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以小傷口清創配合纖維蛋白膠治療Morel-Lavallée病灶: 治療經驗分享與文獻回顧

潘致皓

馬偕紀念醫院

Percutaneous debridement of and fibrin glue injection into a pretibial Morel-Lavallée lesion—a case report and literature review

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Percutaneous debridement of and fibrin glue injection into a pretibial Morel-Lavallée lesion—a case report and literature review
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Background
The Morel-Lavallée Lesion (MLL) is first described by Maurice Morel-Lavellee in 1853. It is caused by a shearing force acting between the subcutaneous tissue and deep fascia, which pull the perforating vessels and lymphatics apart. The hemolymphatic collection in the potential space
Patients with Morel-Lavallée Lesion usually present with tender and enlarging soft tissue

swelling with fluctuation, decreased skin sensation , ecchymosis or even skin necrosis followed by hours to days after the inciting injury. The lesion is frequently occurred in the polytrauma patient, which may explain the reason why the Morel-Lavallée lesion is easily underdiagnosed.

Case Report

A 43-year-old woman presented with recurrent mass lesion over left lower leg for 2 months since a traffic accident. She had undergone repeated needle aspiration with hematoma drainage initially and serous discharge drawing out afterward at other clinic; but the fluctuant mass lesion relapsed few days after the aspiration.

We made a1cm incision under local anesthesia for fluid drainage and applied elsatic bandage for compression. No sing of remission during the 3 months follow-up. So surgical intervention was performed by pseudocyst curettage and dead space sealing by fibrin glue. After the oepration, she had compression bandage for 2 weeks. There was no more seroma formation during the 10 months follow-up.

The Morel-Lavallée lesion (MLL) is an uncommon but substantial source of morbidity in trauma patients. No consensus of MLL treatment so far. From our experience, two small incisions for drainage, curettage & fibrin sealant is applicable for chronic MLL.