EARLY RECOGNITION OF SYSTEMIC DETERIORATION IN SURGICAL INFECTION AMONG PATIENTS WITH DIABETES MELLITUS

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Background. Preventing the systemic spread of surgical infection in patients with diabetes requires a pathway that links wound assessment with evaluation of the whole patient. A localized description of the wound may be insufficient when the clinical condition is changing. Diabetes management, surgical decisions and monitoring are often undertaken by different professionals, making communication a practical part of prevention. The main challenge is to recognize when an apparently local problem is accompanied by systemic deterioration and to act before treatment delays accumulate. Changes in mental status, circulation or urine output warrant attention even when the wound appearance seems stable. Conversely, an abnormal inflammatory marker alone cannot establish the presence of sepsis. A clinically useful approach therefore combines repeated bedside assessment with investigation of the underlying anatomical source and a clear plan for escalation.

Materials and methods. The focus is recognition of deterioration, antimicrobial decision-making and surgical reassessment. No original patient cohort or measured reduction in sepsis incidence is reported.

Results. A changing clinical condition requires reassessment of both infection and alternative causes of deterioration. Suspected sepsis should prompt evaluation for organ dysfunction and an anatomical source requiring intervention. SSC 2026 recommends immediate antimicrobials, ideally within one hour, for probable or definite sepsis and for possible, probable or definite septic shock. Possible sepsis without shock allows a rapid, time-limited investigation, with treatment within three hours if concern persists. This distinction supports proportionate urgency rather than identical treatment of every infected wound. Surgical review should address residual collections and necrotic tissue. Serial documentation of vital signs, mental status and urine output provides a practical record for clinical handover. Improvement after intervention must be assessed clinically rather than inferred from antibiotic administration alone.

Conclusion. Prevention of systemic complications depends on recognizing deterioration and connecting that recognition to timely treatment and source reassessment. An explicit escalation pathway can organize care, but its effect on outcomes requires evaluation in a clinical study.

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