An Alternative Approach to Treating a Cavity Wound

Introduction
Exudate management is a fundamental element of wound healing. When wounds produce insufficient or too much exudate, a wide range of problems can occur that ultimately delay healing, distress patients and consume considerable healthcare resources (M Romanelli, K Vowden, D Weir, Wounds International 2010). Exudate must be effectively managed if the optimal moist environment necessary for wound healing is to be created and the surrounding skin protected from the risks of maceration (Cutting & White 2006).

A 63 year old male was treated originally in 2010 after impaling himself on the exposed arm support of his wheelchair resulting in three wounds to the sacral area - the initial puncture wound and two grade 3 pressure ulcers. A hospital admission was required where Negative Pressure Wound Therapy (NPWT) was administered until the wound healed.

However, in April 2012 during an independent transfer, the patient realised that one of his healed wounds had split open resulting in a trauma wound 5cm deep. By the time the wound was assessed, there were signs of clinical infection and it was highly exuding, causing maceration to the peri-wound area. Other associated risk factors included diabetes, obesity, smoking and reduced mobility.

Method
The wound was initially treated with an antimicrobial dressing secured with a sacral foam dressing to manage exudate levels. This was reinforced with a course of Flucloxacillin, administered systemically. With the infection addressed, the aim now was to heal the wound via secondary intention and manage the continued heavy exudate levels. Cutimed® Cavity foam dressings were chosen as they are soft, conformable and highly absorbent, creating the ideal environment for moist wound healing.

Cutimed® PROTECT, a skin barrier film was applied to the peri-wound area to prevent further maceration. Lastly, an adhesive foam dressing was used to secure the primary dressing in place.

The dressings were used for four weeks with Cutimed Cavity changed every day and Cutimed PROTECT applied every third dressing change.

Results
After three weeks of treatment the wound had reduced in size from 2cm x 3cm x 5cm (L x W x D) (Fig1,2) to 1.8cm x 2.2cm x 3.4cm. (Fig3,4) Cutimed Cavity helped to control exudate levels, was easily removed and did not leave fibres within the wound bed. The patient also reported no pain during dressing removal. Cutimed PROTECT had significantly improved the surrounding skin allowing for better adhesion of the secondary dressing due to the reduction in maceration and presence of healthy skin.

The district nursing team decided to continue using Cutimed Cavity and Cutimed PROTECT in combination through to complete wound healing.

Discussion and Conclusion
The effective management of wound exudate is one of the key performance requirements of the ‘ideal dressing’ (Thomas, S 2008) and an important element of wound bed preparation. For most exuding wounds, this involves maintaining a moist environment at the wound bed whilst removing and containing excess fluid from peri-wound skin to prevent maceration or erosion by proteolytic enzymes commonly found in exudate.

For the management of a cavity wound it is desirable to use a dressing which retains its integrity when saturated, ensuring easy removal, is non fibre shredding and conforms to the wound.

This case study demonstrated that Cutimed Cavity is an alternative cavity dressing that can manage highly exuding wounds and assist in preventing maceration by absorbing exudate within the cavity and preventing pooling. Working in combination with a good skin barrier film (Cutimed PROTECT) enabled vulnerable skin to heal and prevented further damage from occurring.

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