Dr. Juan Carlos Torres del Río explains when surgery is urgent and when staged management is safer

A surgeon explains the clinical red flags that require immediate intervention—and when a staged plan reduces risk and improves outcomes.

Juan Carlos Torres del Río

BARRANQUILLA, ATLáNTICO, COLOMBIA, February 12, 2026 /EINPresswire.com/ -- In an era when “quick fixes” and minimally regulated procedures can circulate widely online, one of the most misunderstood questions in surgical care is also one of the most consequential: When is it truly urgent to operate? For patients facing complex complications—particularly those linked to foreign-body fillers, biopolymers, or severe inflammatory reactions—the decision is rarely as simple as “operate now” versus “wait.” Instead, it often requires a structured, medically grounded approach that weighs systemic risk, tissue viability, infection control, imaging findings, and the patient’s overall stability.

> “Urgency is defined by clinical risk—not fear. Some cases need immediate source control; others need stabilization and a staged plan to reduce complications.”
>
> *Dr. Juan Carlos Torres del Río*

Dr. Juan Carlos Torres del Río, a plastic and reconstructive surgeon known for his work in complex removal procedures and tissue reconstruction, says the urgency question is frequently shaped by fear and misinformation. “Patients often arrive believing there are only two options: immediate surgery or doing nothing,” he said. “In reality, the responsible decision is based on clinical criteria. Some cases are urgent because delaying could threaten tissue, function, or even life. Others require a stepwise plan because operating too soon can worsen inflammation, increase complications, and compromise reconstruction.”

This editorial explains the medical criteria commonly used to decide between immediate surgical intervention and a staged (step-by-step) strategy, as well as the red flags that require urgent evaluation. It is intended to inform readers and journalists seeking a clearer understanding of how surgeons make high-stakes decisions—especially in cases where the underlying problem is inflammatory, infectious, or anatomically complex.

The core distinction: “urgent” is a medical status, not a feeling

Urgency is not defined by how distressed a patient feels—although distress matters and should never be dismissed. In surgical medicine, urgency is typically defined by whether a delay could lead to:

Rapid clinical deterioration (systemic infection, sepsis, airway compromise)

Permanent loss of function (nerve compromise, vascular compromise, compartment-like pressure states)

Tissue death (skin necrosis, progressive ulceration)

Uncontrolled infection or abscess progression

Unstable bleeding or expanding hematoma

Severe, escalating pain with objective clinical signs

Threats to critical structures (urinary obstruction, impaired mobility due to severe infection, etc.)

“In my experience, the most important step is to separate anxiety-driven urgency from medically defined urgency,” Dr. Torres del Río said. “Both deserve attention, but they require different actions. Anxiety needs information and a clear plan. True medical urgency needs immediate escalation.”

Why some patients need immediate surgery

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Certain complications can become emergencies. In these scenarios, surgeons often prioritize stabilization, source control (removing infected or necrotic tissue), and preventing systemic spread.

1) Suspected or confirmed sepsis / systemic infection

When a patient shows signs of systemic infection—fever, chills, rapid heart rate, low blood pressure, confusion, worsening weakness, or abnormal laboratory markers—time becomes critical. The surgical goal may be to drain an abscess, remove necrotic tissue, and reduce the infectious burden while coordinating antibiotic therapy.

“Systemic infection changes everything,” Dr. Torres del Río said. “If a patient is becoming septic, delaying source control is dangerous. The surgical plan becomes less about aesthetics and more about safety.”

2) Rapidly progressing skin compromise or necrosis

If the skin begins to show signs of compromised blood supply—dusky discoloration, blistering, ulceration, black areas, or spreading tissue death—urgent action may be required. Necrotic tissue can become a reservoir for infection and can expand quickly.

In these situations, immediate surgery may be needed to debride dead tissue, prevent further spread, and protect deeper structures. Delays can increase the size of the defect and complicate reconstruction.

3) Deep abscess, fluctuance, or drainage with worsening pain

An abscess is not simply “inflammation.” It is a localized infection that may require drainage, especially when it is deep, enlarging, or associated with systemic signs. Imaging can help confirm the diagnosis and guide the surgical approach.

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“A deep abscess can look like ‘just swelling’ until it becomes severe,” Dr. Torres del Río said. “When infection is present, drainage and source control often cannot wait.”

4) Compartment-like pressure, vascular compromise, or threatened limb/structure

Although rare in many elective contexts, certain inflammatory or infectious processes can create pressure that compromises blood flow or nerve function. Warning signs include increasing pain out of proportion, numbness, weakness, coolness, or changes in distal sensation and color.

When critical circulation or nerve function is threatened, the decision may become urgent because delays can lead to permanent damage.

5) Severe allergic-like or inflammatory systemic reactions with instability

Some foreign-body reactions can trigger systemic symptoms—widespread inflammation, severe swelling, or multi-site involvement—that requires urgent evaluation. While many inflammatory reactions are managed medically first, systemic instability can necessitate hospital-based intervention and, in select scenarios, surgery for source control.

“Inflammation alone does not always mean surgery,” Dr. Torres del Río emphasized. “But inflammation with systemic instability raises the level of concern and requires urgent assessment.”

Why immediate surgery can be risky in other cases

While “operate now” can be lifesaving in emergencies, it can be harmful when the underlying condition is diffuse inflammatory disease, when tissues are unstable, or when the surgical field is poorly defined.

Diffuse inflammation can obscure anatomy

In many foreign-body or chronic inflammatory cases, the material may not be contained in a single pocket. It may be scattered across planes, intertwined with tissue, and surrounded by inflamed structures. Operating in the peak of inflammation can increase:

bleeding risk

incomplete removal

nerve or vascular injury

scarring and contour deformity

wound healing complications

widened tissue loss requiring larger reconstructions later

“Surgery is not just about removing something,” Dr. Torres del Río said. “It’s about removing it safely. If the anatomy is distorted by active inflammation, the risk profile changes.”

Operating too early can worsen tissue damage

Inflammation makes tissues more fragile. That fragility can lead to wound breakdown, poor healing, and higher infection rates. In some cases, aggressive early surgery can create defects larger than necessary.

For this reason, many surgeons prefer to stabilize inflammation, define anatomy via imaging, and plan a staged approach—unless emergency criteria are present.

The staged approach: what “step-by-step” management actually means

A staged plan does not mean delaying indefinitely or ignoring the problem. It means organizing care in phases, often including medical stabilization first, followed by carefully timed procedures.

Dr. Torres del Río describes staged management as “a controlled sequence designed to reduce risk and improve outcomes.”

Phase 1: Stabilize and assess (medical and diagnostic)

This phase typically includes:

full clinical evaluation and history

laboratory tests if indicated (inflammatory markers, infection markers)

imaging to map the problem (ultrasound, MRI, CT depending on the case)

pain and inflammation control

antibiotic therapy when infection is suspected or confirmed

management of systemic conditions (diabetes, hypertension, immune disorders)

“The first phase answers a simple question,” he said: “Is this an emergency—and if not, what exactly are we dealing with?”

Phase 2: Define surgical goals and risks (planning)

Once the condition is stabilized, surgeons plan the procedure with clearer objectives:

targeted removal versus broad debridement

protection of critical structures

minimizing contour deformities

anticipating reconstruction needs

aligning timing with patient safety (nutrition, healing capacity, controlled inflammation)

Phase 3: Intervention and reconstruction (often more than one procedure)

Some cases require more than one surgery. The initial procedure may focus on source control or partial removal, followed by later reconstruction once tissues recover.

“A staged approach protects tissue,” Dr. Torres del Río said. “It also protects expectations. It’s better to explain that recovery and reconstruction are part of a process than to promise a one-time fix that increases risk.”

Clinical criteria that guide “urgent removal” vs “staged management”

Surgeons often assess a combination of factors rather than relying on one indicator.

A) Infection status

Urgent: systemic infection signs, uncontrolled abscess, rapidly worsening drainage, unstable vitals

Staged: low-grade infection controlled with antibiotics, stable localized inflammation without abscess

B) Tissue viability

Urgent: expanding necrosis, threatened skin viability, ulceration with rapid progression

Staged: stable skin, no necrosis, chronic discomfort without signs of imminent tissue loss

C) Anatomical distribution (localized vs diffuse)

Urgent: a defined abscess pocket requiring drainage; localized necrosis requiring debridement

Staged: diffuse spread across planes where immediate wide excision could cause unnecessary harm

D) Pain profile and objective findings

Urgent: severe escalating pain with objective signs (fever, redness spreading quickly, fluctuance, neurovascular changes)

Staged: chronic pain without systemic deterioration, managed while mapping and planning

E) Systemic conditions and surgical readiness

Urgent: emergencies proceed with stabilization protocols

Staged: if the patient has uncontrolled diabetes, anemia, malnutrition, or high surgical risk, optimization first can reduce complications

“Patients sometimes interpret ‘staged’ as ‘the doctor doesn’t want to operate,’” Dr. Torres del Río said. “But often it means the opposite: it means the doctor is taking responsibility for safety and outcomes.”

The patient’s perspective: why the decision feels confusing

Many patients facing complex complications have already experienced uncertainty, misinformation, or previous interventions. They may feel urgency due to:

fear of worsening symptoms

shame or stigma

online pressure and sensational content

inconsistent opinions from different providers

pain and reduced quality of life

Dr. Torres del Río says the solution is not to dismiss fear, but to replace confusion with clarity: “The patient deserves a transparent explanation of criteria. When we explain what would make surgery urgent and what can safely be planned, the patient can regain a sense of control.”

What urgent symptoms should prompt immediate medical evaluation?

While a press release is not a medical triage tool, editorial health guidance often lists red flags that warrant same-day or emergency evaluation. These include:

high fever, chills, or confusion

rapid swelling with worsening redness

severe pain that escalates quickly

fainting, low blood pressure, or rapid heart rate

pus drainage with systemic symptoms

blackening skin, blisters, or spreading ulcers

numbness, weakness, or signs of reduced circulation

sudden functional decline (unable to walk, severe limitation)

“These symptoms don’t diagnose a condition by themselves,” Dr. Torres del Río said, “but they are signals that time matters and evaluation should not wait.”

Why imaging and documentation matter in non-urgent cases

In planned management, imaging is often a cornerstone because it can:

map the extent and depth of affected tissues

distinguish inflammation from abscess

guide safer surgical entry points

reduce guesswork

inform reconstruction planning

In complex cases, documentation—including baseline photos and measurements—can help track progression and guide decisions about timing and scope.

“A staged strategy is built on information,” Dr. Torres del Río said. “Without mapping and documentation, you risk operating in the dark.”

The ethical dimension: avoiding “one-size-fits-all” recommendations

A persistent public-health challenge is that some procedures are promoted online with generalized claims. Dr. Torres del Río emphasized that responsible surgical care avoids universal promises because:

anatomy varies

inflammatory responses vary

material distribution varies

comorbidities vary

surgical history and scarring vary

goals differ between patients

“Two patients can have similar complaints but completely different surgical indications,” he said. “That is why medicine requires evaluation—not templates.”

Recovery and expectations: staged care as a form of transparency

Journalists covering medical topics often look for one key element: what outcomes can be realistically expected.

Dr. Torres del Río said that, in complex removal and reconstruction contexts, a staged plan can align better with realistic outcomes:

recovery is often gradual

contour changes may require secondary procedures

scar management is part of follow-up

functional recovery can be prioritized over immediate cosmetic perfection

mental health support may be beneficial for patients who experienced medical trauma

“When we present staged care properly, it becomes a patient-safety story,” he said. “It’s not delay—it’s structure.”

A preventive framework: reducing the likelihood of urgent scenarios

Although this editorial focuses on decision-making once complications exist, Dr. Torres del Río noted that prevention is also an editorially relevant subject:

verify credentials and clinical settings

avoid unregulated injections and unknown substances

seek early evaluation if symptoms begin

do not self-medicate infections

do not pursue repeated uncoordinated interventions that can worsen tissue planes

“Urgency often emerges when problems are ignored or treated incorrectly early on,” he said. “Prevention is always safer than rescue.”

News relevance: why this topic matters now

Health editors increasingly face a complex environment in which medical topics are amplified by social media, sometimes without adequate context. The distinction between urgent and staged intervention is particularly relevant because it:

improves public understanding of medical decision-making

reduces panic-driven decisions

discourages unsafe “emergency” claims used to pressure patients

highlights patient safety as a core editorial value

Dr. Torres del Río framed it as a communication responsibility: “When a patient understands criteria, they can advocate for themselves, seek the right level of care, and avoid being pushed toward risky choices.”

Closing statement from Dr. Juan Carlos Torres del Río

“The central question is not whether surgery is fast or slow,” Dr. Torres del Río said. “The question is whether surgery is timely—meaning medically indicated, properly planned, and executed under conditions that reduce harm. Some cases are urgent because life or tissue is at risk. Others need a staged approach because operating in the peak of inflammation can increase complications. The safest outcomes come from clinical criteria, not pressure.”

About Dr. Juan Carlos Torres del Río

Dr. Juan Carlos Torres del Río is a plastic and reconstructive surgeon whose clinical work includes complex removal procedures and reconstructive planning in patients with inflammatory and tissue-compromising complications. His approach emphasizes medical criteria, risk reduction, and staged strategies when they improve safety and outcomes.

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