Case studies

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INTRASITE® CONFORMABLE
Conformable Hydrogel Dressing

INTRASITE GEL
Hydrogel Wound Dressing

Contents

INTRASITE◇ Gel in the treatment of excoriated tissue

Tracy Vernon, BA (Hons), RGN. CNS - Tissue Viability, Doncaster Royal Infirmary

Introduction

The management of tissue damage caused by excoriation of the skin as a result of urinary or faecal incontinence can be a challenge to nurses.

Patient one

RK is a 16-year-old girl who suffers from cerebral palsy, spastic quadriplegia, epilepsy and asthma. She is doubly incontinent as a result of her multiple pathological diagnoses. She was admitted to a paediatric ward within our Trust with a chest infection which proved to be Pseudomonas. Several days following admission RK was noted to have a red, excoriated anal area. She had been experiencing severe diarrhoea for some days as a consequence of the antibiotic therapy she had been prescribed. The nursing staff had been applying a barrier cream to the affected areas as this had previously been proven to be effective in the management of excoriated skin.

The nursing challenge

Manage tissue damage on a 16-year-old girl with a multiple pathological diagnosis.

Nursing aims

- To use a treatment which would reduce excoriation
- To use a wound care product which would provide the optimum environment for wound healing
- To have an easy-to-use product for frequent utilisation

Nursing interventions

The nursing staff referred RK to the Tissue Viability Nurse as there was not any sign of improvement following the use of the barrier cream. RK was already known to the Tissue Viability Nurse as she had been involved in RK's care during her previous periods of admission. The Tissue Viability Nurse was able to explain to RK's mother that INTRASITE Gel had been used for the treatment of excoriation in other patients with excellent results. RK's mother consequently gave permission on behalf of RK to use INTRASITE Gel.

Outcome

The nursing staff applied the INTRASITE Gel over the affected area as shown in Figure 1. The INTRASITE Gel was reapplied following the cleansing of the skin every two hours or after each episode of faecal or urinary incontinence. Figure 2 shows a dramatic change in the condition of RK's skin, INTRASITE Gel had been used as indicated above for a period of three days.

Patient two

SC is a three-year-old girl who also suffers from cerebral palsy. She was admitted into the paediatric ward with a severe chest infection.

The nursing challenge

Manage tissue damage on a 3-year-old girl with cerebral palsy.

Nursing aims

- To use a treatment which would reduce excoriation
- To use a wound care product which would provide the optimum environment for wound healing
- To have an easy-to-use product for frequent utilisation

Nursing interventions

Having been prescribed antibiotic therapy she also presented with bouts of severe diarrhoea. SC's parents were happy for INTRASITE Gel to be used, as the barrier creams previously used had not been effective. The gel was applied onto the affected area in a similar way to a cream application.

Outcome

INTRASITE Gel was applied to the affected areas over a six day period. Figure 3 shows the areas of excoriation prior to the use of INTRASITE Gel. Picture 4 shows the results on the sixth day. By using INTRASITE Gel a major improvement has been noted in the condition of SC's skin.

General conclusion

One hopes by sharing two different patient profiles healthcare professionals will see a place for INTRASITE Gel in the management of excoriation. By presenting these case studies, one can illustrate the benefits of using INTRASITE Gel on excoriated skin.

Patient one case study

Figure 1

Figure 2

Figure 3

Figure 4

INTRASITE◇ Conformable in the treatment of necrotic tissue

Michaela Arrowsmith, Tissue Viability Nurse, United Bristol Healthcare Trust

Introduction

The management of skin damage caused by necrotising fasciitis.

The patient

PW is a 29-year-old window cleaner who fell 20 feet from a ladder. Upon impact he sustained a fractured wrist and crushed a large part of his liver. Following a laparotomy and partial lobectomy of the liver for tissue necrosis, he was transferred to the Bristol Royal Infirmary ITU for a further operation on his liver and specialist treatment for liver and kidney failure. Following this operation to stop bleeding internally and remove more necrotic tissue from the liver, he became pyrexial and generally more unwell. It was noticed on his flank a dusky hard area developing rapidly. Following further investigation necrotising fasciitis was diagnosed.

He was taken back to theatre and the infection widely excised. Upon discussion with a neighbouring trust, Betadine™ soaks and JELONET◇ paraffin gauze dressing were commenced on the clean granulating wound.

The nursing challenge

Manage a wound with necrotising fasciitis, to reduce and control exudation.

Nursing aims

- To use a dressing which would clean and lift areas of slough
- To use a wound care product which would stay in contact with the wound
- To provide the optimum environment forwound healing
- To use a dressing which would be easy to remove

Nursing interventions

The Tissue Viability Project Nurse was called in when the exudate levels were too much to cope with and dressing changes were two to three times a day. PW was intubated and unconscious at this time. On inspection of both wounds the fasciotomy wound (Fig 1a) was sloughy and exuding large amounts. A corrugated drain had been inserted into an old jejunostomy site and the drainage was soaking down into the wound itself. It was difficult to determine the tissue type in the wound due to the staining of the Betadine and the jaundiced colour of the patient himself. The laparotomy wounds branched off in two directions across his abdomen. They looked red around the edges and large abdominal sutures were visible. The wound was closed at time of initial assessment.

Due to sloughy tissue and the levels of exudate we decided to start Vacuum Assisted Closure (V.A.C.™) as soon as possible to prepare for grafting (Fig 1b). The V.A.C. therapy continued for two days. It was stopped on the second day due to a point of bleeding down in the groin. It was felt that the bleeding would probably continue as he was being anticoagulated at the time.

The wound looked cleaner and there was an obvious blood supply (Fig 2). The exudate levels remained high. The dressing used from then on was INTRASITE Conformable, a new extension of an already popular dressing used widely throughout the Trust. This is a non-woven sheet impregnated with Intrasite hydrogel. This was chosen as INTRASITE Gel would have been difficult to keep in situ in such a large wound.

Outcome

Within a week the wound was clean and granulating (Fig 3). Small areas of slough were lifting and softening and the dressing was comfortable and conformable. Dressing changes had reduced to once a day.

Case study

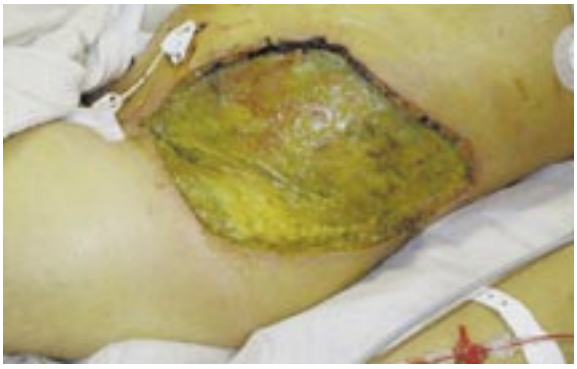

Figure 1a

Figure 1b

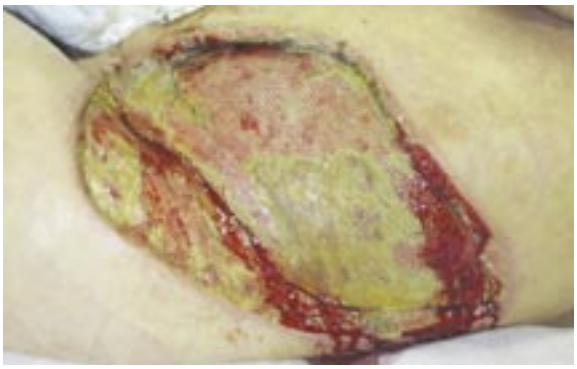

Figure 2

Figure 3

INTRASITE◇ Conformable in the treatment of necrotic pressure ulcers

Tracy Vernon, BA (Hons), RGN. CNS - Tissue Viability, Doncaster Royal Infirmary

Introduction

The presence of necrotic devitalised tissue on a wound bed can delay healing and also increases the risk of wound infection. Hydrogels effectively rehydrate devitalised tissue as the dressing facilitates the autolytic process allowing the separation of viable from non-viable tissue. Difficulties can be found when dressing awkward areas, as care must be taken to maximise the contact of the hydrogel with the wound.

The patient

Gladys is an 85-year-old lady who was admitted to an acute medical ward having had a history of falls at home. She presented with a large necrotic pressure ulcer to her right heel (see figure 1).

The nursing challenge

To manage a necrotic pressure ulcer in an awkward area.

Nursing interventions

INTRASITE Conformable was opened out and placed over the area of the necrosis as per the manufacturer's instructions (see Figure 2), and then covered with ALLEVYN◇ Heel dressing (see Figure 3). This ensures that maximum contact is made with the INTRASITE Conformable and the wound. This dressing regime was carried out every three days. After 10 days the necrotic tissue had been rehydrated to allow sharp debridement to take place (see Figure 4). This procedure was carried out by the Clinical Nurse Specialist - Tissue Viability who has extensive expertise in this area (see Figure 5).

INTRASITE Conformable continued to be used as previously described allowing debridement to be carried out at the weekly visit by the Clinical Nurse Specialist - Tissue Viability (see Figure 6).

Nursing aims

- To use a dressing which would rehydrate hard necrotic tissue
- To use a dressing which would stay in contact with the wound
- To provide the optimum environment for wound healing
- To ensure maximum contact between the dressing and the wound interface
- To select a dressing which would enhance the properties of the primary dressing

Outcome

Sharp debridement is often viewed as being the quickest and most effective method of removing necrotic tissue. Initially this is not always an option when dealing with elderly, frail patients. INTRASITE Conformable has proved to be effective in rehydrating necrosis allowing debridement to be carried out on a weekly basis.This has undoubtedly proved to be a positive outcome (see figure 7).

Case study

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

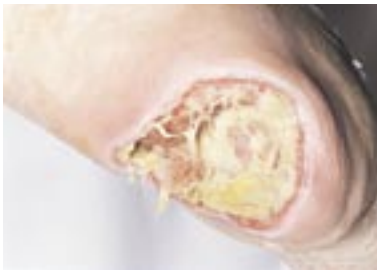

Figure 6

Figure 7

INTRASITE◇ Conformable in the treatment of a pressure ulcer on a newborn baby

Tracy Vernon, BA (Hons), RGN. CNS - Tissue Viability, Doncaster Royal Infirmary

Introduction

The management of babies with wounds can prove to be a challenge for nurses, this challenge can also be greater than before, when the aetiology of the wound is initially unclear.

The patient

Baby P is a twin who was born 5 weeks premature. Twelve hours following the birth of Baby P an area of discoloration was noted on the nape of his neck (see figure 1). The nursing staff referred the patient to the Clinical Nurse Specialist as they had concerns as to how to manage the area of tissue damage. After lengthy discussions with numerous health care professionals it was agreed that the area was due to pressure damage caused by the position of Baby P's twin sister prior to their birth.

The nursing challenge

Manage a pressure ulcer in a difficult area on a pre-term baby.

Nursing aims

- To use a dressing which would rehydrate hard black eschar
- To use a wound care product which would stay in contact with the wound
- To provide the optimum environment for wound healing
- To use a dressing which would be easy to remove
- To use a dressing which would not cause any further damage to the baby's fragile skin
- To select a secondary dressing which would enhance the properties of the primary dressing

Nursing interventions

Initially a hydrocolloid dressing was applied to the area of pressure damage as per the Trust's wound care protocol. Despite using the dressing as per the manufacturer's instructions the wound presented with a hard black eschar when the dressing was removed by the Clinical Nurse Specialist a week later (see figure 2).

Having assessed the wound it was felt that the most appropriate dressing to use was a hydrogel. INTRASITE Conformable was selected as the dressing of choice. Intrasite Conformable was laid over the area of eschar and was covered with ALLEVYN◇ Non-Adhesive polyurethane dressing. The aim of this dressing combination was to ensure that a moist wound environment can be created, which in turn would promote natural debridement through autolysis by gently rehydrating necrotic tissue.

Outcome

Because of the unusual nature of the pressure ulcer the dressing was removed on the following day by the Clinical Nurse Specialist (see figure 3). The eschar had been rehydrated by the hydrogel and had undertaken a colour change. Five days later the wound was showing signs of granulation (see figure 4). Figure 5 shows the wound two weeks later when the pressure ulcer had nearly healed, the decision was made to discontinue the INTRASITE Conformable and use ALLEVYN Non-Adhesive until the wound had completely healed.

Case study

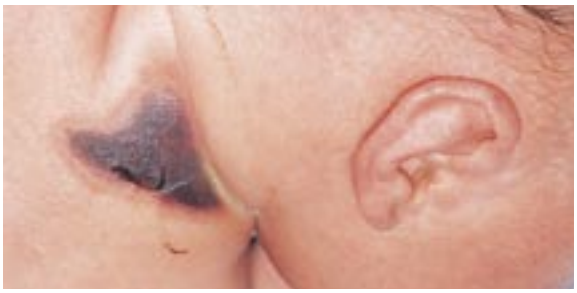

Figure 1

Figure 2

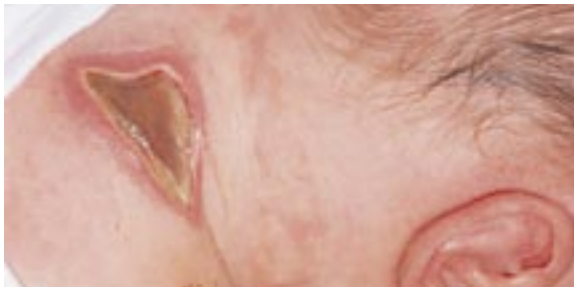

Figure 3

Figure 4

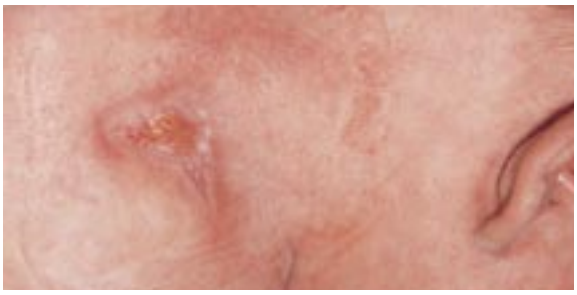

Figure 5

The use of INTRASITE◇ Conformable dressing in the management of a sloughy venous leg ulcer

Janice Bianchi, Research Sister, Dermatology Department, Monklands Hospital, Scotland

Introduction

The standard treatment for uncomplicated venous leg ulcers is graduated compression. When slough is present, however, healing can be delayed. This case history illustrates the care given to a patient with a sloughy venous leg ulcer.

The patient

This patient was an elderly gentleman with an uncomplicated but difficult to heal venous leg ulcer (Fig 1.). The presence of slough was thought be partly responsible for the delayed healing. His ulcer was managed by the nurses in a leg ulcer clinic with PROFORE◇ multi-layer bandages.

The nursing challenge

To manage the sloughy tissue and reverse or control the venous insufficiency.

Nursing aims

- Remove slough
- Prevent wound infection
- Reduce exudate production
- Enhance healing
- Use a dressing which stayed in contact with the wound
- To ensure that the surrounding skin did not become macerated
- The application of sustained, graduated compression to assist in reversing the venous insufficiency

Nursing intervention

INTRASITE Conformable was cut to shape and then applied to the ulcer (Fig 2.) to facilitate autolysis of the sloughy tissue. PROFORE multi-layer bandages were applied to control venous insufficiency. The dressings were changed twice weekly.

Follow-up care

INTRASITE Conformable was discontinued once the sloughy tissue had been removed. The patient would continue to have multi-layer compression applied until complete healing had been achieved.

Outcome

Four weeks after commencing treatment there was a 50% reduction in sloughy tissue, the ulcer had reduced in size (from 32mm x 12mm to 23mm x 11mm), and new granulation tissue was present (Fig 3/4). After eight weeks the slough had been replaced by granulation tissue and fibrin. The ulcer at this time measured 22mm x 11mm.

Case study

Figure 1

Figure 2

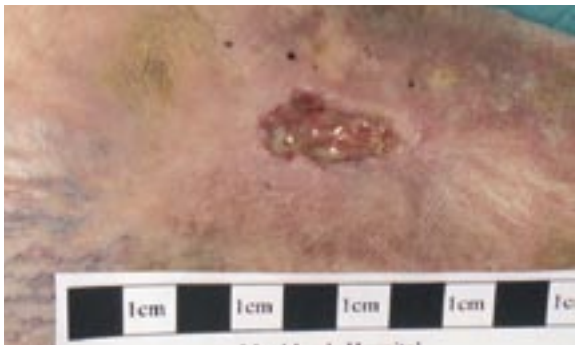

Figure 3

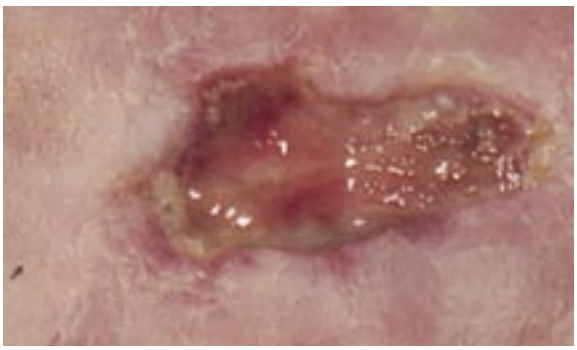

Figure 4

INTRASITE◇ Conformable in the treatment of sacral pressure ulcers

Dot Leader, Assistant Manager, Hassingham House Nursing Home, Norfolk

Introduction

Caring for patients with a pressure ulcer can be a challenging prospect, particularly when the patient is elderly. This challenge can be further enhanced when the patient is recovering from a broken leg and subsequently experiences discomfort in turning and lying on the side of the injury.

The patient

Mrs P, at the age of 92, was admitted to the nursing home from her own bungalow. A year before she fell and broke her right femur and was hospitalised. She was being treated at home receiving weekly visits from the district nurse for a leg ulcer. Mrs P had developed a small sacral pressure ulcer which resulted in her GP referring her to us. On admission, Mrs P was assessed using the Waterlow risk calculator. Mrs P had a risk score of 19, classifying her in the 'high risk' category. She was nursed in bed on her left side, as it was painful to be nursed on the right side due to the break. An airflow mattress was in situ. We also felt as a team that Mrs P was undernourished and dehydrated, as a consequence blood was taken for assessment.

The nursing challenge

To manage a sacral pressure ulcer in an elderly patient.

Nursing aims

- To encourage healing without causing further damage to the wound
- To use a wound care product which would provide the optimum environment for wound healing
- To use a dressing which would be both easy to apply and remove, easing any associated pain

Nursing interventions

INTRASITE Conformable was used as a primary dressing to gently pack the wound. A secondary dressing of ALGISITE◇ M calcium alginate dressing was applied and fixed into position.

This regime was changed on a daily basis.

Over the period of the next five weeks (see Figs 1-5), the wound was successfully debrided and dressing changes then took place every second day.

Outcome

During the treatment, the dressings remained intact and no leakage of exudate occurred. The patient found the dressings comfortable and was therefore compliant to the treatment.

The nursing staff were able to apply and remove the dressings easily.

The wound was debrided easily and no pain was experienced during debridement.

Over the period of the case study, the cavity became noticably smaller and should progress to healing.

Case study

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

INTRASITE◇ Conformable in the treatment of a skin tear

Tracy Vernon, BA (Hons), RGN., CNS - Tissue Viability, Doncaster Royal Infirmary

Introduction

Skin tears are frequently seen in elderly patients and can prove to be challenging for the nurse to manage effectively. When managing a patient with a skin tear it is crucial that the dressing selected does not adhere to the wound causing further damage to skin that is friable and susceptible to tissue damage. The patient, an elderly lady of 80 years was admitted into an acute medical ward with numerous medical problems. While she was in hospital she sustained a large skin tear whilst getting out of bed. The area measured 8cm in length by 6cm in depth. The nursing staff referred the patient to the Clinical Nurse Specialist for further management (see figure 1).

The nursing challenge

Manage a large skin tear on a patient who has poor quality skin.

Nursing aims

- To use a wound care product which would stay in contact with the wound, hence providing the optimum environment for wound healing
- To use a dressing which would be easy to remove
- To use a dressing which would not cause any further damage to the patient's fragile skin
- To select a secondary dressing which would enhance the properties of the primary dressing

Nursing interventions

Having being able to replace the skin flap over the area of skin damage (see figure 2) the key aim was to provide the optimum environment for wound healing to take place. INTRASITE Conformable was chosen as the dressing of choice for the lady's management.

This product was selected as being the most appropriate, as by using a non woven dressing impregnated with INTRASITE Gel a moist, warm environment can be achieved. The INTRASITE dressing was opened out and layered on over the wound in order to maximise the amount of Intrasite that was in contact with the wound (figure 3). ALLEVYN◇ Hydrocellular was then applied over the INTRASITE Conformable as a secondary dressing followed by a bandage to secure. The rationale for the choice of the secondary dressing was to make sure that no adhesive products were placed on the patient's friable skin.

Outcome

The dressings were removed as per the manufacturer's instructions on the third day (figure 4). The dressing was easy to remove, did not cause any trauma to the wound, and the patient did not experience any pain at all. Figure 5 shows the woundten days later when the INTRASITE Conformable was removed allowing the ALLEVYN Hydrocellular dressing to be applied for protection.

Case study

Figure 1

Figure 2

Figure 3

Figure 4

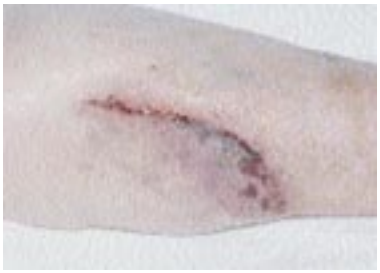

Figure 5

Treatment with INTRASITE◇ Conformable of bullous lesions in Lyell's syndrome

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Introduction

Lyell's syndrome is a generalised reactional mucocutaneous condition of Epidermolysis Bullous caused by an immune system reaction to a medicine.
It is very likely that several aetiological factors are involved : a genetically determined problem with the metabolisation of medicines and an immune reaction with cellular mediation.
Epidermal necrosis seems to be the cutaneous consequence of abnormal activation of programmed cell death messages (apoptosis).
Lyell's syndrome is different from other characteristic pathological conditions such as the local bullous lesions of polymorphic erythema and generalised, fixed drug-related erythema. There is a continuum of severity between a syndrome defined as Steven-Johnson syndrome and Lyell's syndrome: these two entities may be considered as the expression of the same pathological process with different degrees of severity. The factor which triggers these syndromes is linked in both cases to the taking of certain medicines.

The patient

This case describes the treatment of a 17-year-old female admitted to our centre after an initial stay in another establishment. When she arrived, a detailed medical assessment followed by a diagnosis enabled the following treatment objectives to be defined :

1. Alleviating the painful symptomatology and anxiety component associated with the condition.
2. Preventing the onset of infection and ensuring hydroelectrolytic balance by maintaining the perfusion of vital organs.
3. Ensuring correct psychological support in order to promote good self-perception and adaptation to body changes.

Aim

The aim of this case study is to show that a suitable coordinated programme of care can significantly improve :

- Patient care
- The control of clinical symptoms
- Healing outcome

The nursing challenge

Dressing the lesions was the most complex aspect to be undertaken because of the severity of the patient's general condition and, in particular, the extent of the wounds, which corresponded to epidermal-dermal detachment over the entire surface of the body.

Nursing interventions

Dressings were applied to the patient under sedation, with two nurses responsible for the treatment, one responsible for putting the patient into the lateral decubitus position and one responsible for passing the sterile material required for treatment.
The materials used were prepared on a special trolley, in accordance with normal departmental procedure, and included the use of personal protection equipment.
Dressings were first applied to the back of the body, starting with the head and finishing with the lower limbs.
Once the patient was in the lateral decubitus position, she was rinsed with copious amounts of Ringer's solution and the previous dressings were removed.
The same process was repeated in the dorsal decubitus position with the application of a non-adhesive silver nitrate dressing on both sides.

The products used on the wounds where there was epidermal-dermal detachment were hydrogel dressings (INTRASITE Conformable), except on the periorbital areas, the mammary areolas, around the urethra, the vagina and the lips, which were treated with gentamycin and silver sulfadiazine 1% antibiotic ointments and a healing cream (Phytostimulin™).
Particular attention was paid to dressing the hands, which quickly became painful and hypersensitive. Each finger was dressed with hydrogel after spontaneous detachment of the necrotic epidermis.
The protocol was carried out as quickly as possible so as to avoid prolonging the period of sedation and exposing the lesions to the air.

Outcome

The first objective was achieved by medicinal means.
The second was achieved thanks to good haemodynamic compensation under monitoring, and the coordinated choice of medical devices used.
It was at this moment that the team, after reviewing the literature about the treatment, discussed the most appropriate local treatment. It was mutually agreed that the patient should undergo treatment with INTRASITE Conformable a hydrogel dressing, re-impregnated every 24 hours simply with INTRASITE Gel a hydrogel without changing the dressing within 48 hours (a protocol maintained during the first seven days of treatment). The eye contours, the mammary areola and the area of the vulva were spared this protocol. The reasons for this choice are based on the aetiology of the disease as well as on a desire to offer a treatment which ensures good patient compliance when the dressing is applied, changed and reapplied.
The third objective, which is just as essential as the preceding ones, was achieved by encouraging the establishment of a dialogue aimed at reinforcing self-esteem, and this was carried out by all the team members.

Treatment with INTRASITE◇ Conformable of bullous lesions in Lyell's syndrome

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continued

Case study

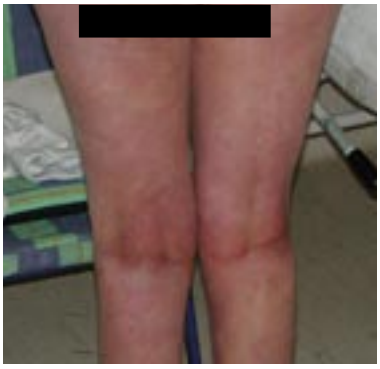
Patient prior to treatment with INTRASITE Conformable

Patient with INTRASITE Conformable *in-situ*

Patient with INTRASITE Conformable *in-situ*

Patient's abdomen after treatment with INTRASITE Conformable

Patient's back after treatment with INTRASITE Conformable



Patient's legs after treatment with INTRASITE Conformable

Patient's legs after treatment with INTRASITE Conformable

Patient's hands after treatment with INTRASITE Conformable

Patient's hands after treatment with INTRASITE Conformable

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