The use of Activon® Tube and Algivon® on an elderly male diabetic patient with a grade 5 sacral wound

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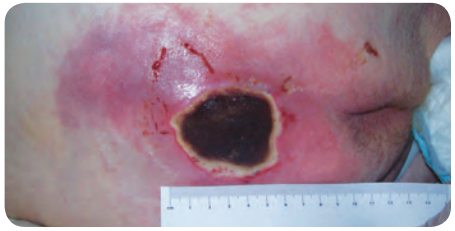
Case study

Resident is a 75 year old male. Suffers from Type 2 Diabetes which is tablet controlled. Waterlow Score was 30 (very high risk) and his BMI was 28 (overweight). He had for several years suffered declining mobility with reduced sensation in both legs. Unable to weight bear. He had been diagnosed with small vessel disease which is as a result of hypertension and his diabetes.

Was hospitalised with dehydration and sepsis and on his return to the care home after a three week stay in hospital he presented with a grade 5 sacral wound.

Unable to ascertain depth at this time due to necrotic tissue present but wound measured 5cm by 4cm with a band of Erythema measuring approx 8cm by 4cm present from wound margins. Mixed wound state with evidence of localised infection, oedema and inflammation. Odour at this time was a big issue due to purulent exudate of serous fluid and blood.

Pain noted during dressing change, current dressing prescribed was a hydrocolloid gel with an adhesive dressing as a secondary dressing.



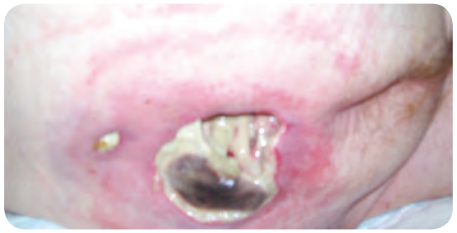
23.10.08

Due to poor physical health and existing pressure sore, nursing management was complete bed rest and an alternating overlay pressure relieving mattress.

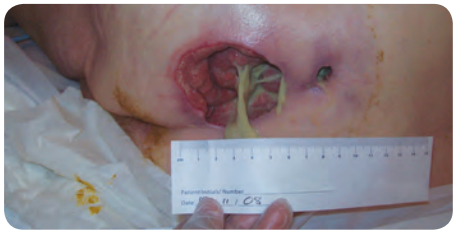
Dressing was reviewed due to maceration and odour issues. Advancis Manuka honey was chosen due to its ability to reduce inflammation, its antimicrobial properties, its ability to debride and quick granulation of wound.

Initial application

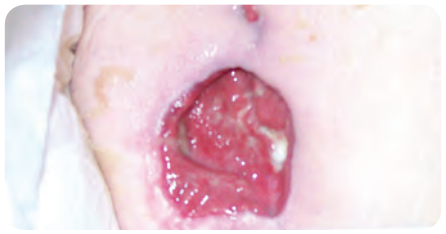
Activon® Tube was applied directly to areas of necrotic tissue with a barrier of cavalon spray around the wound edges to prevent maceration due to levels of exudate. Area was covered with a secondary dressing of Mepilex Border. It was decided to redress the area every 3 days. It was noted that after first dressing application odour reduced significantly. Due to increase in exudate from Day 2 dressings were done as required, sometimes twice daily due to strike through. After four days another break became evident approx 3cm from existing wound margin. Pain reported on dressing change by patient. Slough reduced by approx 75% and was lifting out of cavity in one piece.



06.11.08 *Wound diameter - 5cm by 6cm*
Wound depth - approx 2.5cm



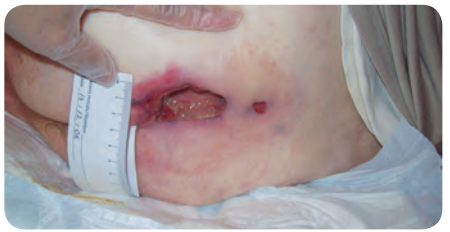
19.11.08 *Wound diameter - 5cm by 6cm*
Wound depth - approx 2.5cm



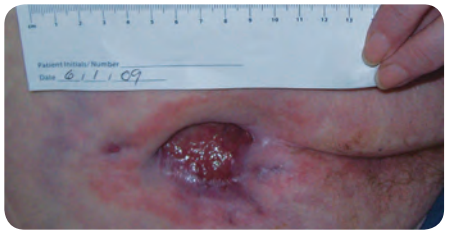
05.12.08 *Wound diameter - 4.5cm by 3cm*
Wound depth - approx 2cm

It was observed that the new wound was tracking from the existing wound. Activon® Tube was substituted for Algivon® to allow the cavity to be packed; all other management was as before. Skin around the wound was much healthier with all signs of erythema gone. There were no signs of localised infection. Pain reported to be minimal at dressing changes. Odour was minimal. Dressing reapplied daily.

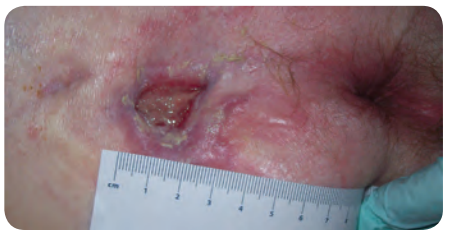
Minimal areas of slough now present. Algivon® continues to be inserted into the cavity. Exudate greatly reduced and wound odour remains minimal. Skin around the wound remains healthy. No reports of pain at dressing change. Wound granulating very well with no new issues. Dressings reapplied on alternate days.



13.12.08 *Wound diameter - 4cm by 2.5cm*
Wound depth – approx 1.5cm



06.01.09 *Wound Diameter - 3.5cm by 2cm*
Wound Depth – 0.5cm



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Small wound and track granulated with large main cavity Grade 4. Remains clean and surrounding skin healthy. Wound odour remains minimal. No reports of pain at dressing change. Dressings reapplied every two days.

Cavity now Grade 3. Wound slough free and granulating very well. Surrounding skin remains healthy. Odour and exudate levels remain minimal. No pain reported at dressing change. Dressings applied every three days.

In a professional capacity product was simple to use. Most hydrocolloids I have used in the past tend to deslough from the top of necrotic area working down to leave a cavity and tend to over granulate wound margins resulting in fissures. This product range worked the opposite enabling the slough to lift out in one piece and granulation was noted to be quicker from base of cavity with wound edges granulating slower ensuring no

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chance of over granulation in the wound margins.

The difference in the odour was evident from first dressing application, and erythema and oedema subsided very quickly. Pain at dressing change was recorded at 8 out of 10, (ten being the maximum pain level) and two weeks after trial commenced this reduced to 4 out of 10 then quickly to nil.

The secondary dressing chosen was due to its non adhesive and absorbing qualities.

Due to the available product range this reduced the need for different products to be used preventing potential error in wound dressing selection by unfamiliar staff.

The rate of wound healing has been exceptional when you take into account the pre morbid factors and on this occasion the gentleman in question has had huge benefits from the use of this product.

Overview

On the 23rd of October 2008, the resident was readmitted to Whitecraigs Care Home from the hospital, with a grade 5 pressure sore at the sacral area. He is a diabetic type 2. Consultation was made with the GP and liaison nurse and the advice was to continue the recommended dressing of the hospital Tissue Viability Nurse, which was hydrocolloid gel and an adhesive dressing as a secondary dressing with Cavilon spray on surrounding skin to prevent maceration. I used them for several weeks but seemed not to make much difference. The necrotic tissue was not lifting and the odour was very offensive.

Home manager was made aware of the progress, that the current products were not very effective. We discussed 'honey' dressings as we had a patient before whom we used honey ointment on her small wound which did help it heal. Home manager then organized a meeting with the representative of Advancis Medical.

The 'honey' dressing was discussed with the patient, family and the GP and they were agreeable to it. The course of treatment was then commenced with dressing materials supplied by the company sales representative, except the Cavilon spray.

The necrotic tissue was lifting in just a day or two after the honey dressing was started. The exudate was still massive (we had been advised this would be the case by rep) but the odour was dramatically reduced. I also notice that the surrounding skin was clear from any maceration. After two weeks of using it, I noticed total clearing of sloughy tissue with granulation from the wound bed and the tissue appears healthy, so we continue using the honey products until the wound started to close.

I was really impressed with the result. I never thought the wound healing would be that fast considering the patient's circumstances.

In my own opinion, honey is very effective in wound clearing and healing and I will recommend it myself as first line treatment/management on wounds especially necrotic pressure sores.

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