A 58-year-old male presented with a two-week history of right-sided abdominal pain with deteriorating skin changes. Due to the COVID-19 pandemic the patient delayed presenting at hospital. A warning diagnosis of necrotising fasciitis was made with concern that there may be underlying bowel involvement. CT scan revealed an abdominal wall hernia and free gas. The patient was taken to theatre immediately. All the infected skin was debrided back to bleeding margins. This was identified as perforation of the small bowel from a prolonged period of incarceration within the abscess cavity. The patient was haemodynamically unstable and on inotropes at this point of the operation. During the debridement there was enteric content noted within the abscess cavity. This was noted as perforation of the small bowel from a prolonged period of incarceration within the abscess cavity. The patient was haemodynamically unstable and on inotropes at this point of the operation. During the debridement there was enteric content noted within the abscess cavity.

The wound was heavily contaminated and there was significant moisture associated dermatitis (MASD) to the right flank (Image 1). Our initial concerns were the risk of infection and the MASD which was causing significant pain. Foley catheters had been used in theatre to contain the enteric contents; however, this was ineffective. The patient’s need to debride contained tissue and contain the enteric fluid, ensuring it was not able to leak onto healthy tissues. The double barrel ileostomy was recessed in a crease within the wound and only visible when parting the skin folds (Image 2). Due to the amount of moisture we were unable to apply a pouch and isolate the ileostomy and a joint decision was made to apply a large wound manager over the wound and stomas.

The wound manager bag aperture was reduced incrementally at each review (every 72 hours) to allow healing at the edges. Digitalisation of the ileostomy by the patient to maintain patency following rapid healing and granulation over the ileostomy (Image 4).

**Key Points**

1. Risk communication is crucial during pandemics to ensure that individuals continue to attend hospitals for acute medical/surgical issues.
2. Wound healing is possible despite significant and continuous faecal contamination.
3. Fluid management is critical to healing wounds and protecting peri-wound tissues in cases where products cannot be applied across the wound bed and an ileostomy is present in the wound.
4. Multidisciplinary approaches are vital to ensure optimal outcomes are achieved in complex cases.
5. In cases where there is an ileostomy within a large wound, healing can be achieved by incrementally reducing the aperture of a wound bag whilst using hydrocolloid powders to protect the epithelialising tissues at the wound edge. Silver hydrofibre dressings may help manage over-granulation effectively in faecally contaminated wounds over an extended period of 21 days.
6. Patient engagement in management plans can be critical to outcomes in compound wounds such as this case.

**References**