a favourable outcome. Hence,
it is a surgical emergency. Mortality is directly proportional to time to intervention. More than 90% of NF patients will also need intensive care and organ supportive therapy; that makes NF a medical emergency. Delay in surgical intervention has been shown to increase the mortality rate.\(^3\)\(^6\)

However, the lack of specific clinical features in the early stages of the disease may be the main reason for failure of early recognition of necrotizing soft tissue infection (NSTI).

The laboratory risk indicator for necrotizing fasciitis (LRINEC) score was first introduced by Wong et al in 2004. Laboratory data such as hemoglobin, serum creatinine, blood glucose, Serum sodium, total white cell count and C-reactive protein (CRP) level are used for early recognition of NF. Only one study has validated the score however with a small group of 28 NF patients. Most studies validated the score system for vibrio soft tissue infection.\(^1\)\(^3\)\(^-\)\(^13\) Two studies have discussed its prognostic value with NF.\(^14\)\(^-\)\(^15\)

A laboratory risk indicator, score of 6 or more in necrotizing fasciatis is considered as high risk for NF. With this background in mind that this study set forward to validate the effectiveness in patients presenting with soft tissue infection using LRINEC scoring system. This kind of trials will be beneficial if its results have good predictive value. It would be a boon to the developing countries like India, where the mortality of disease is high ranging from 7% to 76% and there is also a constraint on resources.

**Objectives of the study**

Objective was to validate the effectiveness of LRINEC scoring system for the diagnosis of necrotizing fasciitis among patients presenting with soft tissue infections to KIMS, Hubballi.

**METHODS**

Prospective study was conducted at KIMS hospital, Hubballi a tertiary care center from October 2016-October 2018 in which the patient presenting with skin and soft tissue infections were evaluated and treated accordingly. Demographic data were recorded including duration of their hospital stay.

**Clinical examination**

Vitals included pulse rate, blood pressure, respiratory rate, and temperature.

Systemic examination included drowsiness, and chest infection.

Local examination included swelling of the involved limb, necrotic patch, discharge from wound site, local rise in temperature, and tenderness.

Comorbidities included diabetes mellitus, hypertension, cardiac disease, and chronic obstructive pulmonary disease (COPD).

**Blood investigations**

It included haemoglobin, random blood glucose, serum creatinine, serum CRP, serum sodium, total white cell count, coagulation profile (PT/INR), and blood urea.

**Imaging**

It included chest X-ray, and X-ray of involved limb and lower limb venous Doppler.

LRINEC scoring system was applied at time of admission.

The need for any operative intervention (debridement/fasciotomy/amputation) was decided.

Diagnosis of NF was made on the basis of clinical features and/or histopathology, irrespective of the result of the LRINEC scoring system.

**Case definition**

NF was defined as case with histopathology results demonstrating necrosis of superficial fascia, polymorphonuclear infiltrate and edema of reticular dermis, subcutaneous fat and superficial fascia or in the absence of histology, gross fascial edema and necrosis detected at surgery or frank cutaneous necrosis seen on physical examination. Culture and sensitivity was sent.

**Study design**

It was a hospital based observational study.

**Source of data**

The study was performed in patients with soft tissue infection using LRINEC score.

**Duration of study**

The study duration was of 2 years from October 2016 to October 2018.

**Inclusion criteria**

Patients presenting to KIMS, Hubballi with symptoms suggestive of soft tissue infection during the study period were included.

**Exclusion criteria**

Patients who have undergone surgical
debridement for present episode of soft tissue infection; and patients with boils or furuncles with no evidence of cellulitis were excluded.

**Statistical analysis**

**Sample size estimation**

All the patients admitted in department of general surgery during the study period with minimum of 70 cases.

**Descriptive statistics**

Quantitative data like age, was calculated as mean and standard deviation. All qualitative data like gender, symptoms, examination findings and histopathology were presented as frequency and percentages.

**Analytical statistics**

Effectiveness of LRINEC scoring system will be analyzed vide sensitivity, specificity, positive predictive value and negative predictive value. Analysis was done by Chi-square and Fisher exact test using statistical package for the social sciences (SPSS) version 16 software. The difference was considered significant if p value was <0.05.

**RESULTS**

In our study sample n=100. 62 patients had LRINEC score >6. 32 patient had score <6 (Figure 1).

**DISCUSSION**

Our study was comparable to Wong et al study. LRINEC scoring system has an impressive ability to diagnose necrotizing fascitis from other soft tissue infections, with positive predictive value of 93.6% and negative predictive value of 94.6%, in our study. We found that in our study
there was fairly false positive rate, hence application of LRINEC score alone has tendency to over treat patients with NF.

The mortality rates for NF vary considerably with the best centers claiming less than 10% and others as high as 75%.\(^1\) \(^5\) Our study showed mortality of 12% in patients with high LRINEC score. There is a host of variables associated with higher mortality. These include delayed initial debridement, age >60, hypotension, acidosis, bacteremia, total body surface area involved more than 250 cm\(^2\), acute kidney injury, hypernatremia, leukocytosis, elevated blood lactate, peripheral vascular disease and number of co-morbidities.\(^1\)\(^-\)\(^13\)

We found in our study that the patients with high LRINEC score had tachycardia, hypotension, tachypnoea, and comorbidities like diabetes mellitus, hypertension and cardiac disease. Presence of these comorbid conditions tend to increase the LRINEC score. Wound culture data showed that beta haemolytic Streptococcus and E. coli were the most important pathogen causing NF in our study.

The difference in mortality rates does not represent the severity of these infections but rather the difference and timing of the methods of treatment. The role of early radical surgical treatment is confirmed as the most important factor affecting outcome.

The selection of appropriate antibiotics keeping in perspective the critical period during which the blood and tissue cultures are not available, our study highlights the importance of early empirical combination antibiotic therapy for patients of necrotising fasciitis. The timely initiation of fluid and electrolyte management, antimicrobial therapy, and surgical debridement with wound care and support for organ failure has markedly reduced the mortality in necrotising soft tissue infections.\(^16\)

We found in our study that 33 patients (33%) who were managed conservatively with IV antibiotics, improved significantly. 67 patients who were operated in our study were taken to operation theater for surgical procedure within 8 hours of admission. However around 50 percent of patients required repeated debridements.

### Table 3: Comparison with other studies.

| Author          | Sensitivity of LRINEC score >6 (%) | Specificity of LRINEC score >6 (%) | Positive predictive value (%) | Negative predictive value (%) |
|-----------------|-----------------------------------|-----------------------------------|------------------------------|-------------------------------|
| Wong et al      | 89.9                              | 96.9                              | 92                           | 96                            |
| Holland et al   | 80                                | 67                                | 57                           | 86                            |
| Our study       | 96.7                              | 89.7                              | 93.6                         | 94.6                          |

### CONCLUSION

The LRINEC score is a useful clinical determinant in the diagnosis and surgical treatment of patients with necrotizing fasciitis, from other soft tissue infections. The LRINEC score is a useful adjunct in the clinical diagnosis of necrotizing fasciitis with a statistically positive correlation. LRINEC scoring system and clinical assessment should be used concurrently for predicting need for early surgical intervention.

**Funding:** No funding sources  
**Conflict of interest:** None declared  
**Ethical approval:** The study was approved by the Institutional Ethics Committee

### REFERENCES

1. Kaul R, McGeer A, Low DE, Green K, Schwartz B. Population-based surveillance for group A streptococcal necrotizing fasciitis: clinical features, prognostic indicators, and microbiologic analysis of seventy-seven cases. Ontario Group A Streptococcal Study. Am J Med. 1997;103:18-24.
2. Morgan MS. Diagnosis and Management of Necrotizing Fasciitis. J Hosp Infect. 2010;75(4):249-57.
3. Voros D, Pissiotis C, Georgantas D, Katsaragakis S, Antoniou S, Papadimitriou J. Role of early and extensive surgery in the treatment of severe necrotizing soft tissue infection. Br J Surg. 1993;80:1190-1.
4. Wong CH, Chang HC, Pasupathy S, Khin LW, Tan JL, Low CO. Necrotizing fasciitis: clinical presentation, microbiology and determinants of mortality. J Bone Joint Surg Am. 2003;85:1454-60.
5. Rea WJ, Wyrick WJ. Necrotizing Fascitis. Ann Surg. 1970;172:957-64.
6. Masjeski JA, Alexander JW. Early diagnosis, nutritional support and immediate extensive debridement improve survival in necrotizing fasciitis. Am J Surg. 1983;145:781-7.
7. Bilton BD, Zibari GB, McMillan RW, Aultman DF, Dunn G, McDonald JC. Aggressive surgical management of necrotizing fasciitis serves to decrease mortality: a retrospective study. Am Surg. 1998;64:397-400.
8. Stamenkovic I, Lew PD. Early recognition of potentially fatal necrotizing fasciitis: the use of frozen section biopsy. N Engl J Med. 1984;310:1689-93.
9. Green RJ, Dafoe DC, Raffin TA. Necrotizing Fasciitis. Chest. 1996;110:219-29.
10. Wong CH, Khin LW, Heng KS, Tan KC, Low Co. The LRINEC [Laboratory Risk Indicator for Necrotizing Fasciitis] score: a tool for distinguishing necrotizing fasciitis from other soft tissue infections. Crit Care Med. 2004;32:1535-41.
11. Holland HJ. Application of the Laboratory Risk Indicator in Necrotizing Fasciitis [LRINEC] score to patients in a tropical tertiary referral centre. Anaesth Intensive Care. 2009;37:588-92.

12. Tsai YH, Hsu RW, Huang TJ. Laboratory indicators for early detection and surgical treatment of vibrio necrotizing fasciitis. Clin Orthop Relat Res. 2010;468:2230-7.

13. Huang KC, Hsieh PH, Huang KC. Vibrio necrotizing soft tissue infection of the upper extremity: factors predictive of amputation and death. J Infect. 2008;57:290-7.

14. Corbin V, Vidal M, Beytout J, Laurichesse H. D’Incan M, Souteyrand P, et al. Prognostic value of the LRINEC [Laboratory Risk Indicator in Necrotizing Fasciitis] in soft tissue infections: a prospective study at Clemont-Ferrand University hospital. Ann Dermatol Venereol. 2010;137:5-11.

15. Su YC, Chen HW, Hong YC, Chen CT, Hsiao CT, Chen IC. Laboratory Risk Indicator in Necrotizing Fasciitis score and the outcomes. ANZ J surg. 2008;78:968-72.

16. Meleney F. Hemolytic Strep gangrene. Arch Surg. 1924; 9:317-64.

17. Khamnuan P, Chongruksut W, Jearwattanakanok K, Patumanond J, Tantraworasin A. Necrotizing fasciitis: epidemiology and clinical predictors for amputation. Int J Gen Med. 2015;8:195-202.

Cite this article as: Nayak S, Kattimani PS. Study of the effectiveness of laboratory risk indicator for necrotizing fasciitis scoring system in the diagnosis of necrotizing fasciitis among patients presenting with soft tissue infections. Int Surg J 2021;8:2041-5.