

Removal of Slough, Exudate Control and Stimulation of a Healthy Wound Bed with ActiFormCool® – A Case Study

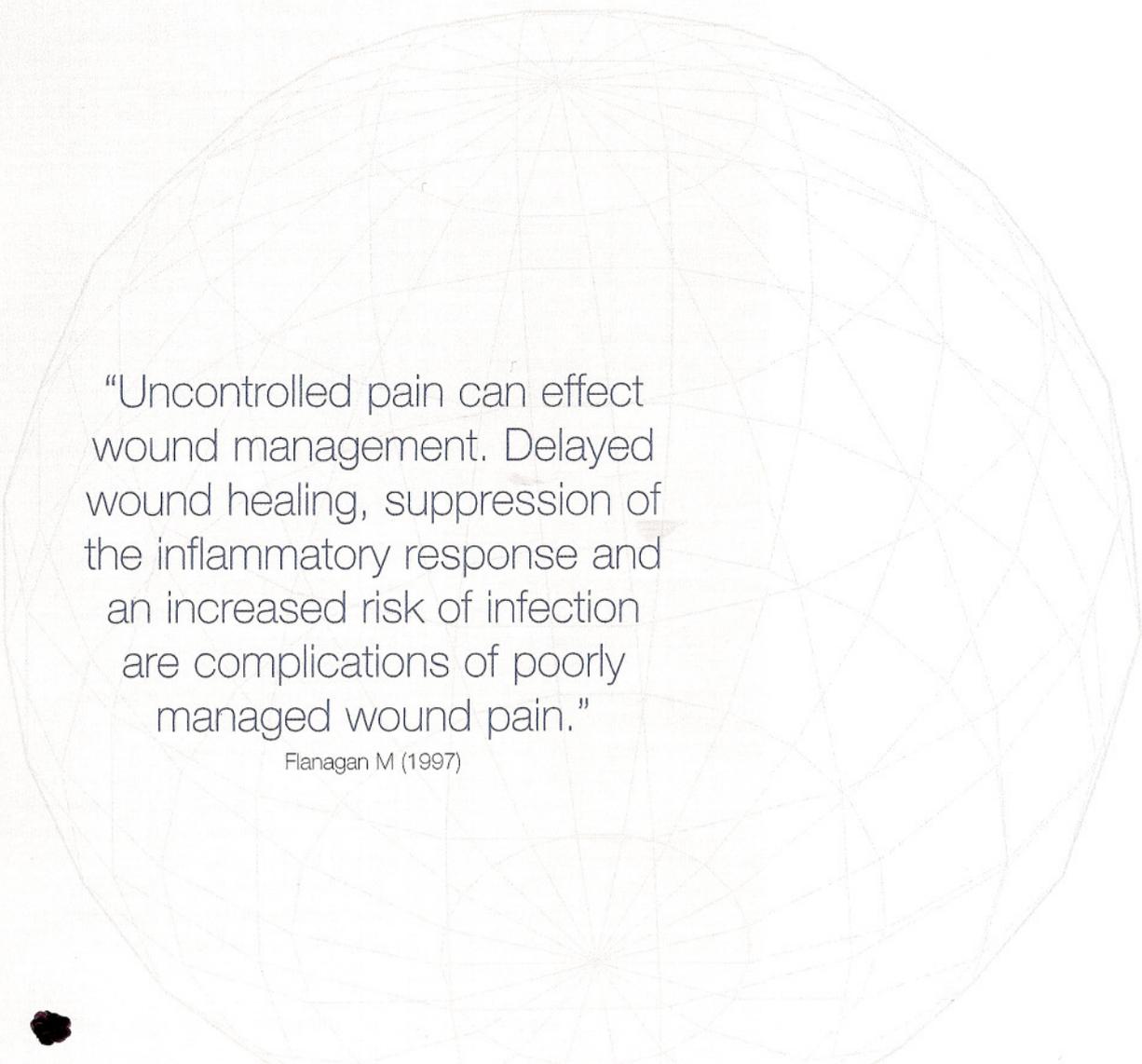
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The Patient

Mrs Jones is an 84 year old lady with limited mobility who can only leave her house when there is someone to take her out in her wheelchair. She presented to the vascular clinic with a very small leg ulcer and pain in her legs that she noted was worse when in bed. Her diagnosis was peripheral arterial occlusive disease that was amenable to angioplasty. Despite intervention to increase blood flow to the lower limb the ulcer continued to deteriorate.

The Ulcer

Mrs Jones ulcer was on the tibial area of her left leg. When she first attended the vascular clinic her daughter stated that it was initially the size of her small finger nail. Following angioplasty the wound area increased, the wound bed became sloughy, and strike-through of exudate was distressing to the patient and her family. It was essential that the exudate should be controlled to prevent resulting skin damage that would lead to a further increase in the size of the leg ulcer. Six weeks post angioplasty the ulcer was approximately 5cm x 4cm with a sloughy wound base which was resistant to the hydration dressing that had been used previously (Picture 1).



“Uncontrolled pain can effect wound management. Delayed wound healing, suppression of the inflammatory response and an increased risk of infection are complications of poorly managed wound pain.”

Flanagan M (1997)

Treatment with ActiFormCool®

The objectives of treatment were to remove slough, manage exudation effectively and minimize ulcer pain. ActiFormCool® hydrogel sheet was applied and changed 3 times per week. After 1 treatment for 1 week slough was diminishing and an increase in granular buds could be observed (Picture 2).

Mrs Jones reported that the dressing was comfortable during wear time. Exudate was held within the gel and no damage to surrounding skin was observed. By three weeks of treatment all slough had been removed with the production of healthy granulation tissue in the ulcer bed (Picture 3).

Conclusion

The presence of slough on the wound bed will act as a barrier to healing (Falanga 2000) and continuing contact of excess exudate on the surrounding skin can cause excoriation and epidermal stripping (Young 2000). Therefore the main objectives of treatment were to remove slough and maintain the integrity of the surrounding skin. The ability of ActiFormCool® to deal with these problems was the major factor in deciding to use it to manage Mrs Jones ulcer.

By using ActiFormCool® the wound was successfully debrided and no strike-through was observed during wear time. Mrs Jones found the dressing comfortable and peri-wound skin integrity was maintained.

References

Falanga V (2000) Classifications for wound bed preparation and stimulation of chronic wounds. *Wound Repair Regen* 8: 347-52
Young T (2000) Managing exudate. *Essential Wound Healing* part Six. Emap Healthcare, London: 2-4



Picture 1
Mrs Jones' ulcer before treatment with ActiFormCool



Picture 2
Following application of ActiFormCool over 1 week slough is diminishing and granular buds can be observed



Picture 3
After 3 weeks slough has been removed with formation of healthy granulation tissue

