# PRIMARY CLOSURE FOLLOWING DRAINAGE OF A RECTUS SHEATH MUSCLE ABSCESS

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*ABSTRACT*

***The primary closure of a rectus sheath muscle abscess was performed on an 11-year-old child following evacuation of its contents under antimicrobial cover. Complete healing was achieved in eight days. This method avoids the delays in wound healing and morbidity associated with conventional drainage and shortens convalescence.***

***Keywords:*** *muscle abscess, evacuation, primary closure.*

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## CASE REPORT

An 11-year-old school-girl was seen with a 10-day history of a painful lump in her upper abdomen which was progressively increasing in size. There were no constitutional symptoms and she was otherwise healthy. On examination, there was an indurated tender swelling 4cm in diameter in the left rectus abdominis muscle. A diagnosis of acute pyomyositis with abscess formation was made. Following intravenous administration of a bolus dose of 500mg of cloxacillin and 500 mg of ampicillin and with the induction of general anaesthetic, the abscess cavity was opened transversely by incising the anterior rectus sheath. Approximately 10 ml of thick white pus was evacuated, the abscess wall curetted and the cavity obliterated with 'O' vicryl sutures (Fig 1 and 2). The skin incision was closed with '2/0' monofilament nylon interrupted sutures. Ampicillin and cloxacillin were continued orally in a dosage of 250 mg each 6 hourly for 3 days. The pus from the abscess cavity grew coagulase-positive *Staphylococcus aureus spp* sensitive to cloxacillin. On the fourth post-operative day one of the skin sutures was removed due to localised redness and oedema. The wound healed by the sixth post-operative day when the remaining skin sutures were removed and the child went home (Fig 3). Three weeks later on review, the child was asymptomatic and the surgical scar was contracting well.

## DISCUSSION

Treating skeletal muscle abscesses by incisional drainage, curettage and primary closure follows the principles adopted in the treatment of pyogenic abscesses in a variety of other locations[1-5]. This method avoids the morbidity and discomfort associated with conventional drainage and reduces hospital stay, shortens convalescence and is cost-effective. Patients with superficial abscesses of less than 5 cm in size with minimal constitutional symptoms may be discharged soon after surgery to continue antimicrobial therapy at home.

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**Fig 1 – The curetted abscess cavity showing muscle fibres forming the floor and three occlusive sutures in place.**

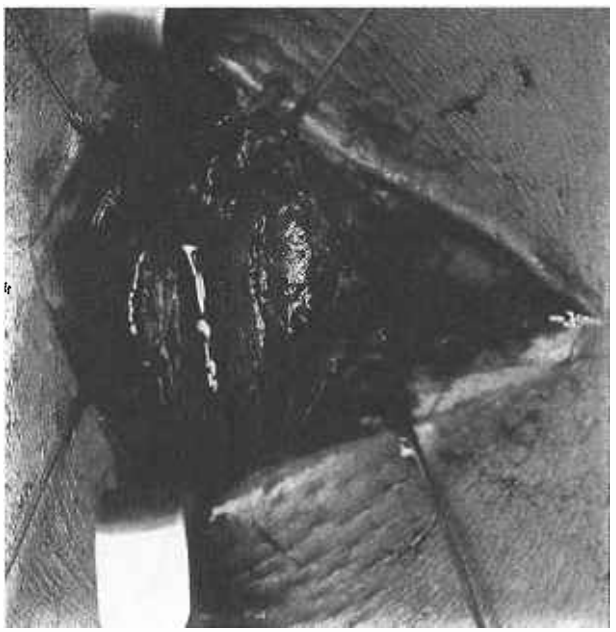


**Fig 2 – The abscess cavity closed with the sutures tied over the rectus sheath.**

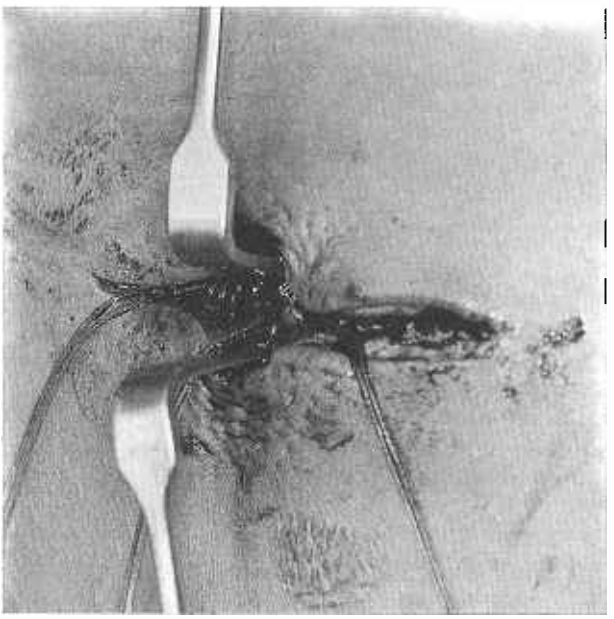
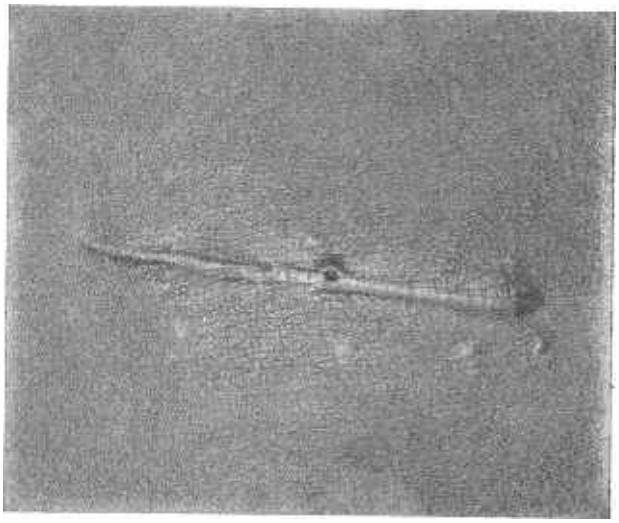


**Fig 3 – Wound well healed on the 8th post-operative day**

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