

WRH Emergency Department Specialty Referrals for those patients requiring Admission or Specialty Review for Abscess Management

Incision and drainage procedures for abscesses should only be undertaken if you are competent to do so. Document consent for the procedure. Consent and explanation of the procedure should cover the following: A large emphasis should be placed on the need for follow-up with a district nurse and regular pack changes, which the patient will need to arrange. This can sometimes last for over a month and so careful explanation is key. Many patients find the follow-up much harder than the initial procedure. Short term risks include bleeding, infection, damage to local structures, and incomplete drainage. Long term risks include recurrence, scarring, and the need for further procedures (including an operation). Other procedures include regular dressing changes.

All patients with an abscess require a BM.

Before undertaking incision and drainage in the ED consider the following factors:

- **Site** Should this be undertaken by a specialty team (see table below)?
- **Is the patient well?** If the patient is unwell with signs of sepsis / underlying pathology, then probably should be referred to a specialty team
Consider if patient has any risks for infective endocarditis (see below)
- **Why now?** Any underlying illness eg. IBD, DM
Longer history possible infected sebaceous cyst, shorter history more likely an abscess
- **Is it ready?** If it can be popped like a spot and has a punctum, it is ready. If not, it will need antibiotics.

Referral should be considered:

- when the abscess involves specific areas (body areas in the table below marked with a * must all be referred)
- when the abscess is very large or deep
- when adequately anaesthetising the abscess will be difficult due to size or site.
- children (will usually be joint care with paediatrics).

Any further imaging that a specialty team requires following referral must be arranged by the specialty team themselves, after they have reviewed the patient; it is not the role of the ED to be requesting further imaging for these patients.

Location of abscess	Specialty	Location of abscess	Specialty
Face/Scalp	Maxillofacial	Abdominal & chest wall	General Surgeons
Jaw	Maxillofacial	Back & flank & buttocks	General Surgeons
Ear	ENT	Axilla *	General Surgeons
Neck - front	ENT	Groin * (non PWID)	General Surgeons
Neck - back	ENT	Perianal / ischioirectal *	General Surgeons
Dental*	Maxillofacial	Groin * (PWID)	Vascular Surgeons
Vulva *	Gynaecology	Related to underlying vascular problem *	Vascular Surgeons
Breast *	Breast Surgeons	Upper & lower limb including joints	Orthopaedics
Penis / scrotum *	Urology	Palms & Soles *	Orthopaedics

PWID – Person Who Injects Drugs, formerly IVDU

Risk Factors for Infective endocarditis include: ● Acquired valvular heart disease with stenosis or regurgitation
● Hypertrophic cardiomyopathy ● Previous infective endocarditis ● Structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect or fully repaired patent ductus arteriosus, and closure devices that are judged to be endothelialised ● Valve replacement.