CASE REPORT 1

This case shows how ActivHeal® Silicone Wound Contact Layer resulted in a positive outcome for a patient who frequently incurred skin tears and had previously been non-compliant with treatment.

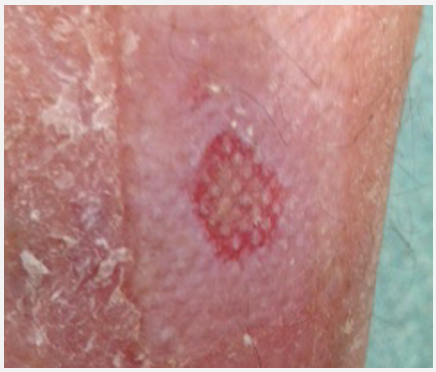

Figure 1.
Initial presentation the wound site is reported to be painful on a scale of 5/10. Slight odour present, some exudate and signs of critical colonisation.

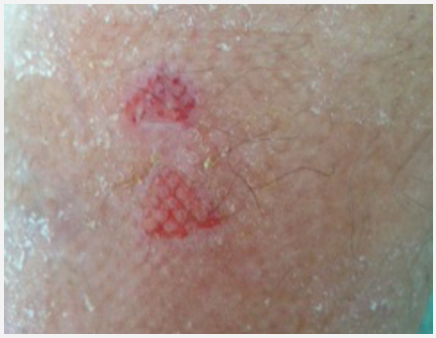

Figure 2.
Wound reported to be less painful, odour no longer present and no visible signs of critical colonisation.

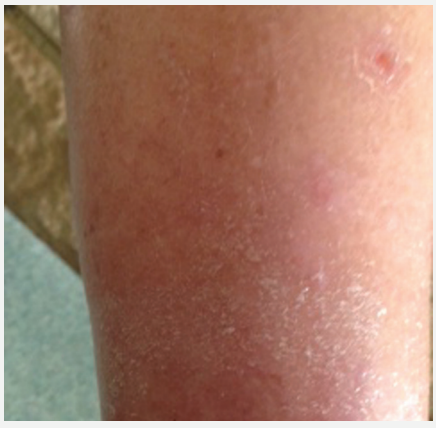

Figure 3.
Wound site reported to be pain free, healthy epithelialised tissue visible. No further treatment required.

This patient was a 68-year-old man who was being cared for by his GP and general practice nurse (GPN). He was a non-smoker who had renal dysfunction, peripheral oedema, Parkinson's disease and arterial disease. He had a skin tear on his lower limb (left anterior calf). He frequently incurred such skin tears through trauma from itching, or as a result of his increasingly unsteady gait, due to the underlying Parkinson's disease. He also liked to remain as active as possible and so continued to play golf, which again often resulted in tearing his skin. He gave permission to take part in the evaluation, although he had previously been non-concordant with the primary care team's dressing choice which he found uncomfortable. This included inadine patches, non-adherent dressings and lightweight conforming bandages, which he did not like to wear as they were visible when he wore shorts. After consultation with the patient, the author decided to use ActivHeal® Silicone Wound Contact Layer, with a basic non-adherent dressing and micropore tape.

At presentation the wound had a slight odour and the patient rated his pain as 5 on a 10-point scale, where 1 was no pain and 10 the worst pain.

At initial presentation, the wound was inflamed with minimal periwound involvement. There was some oozing present which had a slight odour and there were signs of critical colonisation, with a small amount of slough.

After one week of treatment the wound measured 2x2x1cm and was 40% epithelial tissue, 50% granulation and 10% slough. There were signs of critical colonisation and there was a moderate amount of clear, amber, thin exudate and there was a slight odour. The skin surrounding the wound was red, but there were no signs of maceration. The patient rated his pain as 3 on a 10-point scale (where 1 was no pain and 10 was the worst pain). The dressing was being changed twice a week.

After two weeks of treatment there was no longer any slough, epithelial tissue made up 60% of the wound bed and granulation tissue was at 40%. The depth of the wound now measured 0.5cm. There was no longer any sign of critical colonisation and the wound exudate was clear, amber and thin and was now at a low volume. The patient now rated his pain as 1 on the 10-point score.

After three weeks of treatment the wound consisted of 100% epithelial tissue and measured 1x1x0cm, with no signs of critical colonisation or infection and with healthy periwound skin.

When asked about the dressing, the clinician rated it as very easy to use, apply and remove and said it was atraumatic to both the wound and periwound skin. Furthermore, the patient reported no pain both on application and removal, with no analgesia being needed. The dressing had also conformed well to the wound.

The clinician reported that the patient had been concordant with the treatment and found the dressing comfortable and that it met his needs. The dressing had provided a moist healing environment and as the patient was concordant due to his comfort, the outcome was positive. She said she would recommend that the dressing be added to the formulary.

When asked to comment on the dressing, the patient said he liked the dressing as it was light, comfortable and malleable. He rated it very comfortable and he was very satisfied with his treatment. Pain at the wound site varied and decreased over the four-week evaluation period (ranging from 5, 3, 1, 0).

Sarah Mancini, independent nurse specialist in wound care and medical devices at time of writing

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 2

Two weeks of treatment with AcivHeal® Silicone Wound Contact Layer resulted in healing of an oozing rash as a result of shingles. The use of this dressing also reduced the pain that the patient was experiencing and improved her wellbeing.

The patient in this case was a 45-year-old woman with broken lesions on her neck due to having had shingles. She was a non-smoker and before being recruited to the evaluation had received no treatment.

At presentation there were multiple oozing rash sites, measuring 5x6cm and consisting of 15% epithelial tissue, 71% granulation tissue and 10% sloughy tissue (*Figure 1*). There were signs of critical colonisation and spreading local infection and the skin around the rash was red. At this stage, the patient rated the pain that she was experiencing from the rash as 6, on a scale where 1=no pain and 10=worst pain. It was decided to apply ActivHeal® Silicone Wound Contact Layer (*Figure 2*). The patient immediately commented on how comfortable and secure the dressing felt, as it moulded to the curvature of her neck.

When the patient visited clinic the following week, the condition of her rash had improved considerably. There was now 85% epithelial tissue and 15% granulation tissue and the lesions had reduced in size. There was no longer any sign of infection and the skin condition around the rash was healthy — the patient now gave a pain score of 3 (where 1=no pain and 10=worst pain).

After two weeks' treatment with the non-adherent silicone dressing, with weekly dressing changes, the lesions and surrounding skin areas had completely healed. The clinician attributed this to the dressing providing a moist wound healing environment, while also offering protection to the infected skin. When asked about its ease of use, she rated this as 1 on a scale where 1 was very easy and 5 very difficult. Using the same scale she scored ease of application as 1 and removal as 2, and also found the dressing to be atraumatic (giving it a score of 4, where 1=traumatic and 5=atraumatic). The dressing also conformed very well to this anatomical location and remained in place, with the patient experiencing no pain on application or removal.

The patient expressed similar views, finding the dressing comfortable and effective as it provided a light covering to the rash. She rated her satisfaction as 1 on a scale where 1=very satisfied and 5=dissatisfied.

At initial presentation, the patient expressed a feeling of exhaustion and general malaise due to recent illness, and the sores were causing discomfort and pruritus.She also said that her general mood was affected due to change in body image from the visible presence of the sore area. However, the dressing offered comfort and assisted the healing process, which was shorter than expected and no further dressings were needed.

Sarah Mancini, independent nurse specialist in wound care and medical devices at time of writing

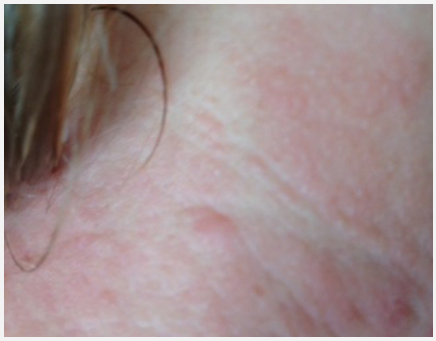

Figure 1.
Oozing rash at initial presentation.

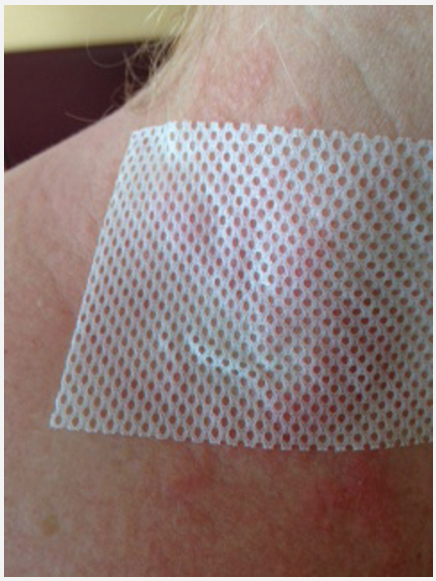

Figure 2.
ActivHeal Silicone Wound Contact Layer conformed well to the neck curvature.

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 3

This patient's quality of life significantly improved when ActivHeal® Silicone Wound Contact Layer both promoted the healing of a surgical incision site on the foot as a result of amputation and provided a comfortable and soothing dressing for the wound.

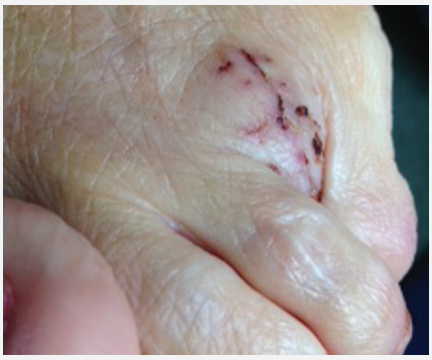

Figure 1.
Surgical incision after toe amputation.

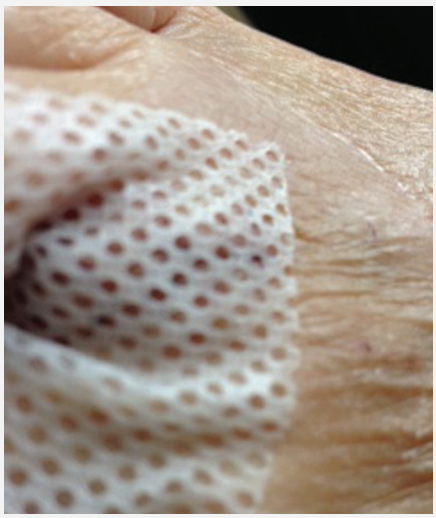

Figure 2.
ActivHeal Silicone Wound Contact Layer in situ.

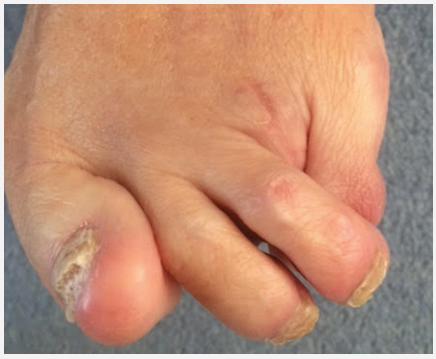

Figure 3.
Healed wound site after two weeks' treatment with ActivHeal Silicone Wound Contact Layer.

This female patient was 70 years old and had a surgical incision as a result of having her fourth toe on the left foot amputated. She was a non-smoker. Before being seen by the author she had two post-surgery follow-up appointments with hospital nurses.

The dressings used immediately after surgery were chosen to support the foot/wound site. However, the surgical site itself was uncomfortable, requiring the patient to take regular analgesia. The patient also found the supportive boot unsightly and, while she was concordant with treatment, as she understood the need for support and protection post surgical intention, due to the nature of the surgery and the boot she expressed some negative feelings around body image, a reaction often related to amputation.

When the patient first presented at the author's clinic one week after surgery, the surgical incision measured 4x1cm and was epithelialising with a small area of sloughy tissue.

Slight critical colonisation was noted but the periwound skin was healthy and only a low volume of thin, yellow-coloured exudate was being produced. There was no odour and the patient rated her pain level as 3 on a scale where 1 was no pain and 10 the worst pain. Thus, the author decided to apply ActivHeal® Silicone Wound Contact Layer, after discussion and agreement with the patient, as it was felt that this was an appropriate choice for this post-surgical wound to promote an ongoing healing environment. Furthermore, being a thin dressing it allowed her to wear normal footwear. During the first week the dressing was changed twice. This was done to check that the wound was healing effectively, as had the wound not been making good progress, referral to the surgical team would have been needed.

At week 2, the tissue types present in the wound bed were epithelial and granulation, and the surrounding skin remained healthy. The patient now rated her pain as 0 on a score where 1 was no pain and 1 the worst pain.

Throughout this two-week evaluation the author found the dressing easy to use, apply and remove (rating all domains 1 on a score where 1=very easy and 5=very difficult). It remained *in situ*, which in the author's clinical experience, can be an issue when dressing toes and feet. The author also found the dressing atraumatic both to the wound bed and periwound skin, again giving this domain the highest score. Similarly, the patient felt no pain on dressing application or removal and no analgesia was needed.

Although the patient rated her pain as 3 over the evaluation period (where 1=no pain and 5=very painful), she gave the dressing the highest scores for comfort and patient satisfaction. She found the dressing lightweight, and said that it was comfortable and soothing to the site on application, as it conformed well to the wound area without pulling on surrounding tissue.

Sarah Mancini, independent nurse specialist in wound care and medical devices at time of writing

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 4

This case presents a 15-year-old patient following surgery for an idiopathic thoracic scoliosis. ActivHeal® Silicone Wound Contact Layer promoted a moist wound healing environment and pain-free dressing changes.

This 15-year-old female required correction of an idiopathic thoracic scoliosis. The curvature noted by the surgeon was greater than 45%, with the added complication of a thoracic syrnx. The patient was young and her general health was good. It was expected that in the absence of developing infection, healing would be fast and uneventful.

The operation took place on 1 February, 2015. The surgery was successful, resulting in two internal rods and 14 screws to correct the curvature. The patient was admitted to ITU post surgery for two days and the wound site was closed with glue. Non-adhesive and Mepore® adhesive dressings (Mölnlycke Health Care) were initially used to the site.

At the first dressing change post surgery the wound was free from infection, with limited visible inflammation throughout the wound other than two small areas of vulnerability, where inflammation was present due to a small break in the skin's integrity. The author decided to apply a silicone wound contact layer (ActivHeal®) as a primary dressing under a non-adherent dressing due to its flexibility and conforming nature. This, in turn, enabled the patient to have optimum movement when mobilising post surgery with the confidence to know that the dressing would remain *in situ*. The nature of the dressing also meant that it did not cause any trauma to the area on dressing change.

The moist nature of the contact layer promoted the optimum healing environment and the clinician was able to use basic non-adherent dressings as secondary dressings secured with micropore tape for added protection to the surgical site.

The three dressing changes outlined in the medical photographs show the progression in the wound healing process over a two-week period. The outcome was successful for this patient as the wound site healed well and she found the silicone dressing comfortable on application and during dressing changes.

Professionally, the clinician found the silicone wound contact layer to be an excellent dressing for this type of wound scenario. It promoted a moist healing environment and pain-free dressing application and removal. It encouraged the healing of this wound site and allowed for the use of basic non-adherent dressing as secondary dressings, thus offering a cost-effective approach to wound management.

Sarah Mancini, independent nurse specialist in wound care and medical devices at time of writing

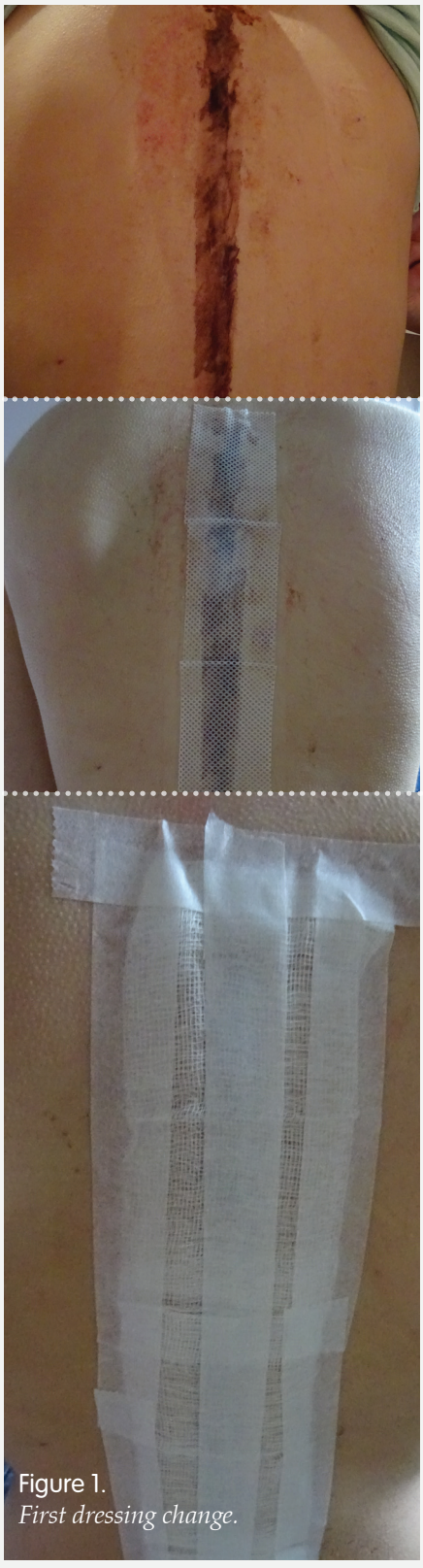

Figure 1.
First dressing change.

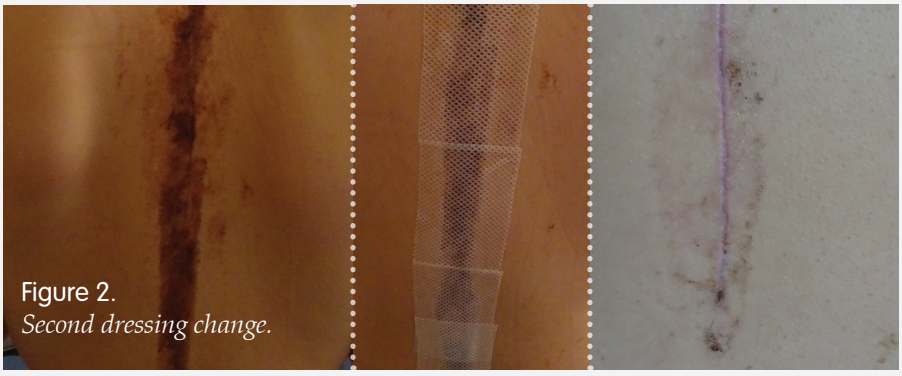

Figure 2.
Second dressing change.

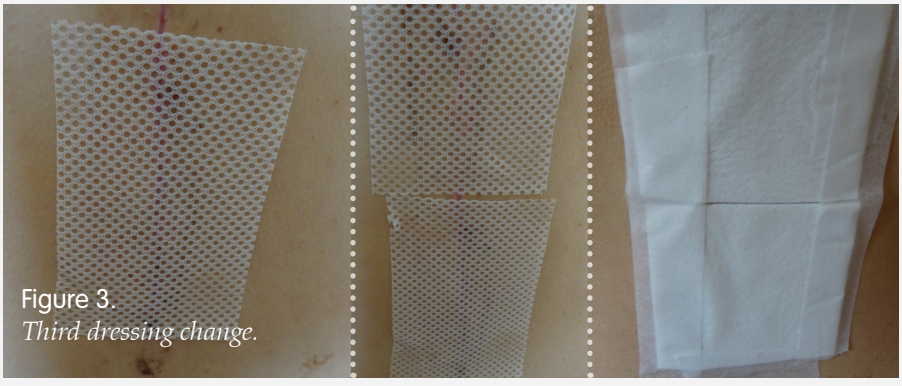

Figure 3.
Third dressing change.

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 5

The patient in this case had a history of renal failure, diabetes and ischaemic disease. Three weeks of treatment with ActivHeal® Silicone Wound Contact Layer reduced the wound's size and, more importantly, improved his confidence in pain-free dressing changes.

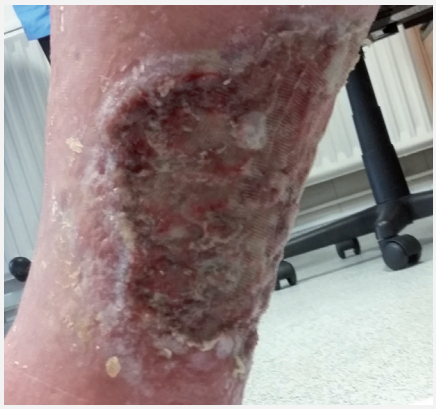

Figure 1.
The wound at initial presentation, before the use of ActivHeal Silicone Wound Contact Layer.

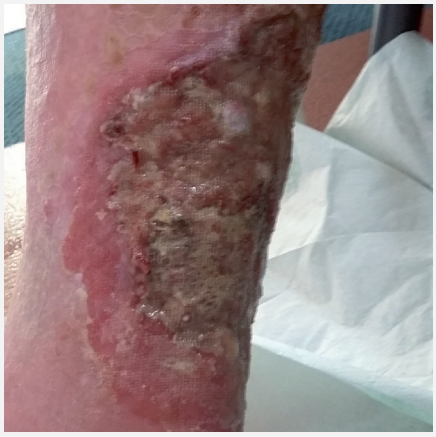

Figure 2.
The wound after early treatment with ActivHeal Silicone Wound Contact Layer.

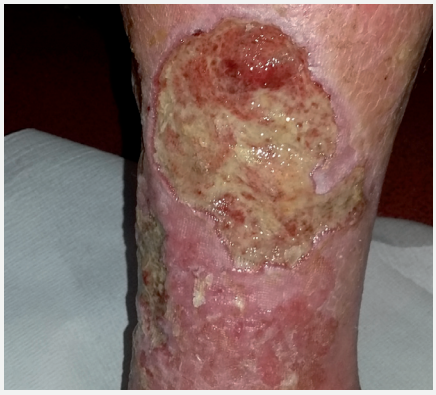

Figure 3.
The wound at a follow-up appointment following the evaluation.

This patient was a 69-year-old man who had developed a venous leg ulcer on his left leg in December 2015. The patient was an ex-smoker who had a medical history of renal failure, diabetes and ischaemic disease.

Before being seen by the author, his care had been shared between district and general practice nurses, who had reported that the patient experienced pain at dressing changes and was allergic to, and did not like, adherent dressings. Dressings that had been used on the wound previously included Zetuvit® E (Hartmann), and crepe and tubular outer bandages. The patient was not considered a candidate for compression due to his renal condition, which meant staff had to balance fluid management with kidney capacity.

At the author's first examination of the wound (*Figure 1*), it measured 6x5cm with a wound bed comprising 25% red granulation tissue and 75% yellow slough. There was also some damage to the periwound area, with visible excoriation and maceration; this was potentially related to dressing changes. The wound displayed a high volume of exudate, which was cloudy and 'creamy' white in colour with a medium consistency. There was a slight odour emanating from the wound and the patient rated his pain as '2' on a scale where 1 indicated no pain and 10 the worst pain. In an attempt to promote an ongoing healing environment, the author decided to trial the use of ActivHeal® Silicone Wound Contact Layer.

After week one of the new dressing regimen, the wound measurements and the contents of the wound bed remained the same, as did the exudate volume and consistency. Similarly, the pain levels had remained at '2', and the odour levels were still slight.

At the author's second visit, however, while the content of the wound bed had remained the same, the wound had altered in size slightly, now measuring 5.5x6cm (*Figure 3*). The author also noticed the presence of cellulitis in the wound (the leg was hot to the touch, the patient's pain score had risen to '6' and there was a hardening of the limb) and spreading infection, which required systemic antibiotic therapy. Exudate production had increased, while the exudate had become green in colour with a thin, 'runny' consistency. The odour was still slight, however.

At the third consultation, the content of the wound bed had changed slightly, with 20% granulation and 80% slough, but the infection appeared to have resolved, with reduced redness and hardness in the limb. The exudate output of the wound had also decreased, and while the odour had increased slightly, the patient's pain score had markedly reduced to '3'.

At the final consultation, the slough in the wound bed had reduced slightly, returning to 75%, while the wound size had also reduced to 5.5x5.5cm. The condition of the periwound skin had improved with only some areas of redness; similarly, the wound odour had lessened and the pain score had stabilised at '3'.

Overall, the author found the ActivHeal Silicone Wound Contact Layer very easy to use — in particular, the dressing was very easy to apply and remove and stayed in place when outer dressings were changed. The dressing was also atraumatic to the wound bed and periwound skin, and conformed well to the wound. The dressing was changed twice-weekly throughout the evaluation and the patient commented that not only did it improve his comfort levels, it also improved his confidence in pain-free dressing changes.

Jackie Griffin, tissue viability clinical nurse specialist, Montgomery County Infirmary, Powys Health Board, Wales

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 6

This case shows how a pressure ulcer in a difficult-to-treat anatomical area achieved complete healing (100% granulation tissue) with ActivHeal® Silicone Wound Contact Layer over a four-week period.

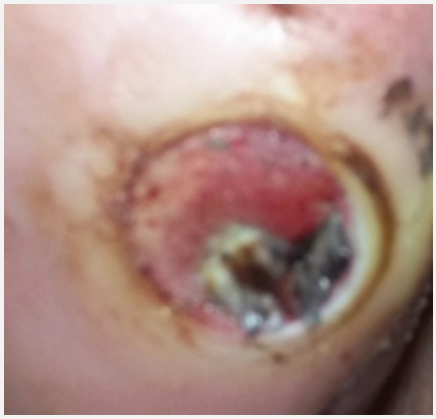

Figure 1.
Pressure ulcer at initial presentation, before the use of ActivHeal Silicone Wound Contact Layer.

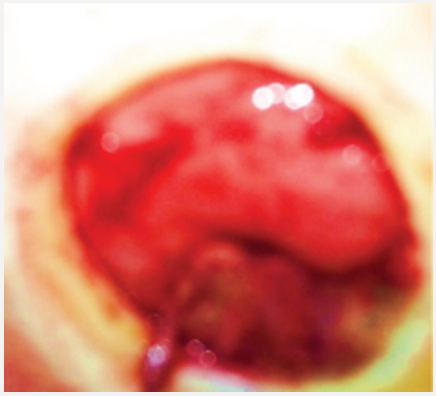

Figure 2.
The wound after one week's treatment with ActivHeal Silicone Wound Contact Layer.

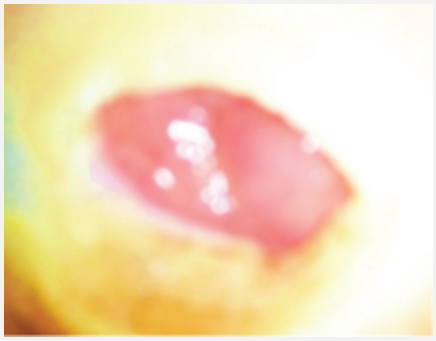

Figure 3.
The wound at the end of the four-week evaluation.

This patient was a 76-year-old man who developed a pressure ulcer on his foot under his little toe, as a result of ill-fitting footwear. The wound had been present for three months and was being treated with twice weekly dressing changes by the care home staff. He had diabetes, but was a non-smoker.

The location of the wound meant that it was difficult to dress and, as it had been present for three months with no improvement, the authors decided to try a new dressing, ActivHeal® Silicone Wound Contact Layer. At initial presentation the wound consisted of 50% granulation, 50% necrotic and 10% sloughy tissue, with signs of critical colonisation. The periwound skin was also macerated and a medium volume of exudate was being produced that was yellow in colour. However, there was no odour and the patient was experiencing some pain.

Over the four-week evaluation period, the tissue type present in the wound steadily improved:

- Week two: 60% granulation tissue; 40% necrotic tissue
- Week three: 90% granulation tissue; 10% necrotic tissue
- Week four: 100% granulation tissue.

The dressing was changed on a weekly basis and was used with a hydrofiber packing. It was found to be easy to use, despite the difficult anatomical location, with the clinicians scoring application and removal as 1 (on a scale where 1=very easy and 5=very difficult).

It was also atraumatic both to the wound bed and periwound skin and helped to minimise any pain that the patient felt at dressing changes. Indeed, the clinician commented that due to the reduction in pain, patient compliance improved as he allowed dressing changes to take place as and when needed.

The patient was also satisfied with the dressing and gave it the highest score in the domains of patient comfort, satisfaction and reducing wound pain.

Jackie Stephen-Haynes, professor and consultant nurse, tissue viability, Birmingham City University and Worcestershire Health and Care Trust; Rosie Callaghan, tissue viability specialist nurse, Worcestershire Health and Care Trust

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 7

The patient in this case had a venous leg ulcer of one year's duration. The use of ActivHeal® Silicone Wound Contact Layer helped to prevent compression bandages from adhering to the wound bed and thus aided with dressing changes.

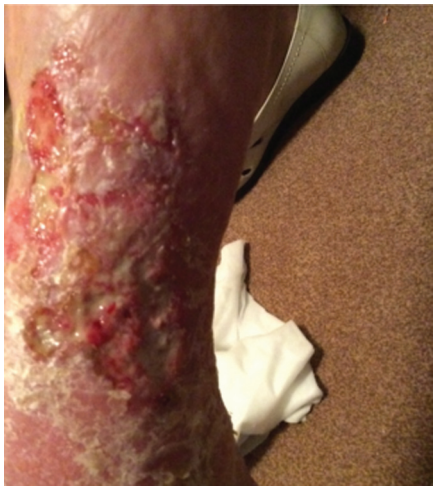

Figure 1.
Venous ulcer at initial presentation, before the use of ActivHeal Silicone Wound Contact Layer.

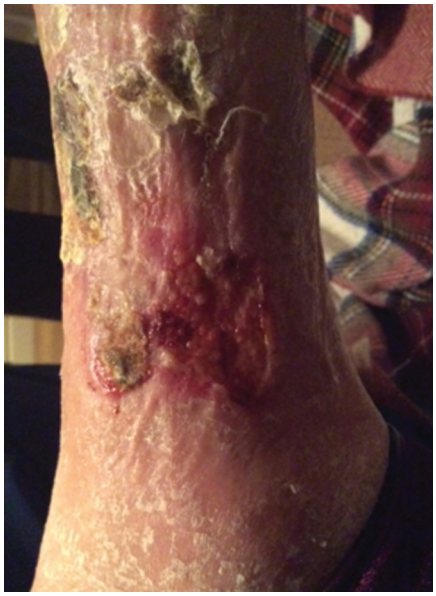

Figure 2.
Venous ulcer after four weeks' treatment with ActivHeal Silicone Wound Contact Layer.

This 82-year-old female patient presented with a venous ulcer to her right lower leg of one year's duration. She had previously been seen weekly and been treated with a silicone wound contact layer and compression therapy.

At initial assessment, the wound consisted of 10% epithelial tissue, 70% granulation tissue and 20% slough, and measured 10cm in length and 8cm wide. There was no sign of infection, but the periwound skin was macerated. It was decided to change the treatment regimen to ActivHeal® Silicone Wound Contact Layer.

After one week's treatment with the new dressing no improvement was seen in the wound's condition, but by week two the percentage of granulation tissue had increased to 80%, with a reduction in sloughy tissue (10%). The wound size had also decreased and now measured 6x7cm. Although at this stage the condition of the periwound skin remained unchanged, by the third week this had improved. Throughout the four-week treatment period dressings were changed weekly. On a scale of one to 10 (where 1=no pain and 10=worst pain), the patient rated the pain she experienced as 3.

The silicone wound contact layer was used under compression and the clinicians said that it helped to stop the compression adhering to the wound, thereby helping with the weekly dressing changes. It was also easy to apply and remove, with the clinicians giving these wound-related procedures a score of 1 on a scale where 1=very easy and 5=difficult. It was also found to be atraumatic to the wound bed and fragile periwound skin and helped to improve the integrity of the tissue.

At dressing changes the patient experienced no pain at all so there was no need to provide any analgesia. The clinicians found that the dressing stayed in place as long as expected and that it remained intact on removal and concluded that the silicone wound contact layer positively contributed to wound healing.

The patient also had a positive experience of using this dressing, as she found it very comfortable to wear, without causing any wound pain.

Jackie Stephen-Haynes, professor and consultant nurse, tissue viability, Birmingham City University and Worcestershire Health and Care Trust; Rosie Callaghan, tissue viability specialist nurse, Worcestershire Health and Care Trust

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 8

This case involves an elderly man with a skin care to his arm, which healed effectively in two weeks with ActiveHeal® Silicone Wound Contact Layer despite the fragile nature of the skin.

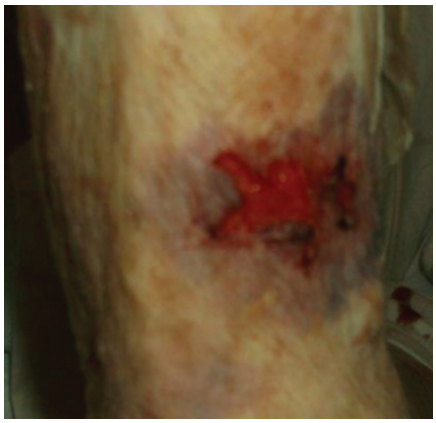

Figure 1.
Skin tear at initial presentation, before the use of ActivHeal Silicone Wound Contact Layer.

This patient was a 67-year-old man who was living in a care home. During routine skin inspection, it was found that he had incurred a skin tear to his arm — while putting on a tight shirt he had caught his arm. With skin tears, one of the most important aspects of assessment and management is to minimise any further trauma and preserve viable tissue. Thus, the authors decided to cover the wound with ActivHeal® Silicone Wound Contact Layer to promote healing and protect the fragile periwound skin together with a foam adhesive. This patient also had a poor nutritional status, which is known to delay healing.

At presentation, as much of the skin flap as possible was put back in place, with the wound at this stage measuring 2x1x1cm. The condition of the periwound skin was delicate and the wound was producing a low volume of exudate, which was clear and amber-colored. There was no odour present and the patient rated the pain that he was experiencing from the wound as 1 (on a scale where 1=no pain and 10=worst pain).

The clinicians gave the silicone wound contact layer the highest score for ease of use, although did comment that it was quite fiddly to ensure that the wound contact layer and foam dressing aligned. However, dressing removal was very easy, causing the patient no pain and with the dressing remaining intact. The wound contact layer was also atraumatic to the periwound skin (being rated 5 for this domain on a scale where 1=traumatic and 5=atraumatic). The clinicians also indicated that the dressing conformed well to the wound.

By week two of treatment the wound had healed and the clinicians commented that it had held the skin tear in place and allowed the serous fluid to drain. The patient also found the dressing comfortable to wear and was satisfied with the treatment regimen.

Throughout the two-week period of wound management, the patient had no pain, which was significant as skin tears can be painful due to trauma affecting the superficial nerve endings in the wound (Beldon, 2008).

REFERENCE

Beldon P (2008) Classifying and managing pretibial lacerations in older people. *Br J Nurs* 17(11 Suppl): S4–S18

Jackie Stephen-Haynes, professor and consultant nurse, tissue viability, Birmingham City University and Worcestershire Health and Care Trust; Rosie Callaghan, tissue viability specialist nurse, Worcestershire Health and Care Trust

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 9

This male patient had a challenging venous leg ulcer which was causing considerable pain. The use of ActivHeal® Silicone Wound Contact Layer helped to reduce pain and protect the development of new epithelial tissue, thereby promoting healing.

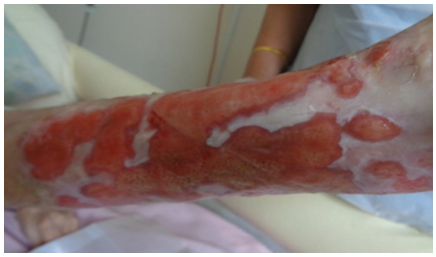

Figure 1.
Venous ulcer at initial presentation, before the use of ActivHeal Silicone Wound Contact Layer.

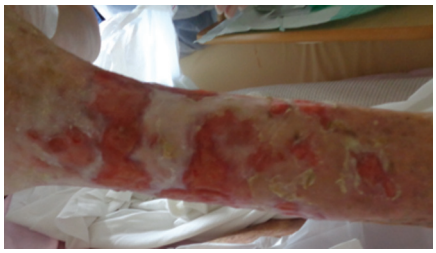

Figure 2.
Venous ulcer after two weeks' treatment with ActivHeal Silicone Wound Contact Layer.

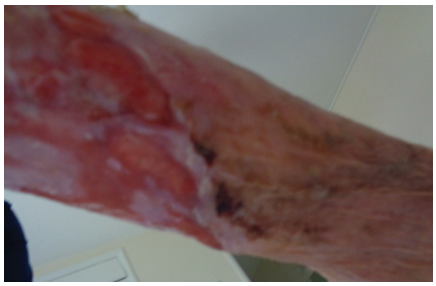

Figure 32.
Venous ulcer after four weeks' treatment with ActivHeal Silicone Wound Contact Layer. The volume of exudate had reduced considerably and the dressing had prevented any damage to new epithelial tissue.

This 84-year-old male patient had venous ulcers which spread from his knee to ankle and had been present for six months. The clinicians involved in his care said that they were proving very difficult to treat. The ulceration also caused the patient a great deal of pain and he had been having dressing changes every three days. He was a non-smoker but had a diabetes.

At the start of this evaluation on 14 December 2016, when it was decided to change the treatment regimen to ActivHeal® Silicone Wound Contact Layer with an antimicrobial absorbant pad, the wound bed consisted of 20% epithelial and 80% granulation tissue, but was producing an excessive volume of exudate and was slightly odorous. The periwound skin was macerated and the patient needed daily dressing changes. He rated his pain as 5 on a score, where 1=no pain and 10=the worst pain.

Over the following two weeks of treatment with the silicone wound contact layer, while no improvement was seen in the wound's condition, the volume of exudate reduced. While dressing changes were still daily in week two, by week three (4 January, 2017) they were only needed three times a week and the patient now rated the pain he was experiencing from the wound as 3 (on the same pain score as above).

Throughout the course of the four-week evaluation the clinicians gave the silicone wound contact layer the highest scores for ease of application and removal. It remained intact on removal and stayed in place without any rolling of the edges. They also rated it as being atraumatic to both the wound bed and surrounding skin (rating it as 5 where 1=traumatic and 5=atraumatic), which helped to improve the condition of the periwound skin, as this was very macerated at the start of treatment with this dressing.

The clinicians felt that the dressing positively contributed to healing because as well as being easy to use, it did not damage newly formed epithelial tissue at dressing changes.

It also improved the pain that the patient had been experiencing as he no longer found dressing changes painful and no analgesia was needed. The wound pain he had previously experienced also lessened (at the end of the four-week evaluation he rated it as 2 on a score where 1=no pain and 5=very painful).

The patient was very satisfied with the dressing giving this domain the highest score of 1 (where 1=very satisfied and 5=dissatisfied), and also found it comfortable to wear.

At the end of the evaluation period, the clinicians specifically highlighted the dressing's ability to remain in place and to promote healing by not causing any damage to newly formed tissue.

Jackie Stephen-Haynes, professor and consultant nurse, tissue viability, Birmingham City University and Worcestershire Health and Care Trust; Rosie Callaghan, tissue viability specialist nurse, Worcestershire Health and Care Trust

ActivHeal® Silicone Wound Contact Layer = Askina® SilNet Plus

CASE REPORT 10

This case involves an elderly man with a venous ulcer to his leg. ActiveHeal® Silicone Wound Contact Layer helped to reduce the pain he had been experiencing and performed well under compression.

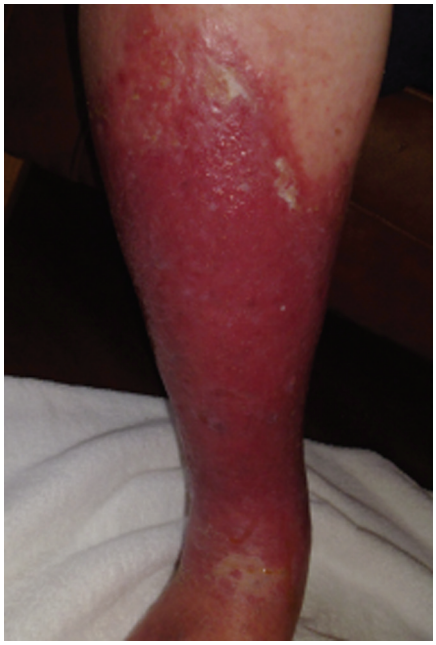

Figure 1.
Venous ulcer at initial presentation, before the use of ActivHeal Silicone Wound Contact Layer.

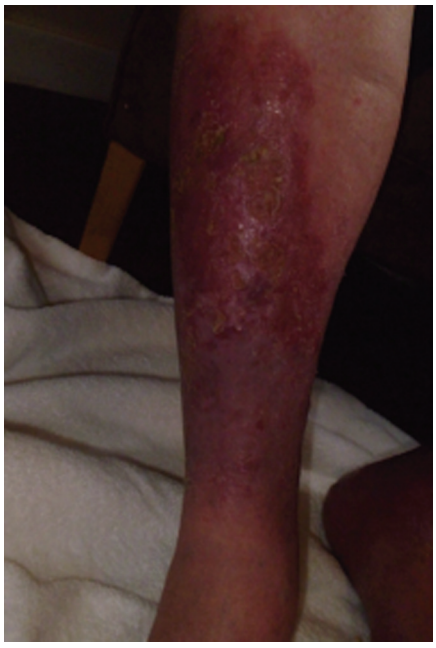

Figure 2.
Venous ulcer after four weeks' treatment of ActivHeal Silicone Wound Contact Layer.

This patient was a 74-year-old man who was living in a care home and had a venous ulcer to his leg. The ulcer had been present for four weeks, and was being redressed on a daily basis before taking part in this evaluation. He had a poor nutritional status, but no other comorbidities. The patient was concerned about changing his treatment regimen, as he had previously experienced dressings sticking to his wounds.

At presentation the ulcer comprised 100% sloughy tissue and measured 4x3cm. There were signs of local infection and the periwound skin was red and macerated. At this stage the wound was producing a high volume of exudate and causing the patient considerable pain. Indeed, on a pain scale of 1–10, where 1 was no pain and 10 the worst pain, the patient rated his pain as 8.

After just one week of treatment with ActivHeal® Silicone Wound Contact Layer, while the wound had not reduced in size and there was no change in exudate volume, the patient rated the pain he was experiencing from the wound as 3. Furthermore, the sloughy tissue also lifted and the wound bed now consisted of 90% granulation tissue with just islands of slough making up 10%.

By week two, the volume of exudate being produced lessened to high and dressing changes were now taking place every three days. At this stage, the silicone wound contact layer was being used with an absorbent silver dressing with a bandage to keep it in place.

At week three, compression was introduced to the treatment regimen, enabling the clinicians to leave the silicone wound contact layer in place for longer, just changing when the upper padding was wet. The clinicians commented that this reduction in dressing changes further helped to reduce wound pain for the patient. By week four, the wound had reduced in size to 3x3cm.

On a score of 1–5 (where 1=very easy and 5=very difficult), the clinicians gave the dressing a rating of 2 for ease of application and removal, and also marked it as being atraumatic to both the wound bed and surrounding skin. Of particular note was the fact that it did not stick, which had been a real concern for the patient, due to a previous dressing experience. The clinicians commented that the silicone dressing was very effective, as it was easy to remove without causing any pain to the patient, and remained intact and did not stick. The dressing also conformed well to the wound bed and remained in place throughout wear time, without any rolling of the ages and also performed well under compression.

The patient's misgivings were also allayed as he found the dressing very comfortable to wear and was very satisfied with the treatment (giving both these domains the highest scores in the evaluation). The pain he had been experiencing also lessened, with him rating it as 2 by the end of the evaluation.

Overall, the use of ActivHeal® Silicone Wound Contact Layer had a positive outcome for this patient, as it performed optimally with compression therapy — which is considered the gold standard of treatment for leg ulcers — was comfortable to wear, and helped to reduce wound size and the pain that the patient had previously been experiencing.

Jackie Stephen-Haynes, professor and consultant nurse, tissue viability, Birmingham City University and Worcestershire Health and Care Trust; Rosie Callaghan, tissue viability specialist