

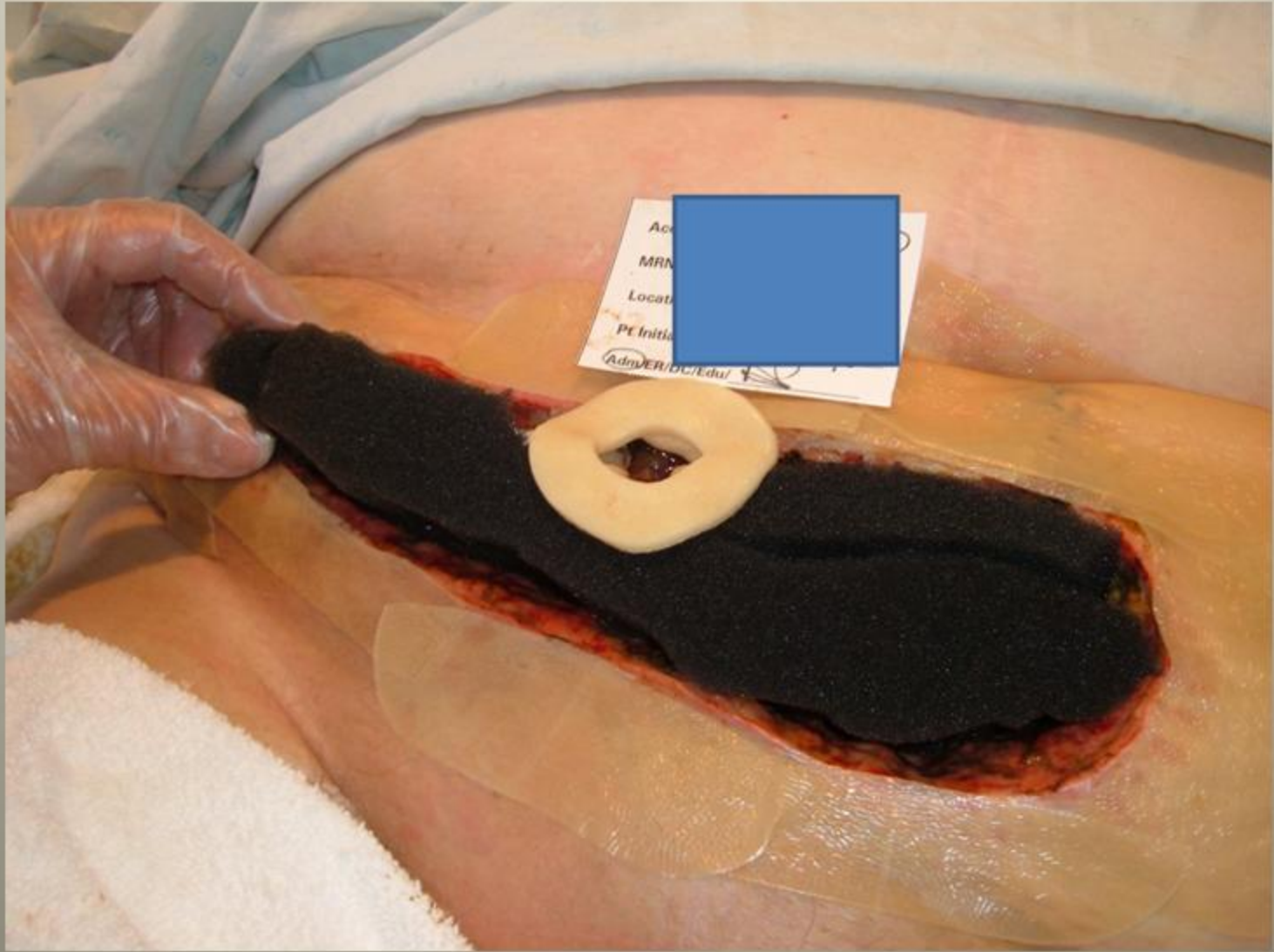
Case Study-Fistula Management following Surgery

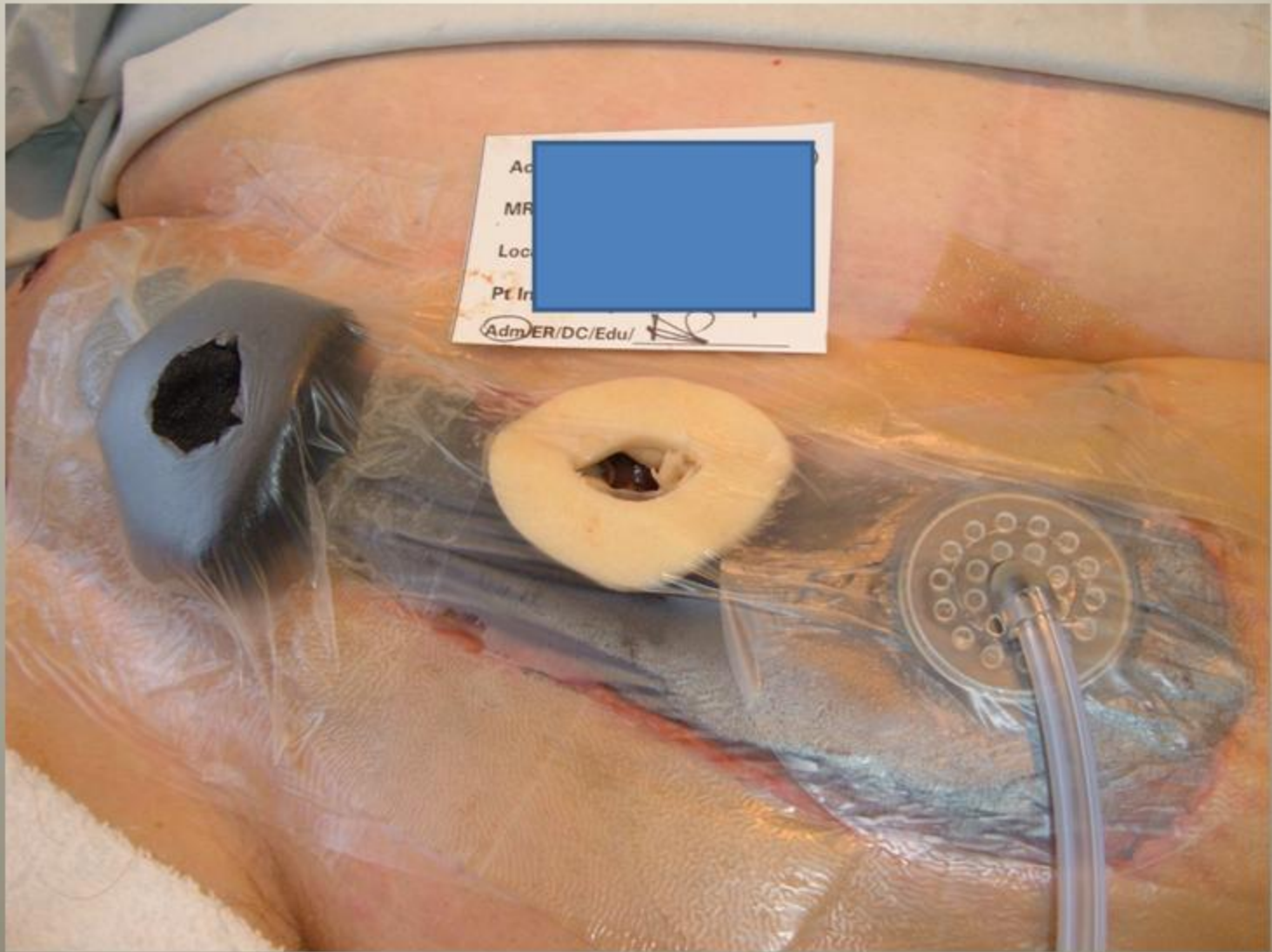
A 57 yr old female developed a fistula following surgery for a bowel stricture associated with Crohns.

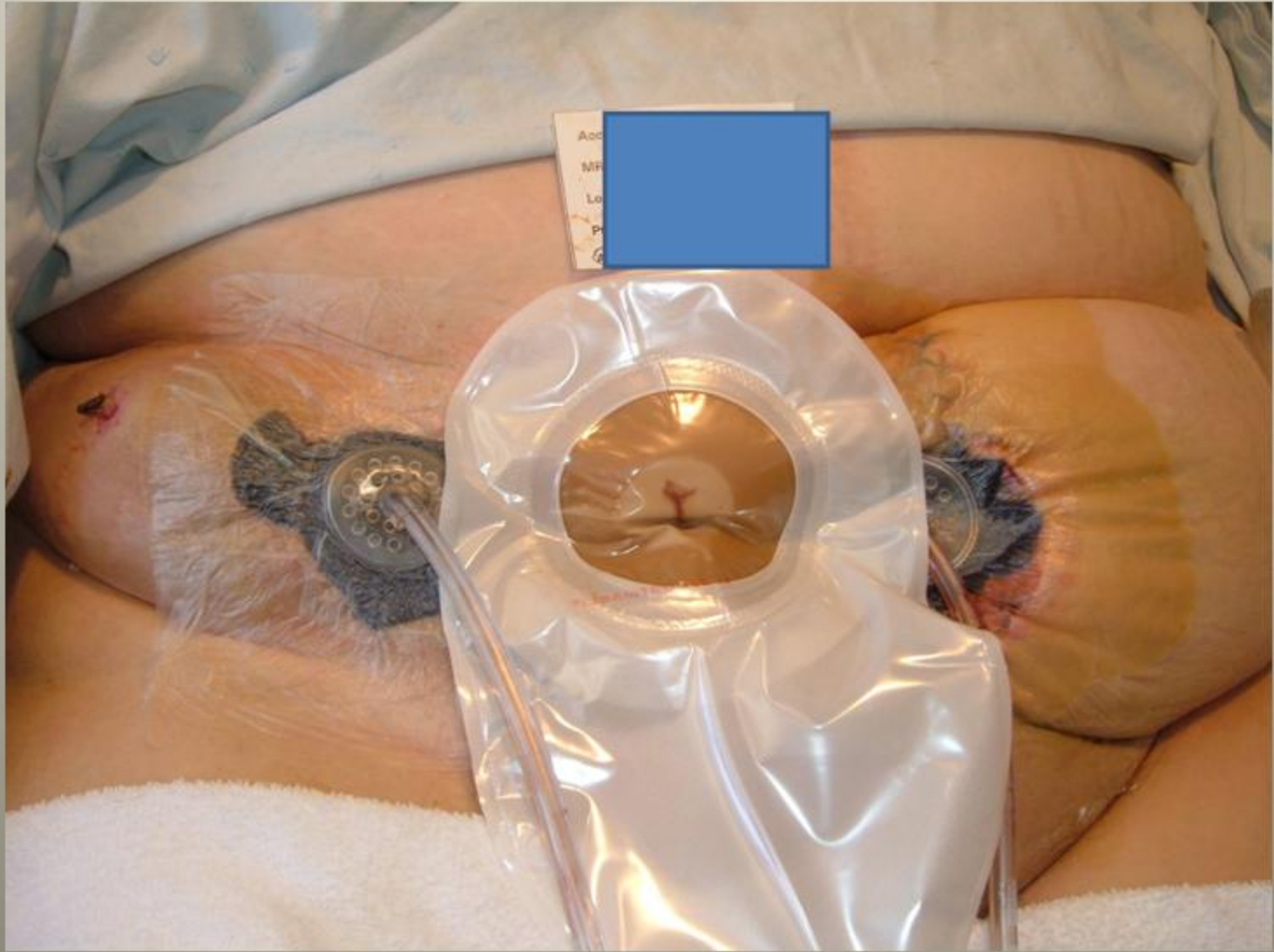


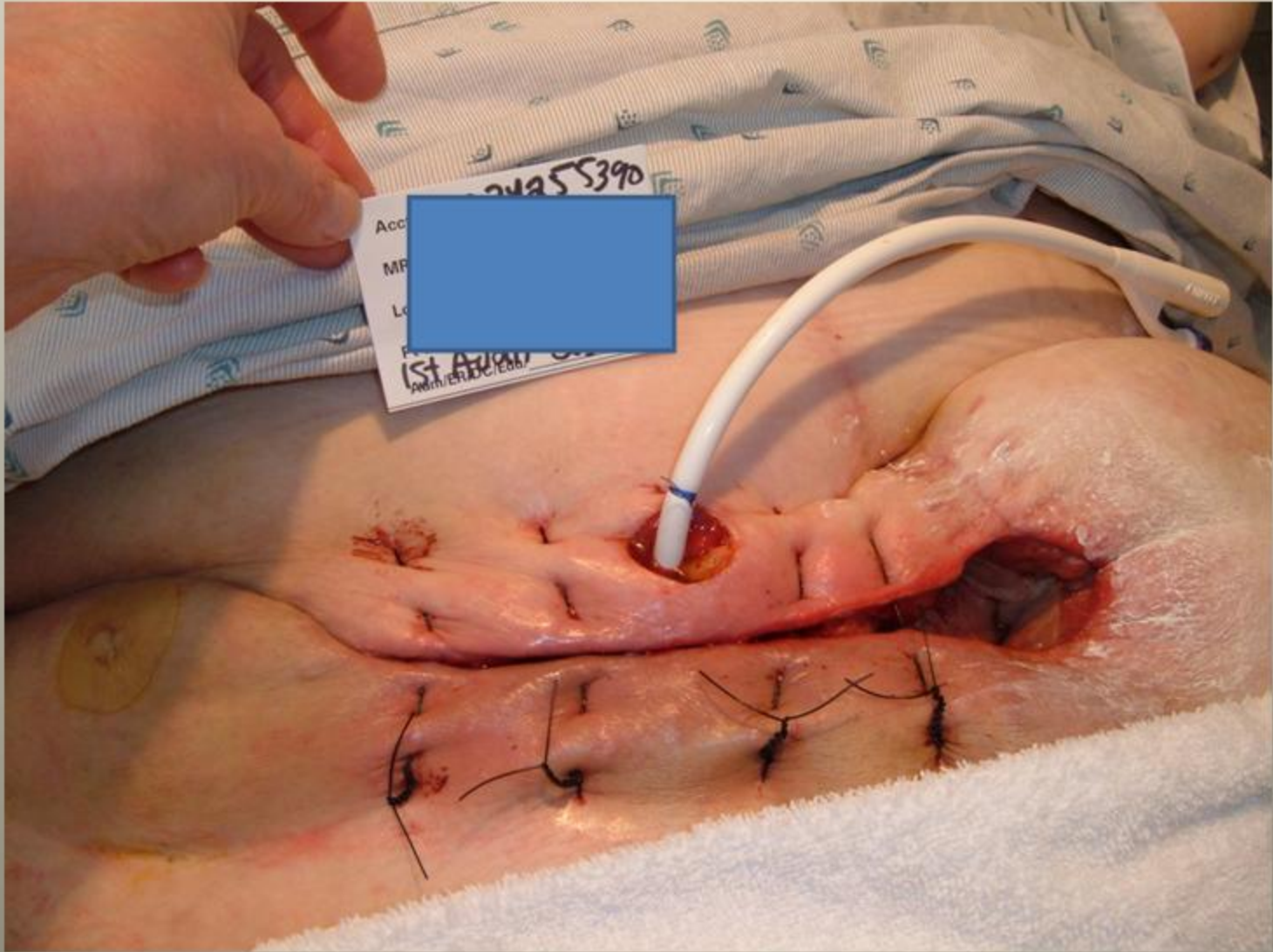


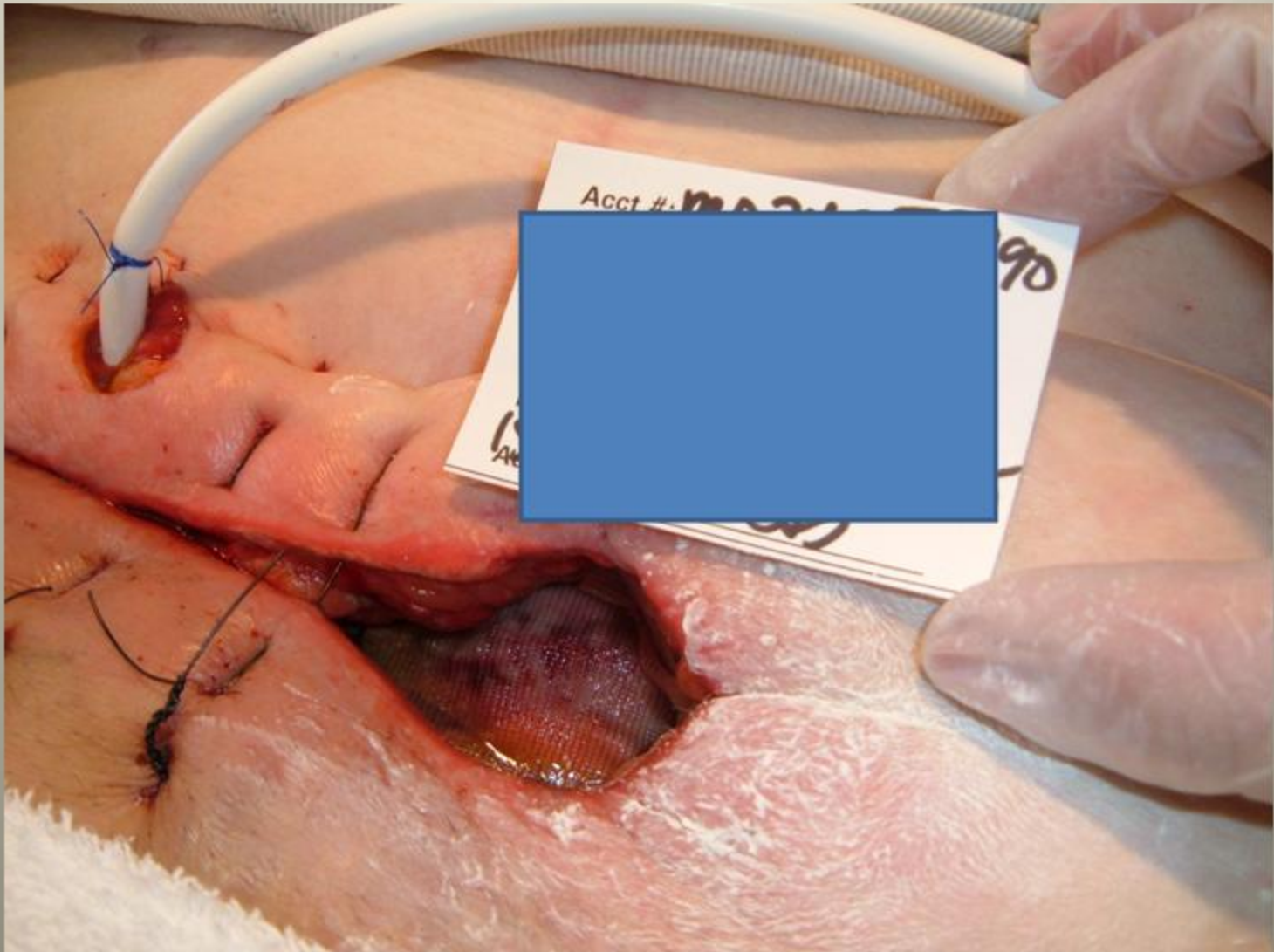


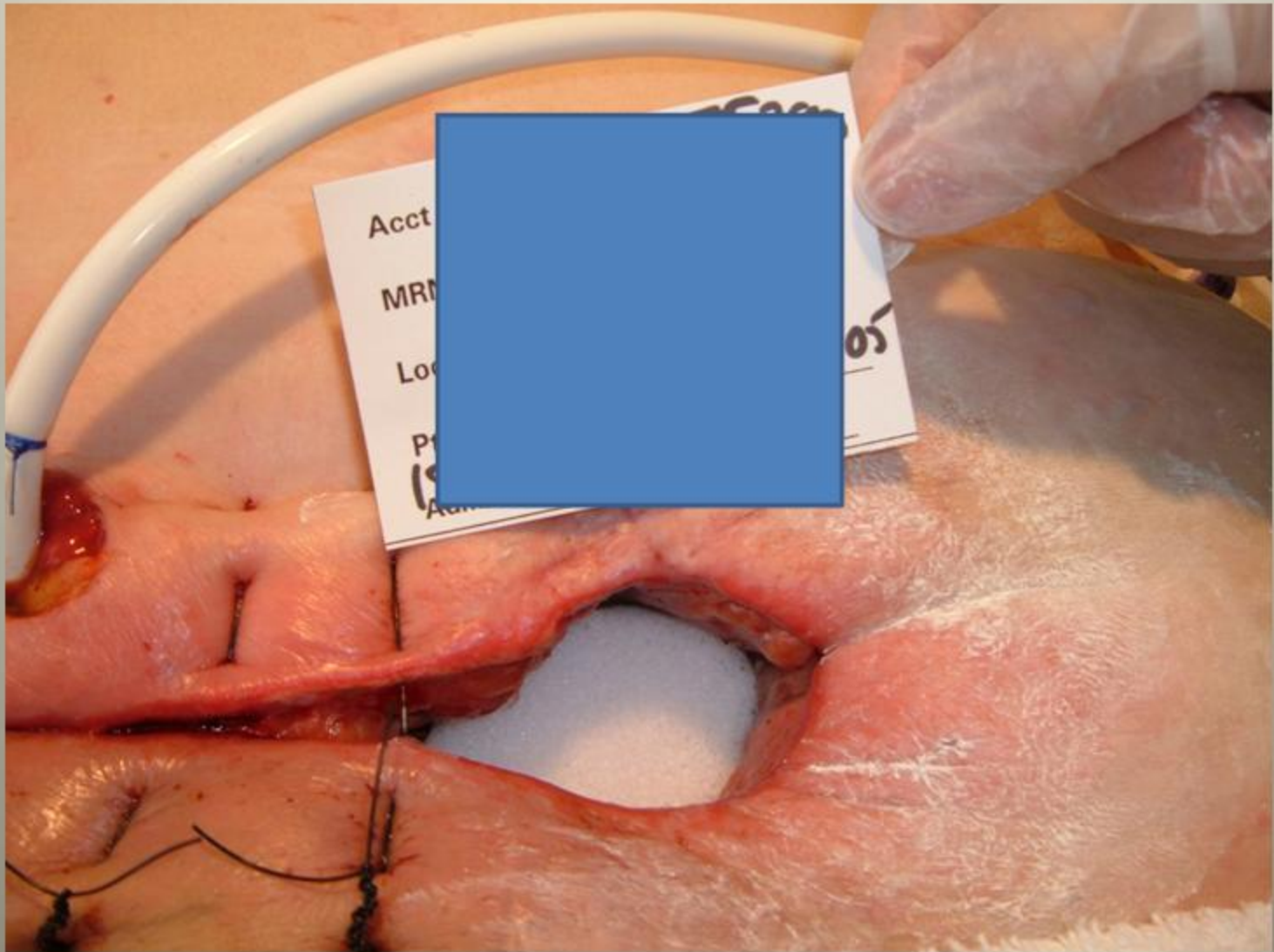


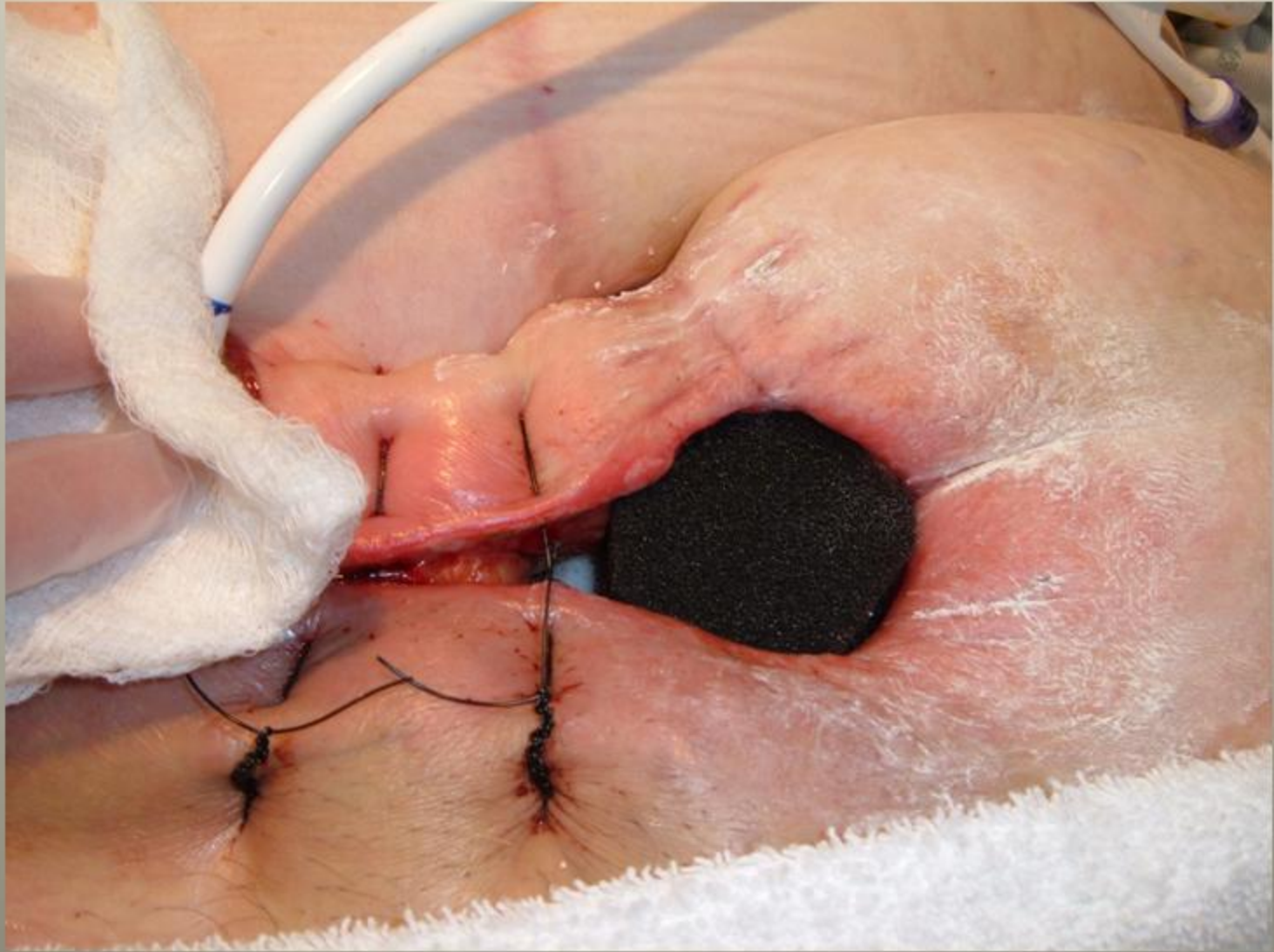


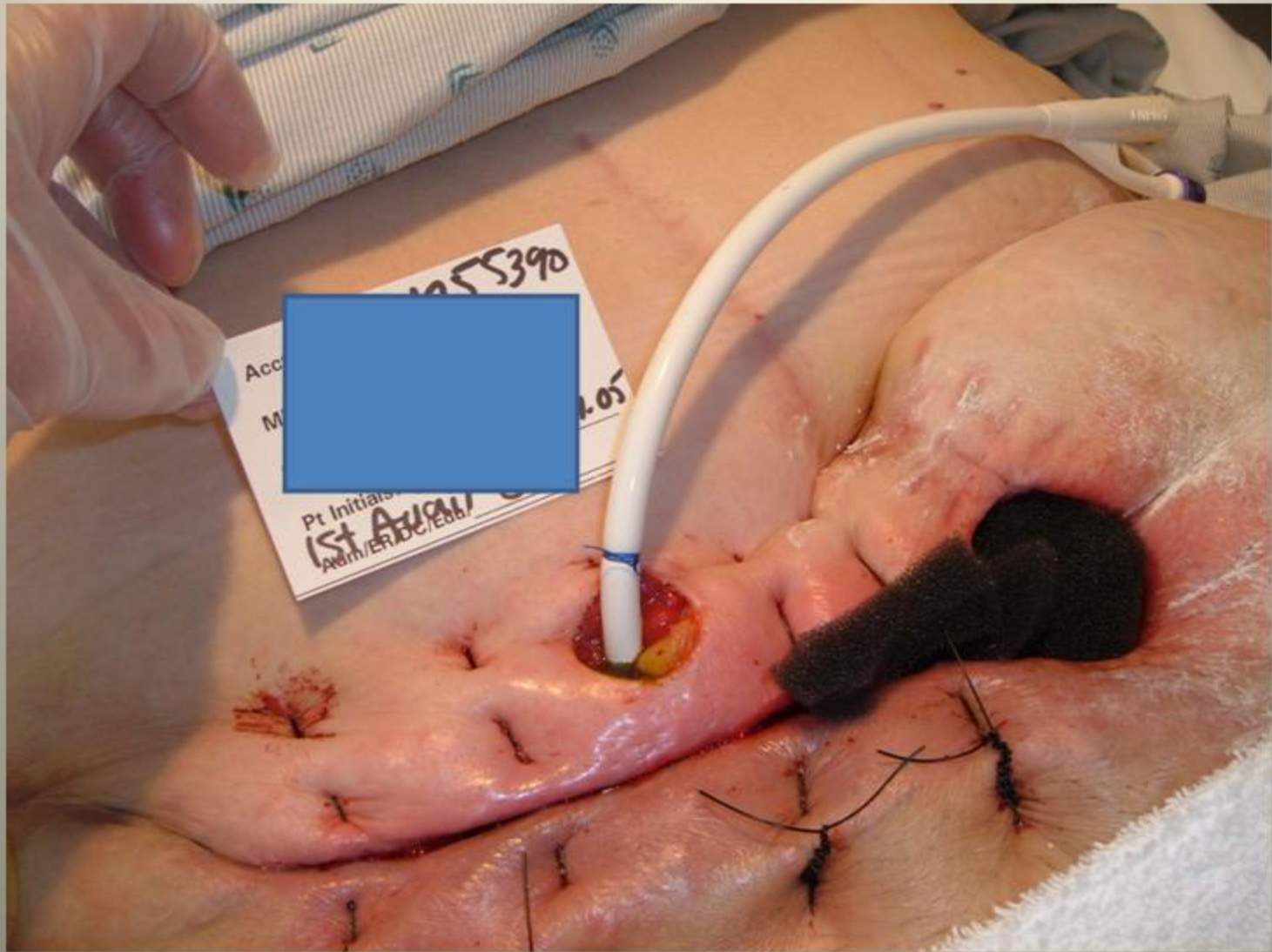




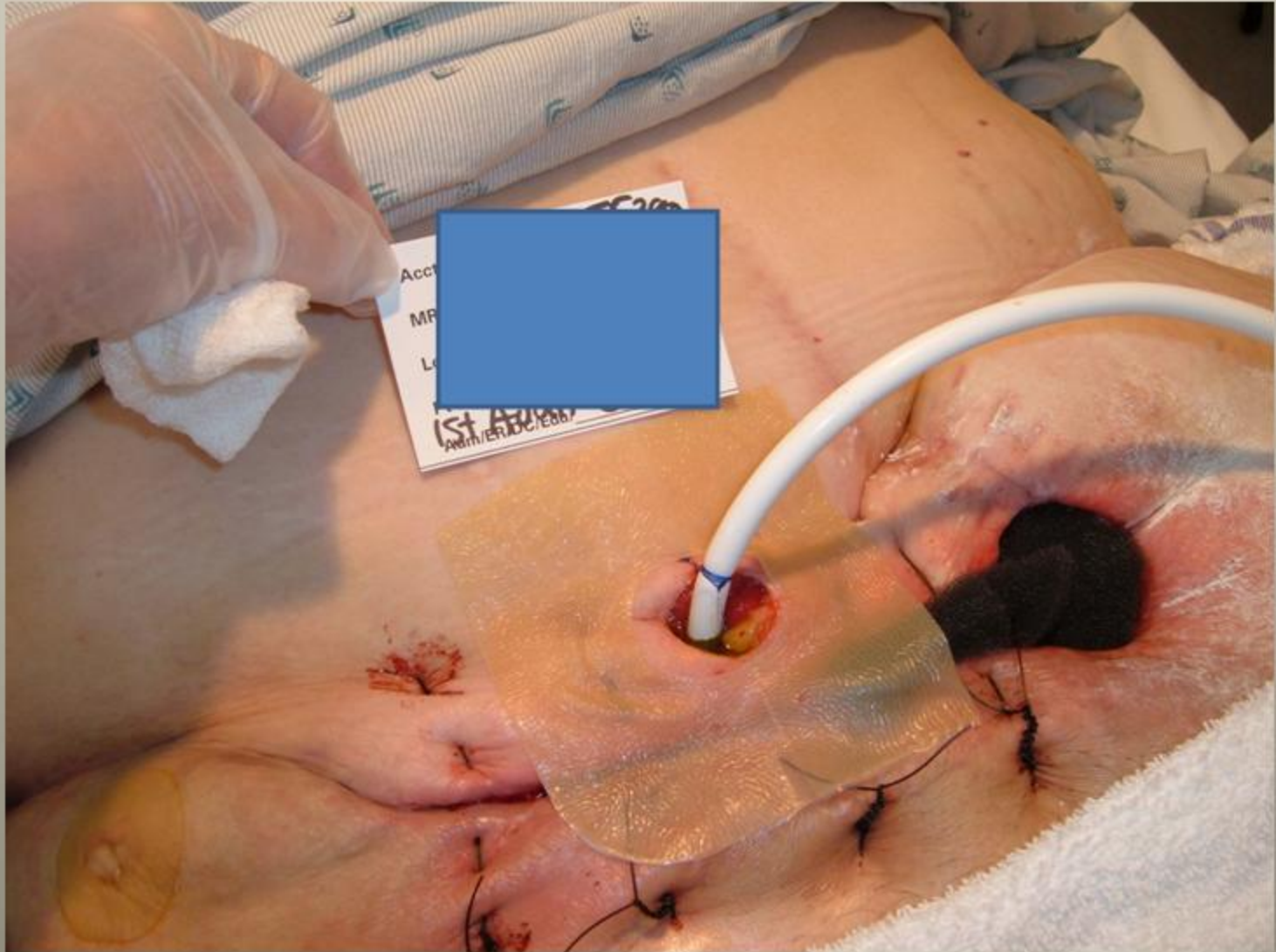


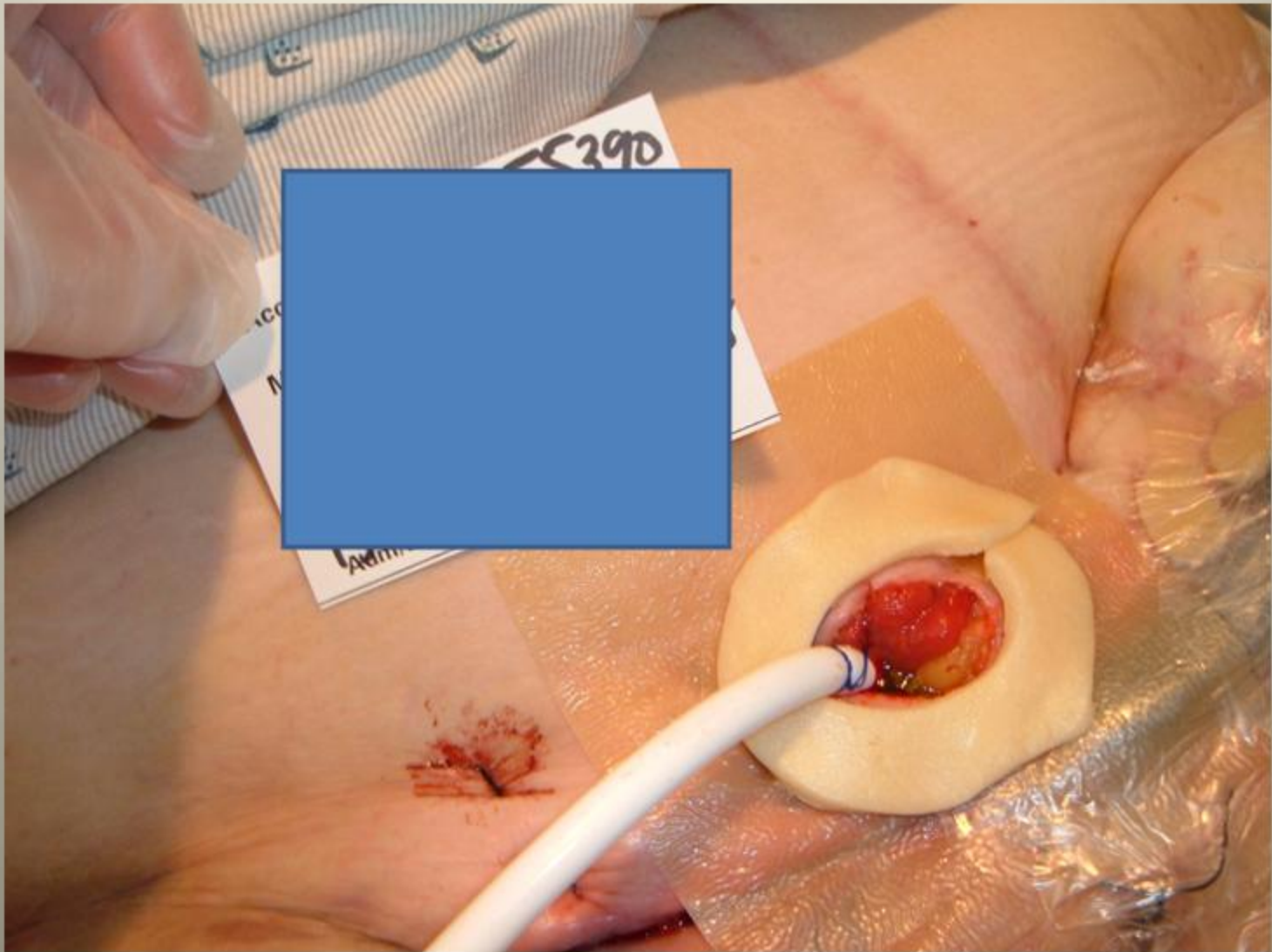






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Diabetic Ulcer



Charcot Foot



Callous



Heel



Metatarsal Head



Heel



Cracks, Fissures



Sites of Repetitive Trauma

Diabetic foot ulcer



Pre amputation



Hydrofiber AG for New Amputations



New Surgical Wounds

Place a strip or ribbon cut of Hydrofiber AG cover with a extra thin hydrocolloid or thin film dressing-

Wound margins can be observed, any exudate will be absorbed preventing maceration

No bulky dressing to interfere with mobility or fall off.

Diabetic foot ulcer newly debrided





Diabetic foot ulcer after debridement



Following treatment with for 3 months



Wound Progression



Venous Ulcers

Venous Ulcers

- "... account for 70-90% of all leg ulcers"⁶
- More common in women than men⁶
- Risk increases with age⁶
- History of deep vein thrombosis (DVT) also increases risk of developing venous ulcers⁶



Venous Stasis Surrounding Skin Assessment⁹

- **Venous dermatitis**: erythematous weeping, scaling, crusting
- **Hemosiderosis**: brown staining
- **Lipodermatosclerosis**: Atrophy Blanche
- **Temperature**: normal; warm to touch
- **Edema**: pitting or non-pitting; possible induration and cellulitis
- **Scarring** from previous ulcers, ankle flare, tinea pedis
- **Infection**: Induration, cellulitis, inflamed, tender bulla
- **Pain** – Minimal unless infected or desiccated
- **Peripheral pulses** – Palpable/present
- **Capillary refill** – Normal (< 3 sec.)⁹



Protect periwound skin

- Appropriate frequency of dressing changes so that exudate does not pool on the surrounding skin¹⁸
- Use absorptive dressing appropriate to level of exudate¹⁸
- Use skin barrier to protect periwound skin from moisture¹⁸



Venous Ulcers⁶



Highlights of Reducing the Risk of Developing Venous Ulcers

- Treat varicosities (ie, weight control, exercise, avoid crossing legs and tight clothing).
- Compression therapy to improve venous return.
- Light compression may be beneficial for patients with lower-extremity venous disease and/or lipodermatosclerosis who are unable to apply or tolerate high compression garments.
- Strengthening calf muscles (ie, walking).
- "Individuals with mixed venous/arterial disease have special care requirements."



Create an Environment for healing

- Cleanse the skin
- Protect peri-wound skin from maceration
- Moist wound bed
 - Absorptive products to absorb excess fluid
- Compression wraps to decrease edema

Venous Stasis with Cellulitis



Venous stasis, fragile skin, maceration





Compression Overview

- Compression is seen as the cornerstone of therapy for managing venous ulcers¹²
- The mainstay of management for lower leg edema is to treat the underlying condition and a combination of leg elevation, exercise and compression⁸
- Clinicians should be competent in selecting and applying compression according to the individual patients needs¹³

Ankle Brachial Index¹⁷

- ABI is a noninvasive test to detect LEAD
- An indirect method of assessing arterial blood flow in the lower limbs by comparing the brachial systolic pressure to the systolic pressure at the ankle
- Using a Doppler measure the brachial, dorsalis pedis and posterior tibial systolic pressures.
- $ABI = \frac{\text{Higher Ankle Systolic}}{\text{Higher Brachial Systolic}}$

Interpretation of ABI¹⁷

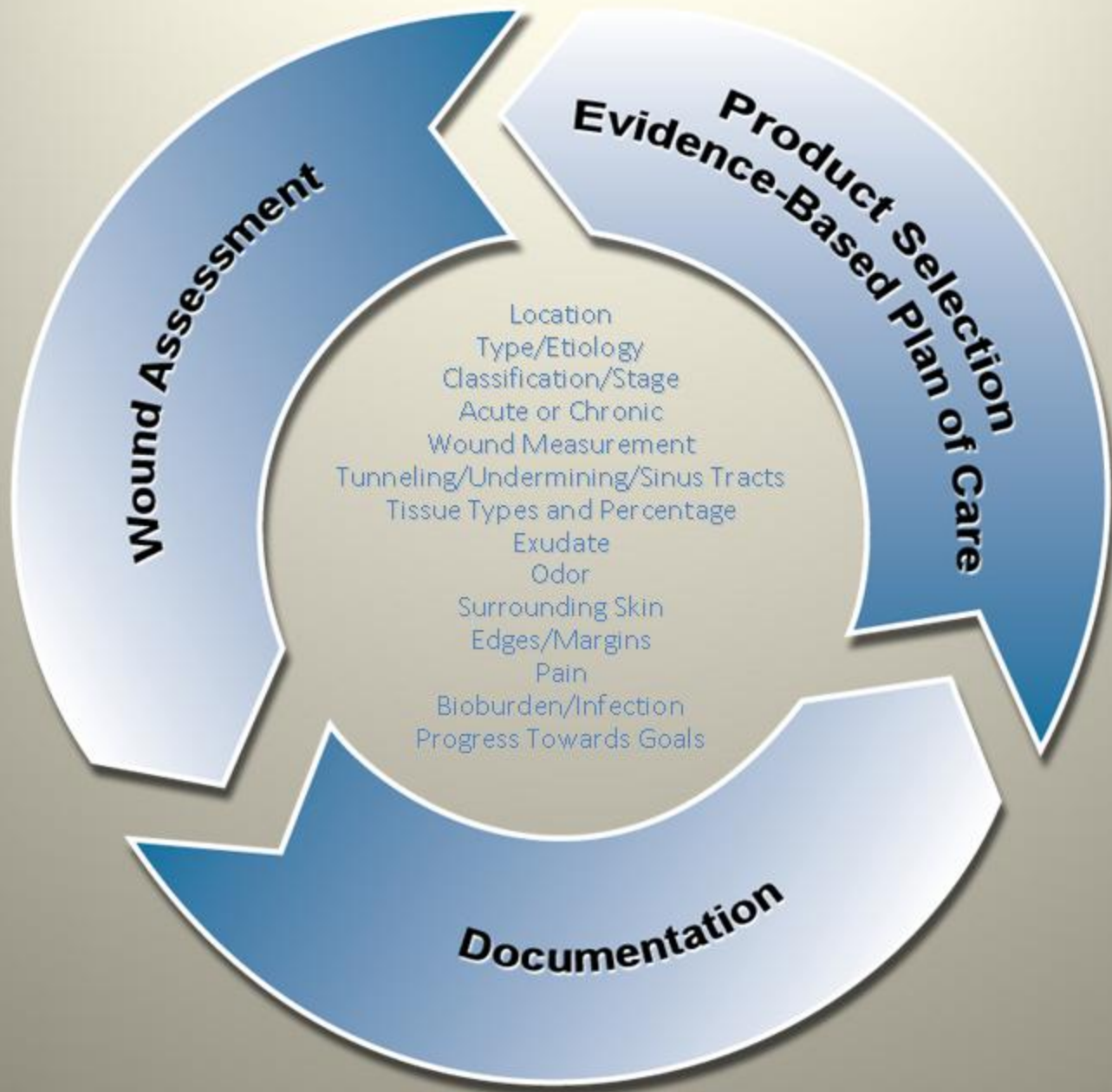
ABI	Interpretation
> 1.3	Elevated (non-compressible arteries)
≥ 1.0	Normal
≤ 0.9	LEAD
$\leq 0.6-0.8$	Borderline
≤ 0.5	Severe Ischemia
≤ 0.4	Critical limb ischemia

Patients with nonhealing wounds and LEAD should have ABI rechecked every 3 months because ABI may decrease over time¹⁷

Wound Classification and Interventions

SUMMARY

- Wounds can not be appropriately managed until the etiology has been determined
- Accurate wound classification will help to determine appropriate management and treatment options
- Understanding evidenced-based protocols of care for the prevention and management of lower extremity ulcers of vascular etiology may improve outcomes



Barriers to Cost Effective Wound Care with Positive Outcomes

- Barriers to Care
 - Co morbidities
 - Staffing and knowledge issues
 - Environment for wound healing
 - Patient Compliance

Nursing Efficiency Study

- Nursing Efficiency Study of 45 nurses
 - 33 reported wound care most time-consuming task
 - All requested standardized protocols
 - Goal to decrease frequency of dressing changes and costs of dressing changes (labor and supply) by 50%
- Benchmarking
 - Former protocols included wet to dry dressings changed 2 to 3 times per day
 - Burdensome and labor intensive for staff
- Results
 - Standardized protocol developed including AQUACEL Hydrofiber dressings
 - Average savings (labor and supply) over 6 months was \$66,177
 - Based on a 12-hour shift, over 20 days of nursing time was saved
 - 89.1% decrease in overall costs (based on 322 patients)
 - 93.8% decrease in nursing time

Management of Wound Care Cost¹⁸

- Cost-effectiveness is not sufficiently measured by the price of the dressing
- Cost-effectiveness reflects the cost of achieving a desired outcome
 - Cost of all dressing material
 - Nursing time
 - Treatment cost for complications
 - Other related expenses
- Reimbursement issues

6/08/10



6/11/10



6/11/10





6/18/10



6/18/10

