USE OF URGOCLEAN® IN DIABETIC FOOT ULCERS

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INTRODUCTION
The debridement stage is an essential phase in the wound healing process for which autolytic debridement is widely used in the local management of sloughy diabetic foot ulcers.

As part of a local evaluation, a new hydro-desloughing absorbent dressing URGOCLEAN® for exuding and sloughy wounds was assessed over a 6 week period.

The objective of the evaluation was to measure the reduction in sloughy tissue and wound surface area in the local management of diabetic foot ulcers.

METHOD
49-year-old male patient suffering with a diabetic foot ulcer was evaluated for 6 weeks using URGOCLEAN®.

The wound had previously been treated with a honey dressing prior to the use of URGOCLEAN®.

The patient was followed-up over a six week period and assessed weekly. Tracings of the wound and photographs were also taken.

RESULTS
The area of the diabetic foot ulcer at the initiation visit was 2.4cm x 2.5cm, by week 4 the wound surface area had reduced to 1.7cm x 1.3cm.

The percentage of slough had also dramatically reduced by 100% after 28 days.

The clinician also noted that the level of exudate had reduced from moderate to low.

DISCUSSION AND CONCLUSION
URGOCLEAN® reduced the wound size and percentage of slough in a six week old non healing diabetic foot ulcer in four weeks.

No pain was experienced by the patient at any of the dressing changes.

The patient is now seen by the clinician every three months rather than every week.

The clinician stated that the results of UrgoClean were: “Rapid de-sloughing and aided fast wound healing”.

The patient stated: “It looks like someone has wafted a wand over the wound”.
USE OF URGOCLEAN® ROPE DRESSING IN A NON HEALING PRESSURE ULCER

INTRODUCTION

URGOCLEAN® is a flat, thin, non-woven sterile rope composed of hydro-desloughing fibres (polyacrylate) with high absorption and integrity. A sterile probe is included to facilitate application which can also be used to assess wound depth.

URGOCLEAN® rope dressing is composed of two types of fibres: hydro-desloughing fibres and polyethylene fibres which provide the fibrillar structure, and tensile strength necessary to hold it together after gelling following contact with exudate.

As part of a local evaluation, URGOCLEAN® for exuding and sloughy wounds was evaluated over a 6 week period.

The objective of this evaluation was to assess the reduction in necrotic tissue in the local management of a pressure ulcer.

METHOD

45-year-old male patient, wheel chair bound due to Spinda bifida suffering from a pressure ulcer situated on the right side of the lower rib cage.

The wound had previously been treated with Aquacel before using the desloughing absorbent rope 5cm x 40cm.

The patient was followed-up over a six week period and assessed weekly.

RESULTS

At the initiation visit the wound bed was covered in 40% of slough and 60% necrotic tissue.

After six weeks the necrotic tissue had completely disappeared and the slough had reduced by 37%.

DISCUSSION AND CONCLUSION

URGOCLEAN® eliminated all necrotic tissue in 4 weeks.

The patient’s comfort level with the dressing was excellent. Secondary dressings were required in this case to protect to the wound, Sorbion pad and Mepilex Border were used.

Urgoclean very effectively debrided a very difficult wound. The patient and his family had great confidence in the product.
THE EFFECT OF URGOCLEAN® ON THE DEBRIDEMENT OF A HARD TO HEAL PRESSURE ULCER

INTRODUCTION
Debridement is the removal of non-viable tissue from the wound bed to encourage wound healing. Wound debridement is an essential part of wound care and its role in the preparation of the wound bed is well documented (Falanga, 2001; EWMA, 2004; Wolcott et al, 2009). Debridement is indicated when there is a build-up of necrotic tissue in the wound bed. Early appropriate wound debridement facilitates healing, reduces risk of infection and improves patient quality of life (Vowden and Vowden, 2011). Many clinicians will encounter wounds that are ‘hard to heal’ where, despite best efforts wound healing is prolonged or never achieved (EWMA, 2004). This case study examines such a ‘hard to heal’ wound along with the debriding potential of a dressing which is composed of hydro-desloughing fibres with a high absorption capacity and a lipido-colloid layer that is soft-adherent to the wound (technology lipido-colloid) (URGOCLEAN®).

BACKGROUND
A 57-year-old male was admitted following collapse due to a cerebrovascular accident which had resulted in him being on the floor for 3 days. Resulting in an unstageable pressure ulcer to the left outer mid-thigh measuring 15cm x 15cm, covered in 100% necrotic tissue. He had a long-standing history of peripheral vascular disease, and this underlying aetiology alongside his period of immobility on the floor resulted in pressure damage causing extensive devitalised tissue damage to the left foot and lower leg. This unfortunately led to the lower limb and foot being vascularity unsalvageable, resulting in an above knee amputation.

Numerous wound management regimes for the pressure ulcer on the thigh were carried out over a period of 6 months period which involved various debriding options including: sharp debridement, alginates, hydrogels, sterile maggots, NPWT with varying degrees of success and resulting in the slow progression of debridement of the devitalised tissue uncovering a category IV pressure ulcer with exposed devitalised tendon.

Other challenges to wound care also included patient concordance and anticoagulant therapy resulting in bleeding.

METHOD – TREATMENT INTERVENTION

- **URGOCLEAN®** was used to: encourage debridement of devitalised tissue; manage exudate; act as a haemostat and maintain a moist wound environment to encourage wound healing potential
- The patient commenced **URGOCLEAN®** rope dressing with an absorbent secondary dressing on 1st June 2012
- The patient’s wound dressing was reviewed regularly by the Tissue Viability Nurse.

RESULTS
The patient was reviewed again on 7th and 15th June and 6th July 2012, at each review significant debridement and granulation was noted alongside reduction in odour and exudate levels. The wound achieved full debridement and almost complete wound healing by 9th September 2012.

DISCUSSION AND CONCLUSION
In this case study the chosen dressing proved to be a very effective agent at encouraging debridement and ultimately promoting granulation and epithelisation in a particularly difficult to heal pressure ulcer. Almost complete wound healing was achieved within a 3 month period, whereas previous methods of wound management had demonstrated little effectiveness over a 5 month period. In light of the outcome the author would definitely consider its use in the future in the effective and timely debridement of necrotic wounds such as deep pressure damage.

REFERENCES:
INTRODUCTION
The characteristics of the tissue within the wound bed play an important role in the wound healing continuum.

Slough is devitalised tissue that is usually moist, soft and often stringy in consistency, it is usually yellow, white or grey in colour and must be removed so that granulation can occur.

A new hydro-desloughing dressing is now available for sloughy & exuding wounds which has a high capacity to absorb exudate & trap sloughy residues. It has a soft-adherent TLC layer to ensure pain free & atraumatic removal.

URGOCLEAN® is highly conformable and allows for one piece removal.

The evaluation was undertaken in a busy city centre clinic visited by a large number of patients with a wide variety of wounds making it an ideal environment to test the efficacy of URGOCLEAN®.

METHOD
Wounds acceptable for inclusion were chronic exuding wounds that required slough removal, acute wounds, malignant wounds and those without any clinical signs of spreading infection. The wounds were followed up on a weekly basis by the clinician who documented the progress and took photographs.

Wounds were followed up until healing or an alternative dressing was more suitable i.e. the wound demonstrating no slough and minimal exudate.

DISCUSSION AND CONCLUSION
Failure to eliminate slough will result in non-healing of a wound and also increase the risk of infection so correct management of the wound bed is essential.

The results of this study demonstrate the efficacy of URGOCLEAN® in the treatment of numerous types of exuding and sloughy wounds, in patients with co-morbidities. This is combined with excellent tolerance and acceptability by both clinician and patients.
INTRODUCTION
This case study concerns a 62 year old male suffering with type 2 diabetes who was admitted to hospital with sepsis of his right foot due to an injury whilst out fishing (Kerr 2012). Surgical debridement was performed by the orthopaedic surgeon and he was then referred to the podiatry department for wound care and advice.

He had four wounds which were left open to heal by secondary intention; 3 on the plantar arch and one on the lateral border over the styloid process, all grade 3 B (Texas wound classification).

Initially, following surgical debridement, the wounds appeared to be healthy and granulating but on the second dressing change the wounds were malodorous with copious purulent exudate.

The patient was systemically unwell and feared losing his foot.

METHOD
After discussing the risks and benefits to the patient allowing him time to arrive at informed choice, Bio-surgical debridement utilising “free range” Larvae were applied to his foot. On removal the wounds were again red and granulating although the plantar fascia was exposed on the 3 plantar wounds that communicated with the lateral wound.

To ensure the wounds remained clean and free from slough, Urgoclean® was the chosen treatment, to aid drainage and remove any residual slough that may not be visible in the cavity and within a week the patient was deemed fit for discharge home. The wounds had improved and the patient was fitted with a removable cast and temporary footwear. He was followed up with District nursing visits, initially three times a week and weekly podiatry outpatient appointments.

RESULTS
Within 8 weeks the wounds had practically healed on the plantar aspect and totally healed on the lateral border.

District nursing visits reduced from 3 per week to once a week over this time. Throughout this period the patient did not require any antibiotics or re-admission. The consultant orthopaedic surgeon discharged him with the option of being referred back from podiatry if necessary.

DISCUSSION
Working as a multidisciplinary team ensures the pathway for patients is smooth and the patient is kept informed of all procedures/treatments.

Having an understanding of each other’s skills is paramount to patient care.

The orthopaedic surgeons rely on the secondary care of podiatrists for advice on wound care and learn from clinicians the importance of a thorough and holistic assessment and that correct dressing selection for each type of wound is crucial to aid healing.

CONCLUSION
Utilising dressings that require less frequent change, not only aids the healing process as the wound bed is not disturbed but is cost effective as the numbers of dressings required are reduced (Schmutz 2008).

Reducing nurse time is a key driver of costs, as work conducted by Drew and Posnett illustrated. The time taken, not only to heal the wound, but to treat the wound, has a hugely positive effect on the patient’s quality of life.

The patient in this case study was desperate to return to his fishing and UrgoClean® achieved this objective. It was demonstrated to be both clinically and cost effective, being easy to apply and requiring less frequent dressing change. Using UrgoClean® helped restore the patient’s quality of life and ultimately helped to save the patient’s limb.

REFERENCES
INTRODUCTION
Selecting the ideal dressing is a key part of the wound management plan. Wound assessment and dressing selection determines whether any pain, infection, exudate or friable skin is managed appropriately whilst providing the optimum wound healing environment to ensure full healing is achieved at an appropriate rate.

UrgoTul® Absorb Border is an absorbent foam dressing with a silicone adhesive border and shower-proof backing for the management of acute and chronic exuding wounds. The absorbent foam is covered with a healing matrix, TLC (Technology Lipido-Colloid). There is evidence to indicate the TLC layer promotes fibroblast proliferation at the wound bed, promotes non-adherence to the wound bed, protection and improvement of peri wound margins and the surrounding skin. This facilitates atraumatic and painfree removal on dressing change.1

UrgoTul® Absorb Border can be used for a variety of wounds throughout the different stages of the wound healing process with varying levels of exudate.

Correct dressing choice can positively impact on not only healing rates and the patient's quality of life but financial aspects as well.

METHOD
All patients agreed to be involved in the evaluation of UrgoTul® Absorb Border, UrgoClean® and UrgoStart®. The main objective of these evaluations was to assess the level of efficacy of new UrgoTul® Absorb Border. Other outcomes were to decipher clinician and patient acceptability, wear time, absorbency capabilities, the effect on the peri wound area and the speed of wound healing. The main focus for UrgoClean® was to demonstrate the desloughing capabilities.

CONCLUSION:
UrgoTul® Absorb Border clearly demonstrated the efficacy of use for a wide variety of wounds as both a primary and a secondary dressing for varying levels of exudate by managing, preventing and reducing maceration and increasing wear time. Atraumatic, pain-free dressing removal was also demonstrated which allowed patient comfort, enhanced healing rates and provision of the optimum wound healing environment.

UrgoClean® reduced the percentage of slough to less than 5% in 18 days, whilst coupled with UrgoTul® Absorb Border the dressing regime enhanced exudate handling, patient comfort, protection of the surrounding skin and wear time.

Both the clinicians and patients confirm that none of the woundcare dressings used throughout the evaluation adhered to the wound bed making this dressing and these dressing regimes an ideal choice for a wide range of both acute and chronic wounds.

REFERENCE
TREATMENT OF A DIABETIC FOOT WOUND POST FIRST RAY AMPUTATION WITH THE USE OF URGOCLEAN® AND URGOTUL® ABSORB BORDER

INTRODUCTION
Promotion of healing in the diabetic foot provides many challenges for podiatrists, due to the aetiological changes related to diabetes within the foot. Aiming for optimal conditions within the wound bed is essential to facilitate the healing process. Meeting the associated challenges such as devitalised tissue and managing exudate levels is paramount if an effective trajectory of healing is to be achieved.

A hydro-desloughing absorbent dressing, UrgoClean®, has been developed to facilitate proliferation of fibroblasts within the wound bed, facilitate the debridement of devitalised tissue and manage exudate levels. This dressing also offers pain free, atraumatic dressing changes due to a patented Technology Lipido-Colloid layer on the wound contact surface.

UrgoClean® was chosen to meet the challenges of promoting the healing of a post amputation wound in a diabetic patient.

UrgoTul® Absorb Border is a silicone adhesive foam dressing with Technology Lipido-Colloid on the wound contact surface. Behind the foam lies a highly absorbent layer which locks in exudate preventing maceration. This provides all the benefits highlighted above, in an effective all-in-one dressing.

METHOD
On the 11th December 2013 a 60 year old gentleman was referred by the Vascular and Orthopaedic teams post operatively for dressing changes after undergoing a 1st Ray (great toe) amputation due to suspected osteomyelitis.

He was a poorly controlled type 2 diabetic taking oral anti hypoglycaemic medication. After evaluation of the evidence for UrgoClean®, it was decided that this dressing would be suitable to use to meet the challenges presented. These were predominantly managing exudate and the need to debride sloughy tissue. The use of this dressing was complemented by the use of a pressure relief ankle foot orthosis (boot). Shared care between the podiatry staff and the community nursing staff took place changing the UrgoClean® pad initially every 2-3 days and later reduced to weekly as the exudate levels decreased.

When removing slough was no longer the priority in treatment, UrgoTul® Absorb Border was utilised to reduce dressing bulk while continuing to promote the proliferation of fibroblasts, ensuring the promotion of robust granulation and epithelialisation.

RESULTS
The initial wound on first presentation in December 2013 was 9.7cm x 7.2cm.

By June 2014 the wound had reduced in size to 1.4cm x 0.5cm. This represented an approximate reduction of wound surface area of 99% in 6 months. The exudate levels were managed effectively with equally effective facilitation of autolytic debridement. Robust granulation tissue also began to form early resulting in a faster than expected healing trajectory with effective epithelialisation. It was also noted that the wound margins were protected from maceration and remained robust. Pain free and atraumatic removal resulted in a fully concordant patient and reduction in the disturbance of the newly formed granulation tissue at the wound bed. When UrgoTul® Absorb Border was then used from June 2014, the wound continued to progress as previously to full healing. Scar tissue also appeared reduced.

DISCUSSION & CONCLUSION
This case study demonstrates that UrgoClean® and UrgoTul® Absorb Border were an effective choice for meeting the challenge of promoting effective healing within the diabetic foot.

UrgoClean® effectively managed exudate, slough, promoted granulation through the proliferation of fibroblasts, all while protecting the peri wound margins promoting epithelialisation and offering pain free, atraumatic removal.

UrgoTul® Absorb Border continued to promote healing when removal of slough was no longer the priority. The dressings were easy to utilise and translate from a specialist to a generalist setting. UrgoClean® and UrgoTul® Absorb Border therefore offer the clinician and the patient improved outcomes in what is often seen as a challenge when healing wounds on the diabetic foot.
### INTRODUCTION

Desloughing wounds has historically been considered a type of debridement. There is a train of thought that desloughing should be in its own distinctive category as ‘desloughing’ rather than merged with debridement. Debridement covers removal of a range of devitalised tissue whereas desloughing refers only to the removal of slough.

Wound bed preparation is an imperative part of this process; therefore, unmanaged slough on the wound bed surface inevitably results in non-progression and requires effective removal (1).

**UrgoClean** is a slough-trapping dressing and is the only dressing available that falls into the newly created category for desloughing dressings. It is available as a rope with a probe or a pad. **UrgoClean** traps the slough and simultaneously manages exudate and gives confidence to the clinician for one piece, pain free removal. The TLC Healing Matrix is known to enhance fibroblast proliferation and provideatraumatic removal.

### METHOD

Tissue viability received a referral to review a 78 year old, very frail, female patient with Parkinson’s disease who required removal of slough from a category 3 pressure ulcer on her left hip. The wound measured 75mm x 60mm x 8mm and presented with 80% slough. It had been present for 4 months and was being managed with a calcium alginate and silicone foam dressings with no improvement seen. **UrgoClean** was used to deslough the wound and **UrgoTul Absorb Border** was used as a secondary dressing. **UrgoTul Absorb Border** was used to increase the wear time through exudate management and the benefits of the TLC Healing Matrix being in contact with the surrounding skin (2). Dressings were routinely changed every 2 – 3 days depending on the varying levels of exudate.

### RESULTS

At day 10 the slough had reduced from 80% to less than 30% and by week 11 there was no evidence of slough present and the wound measured 50mm x 50mm x 3mm. To ensure any undermining decreased in line with wound size reduction the rope version of the **UrgoClean** dressing was occasionally used coupled with **UrgoTul Absorb Border**. When **UrgoClean** rope was used, the benefits of the TLC Healing Matrix were still gained by continued use of **UrgoTul Absorb Border** which allows the TLC Healing Matrix to be directly in contact with the wound bed. At week 30 the wound measured 40mm x 25mm and was on the correct trajectory for full healing.

### DISCUSSION & CONCLUSION

Wound management can be a challenge for clinicians and an ordeal for the patients therefore differentiating between debriding and desloughing could be interpreted as forward thinking because this allows the clinician to be more specific in their dressing choice. The initial reduction of slough within such a short period of time was very dramatic and had a positive impact on the patient, patients’ spouse, the clinical staff and the wound healing process. The hydro-desloughing absorbent properties of **UrgoClean** (2) demonstrated effective and timely desloughing. The TLC Healing Matrix properties of **UrgoClean Pad** and **UrgoTul Absorb border** ensured enhanced fibroblast proliferation, protection of the surrounding skin, atraumatic removal and patient comfort with pain free dressing changes (3).

### REFERENCES

(1) TLC dressings Made Easy. Wounds UK 2014 | McGrath A, Newton H, Trudgian J, Greenwood M
(2) Improving clinical outcomes and patient experience through use of desloughing; Aug 2015; Clinical Focus, BJCN; Lorraine Grothier
USE OF URGOCLEAN® IN A NON HEALING ACUTE WOUND

INTRODUCTION
The modern concept of “wound bed preparation” is to correct any anomalies that might obstruct wound healing at any time. This gives particular importance to debridement and the control of wound exudate.

The prolonged presence of necrotic devitalised tissue or sloughy deposits produced by exudate is one of the main causes of delayed healing. This is due to the chronic inflammation that this triggers and the ever present risk of secondary infection.

As part of a local evaluation, URGOCLEAN® for exuding and sloughy wounds was initiated.

The objective of this evaluation was to access the reduction in sloughy tissue in the local management of a leg ulcer.

METHOD
57-year-old female patient suffering from an 8 month old acute wound caused from what the patient believed was either a scratch or insect bite.

The wound had previously been treated with Sorbion.

The patient had been on the waiting list for versajet hydrotherapy before evaluating URGOCLEAN®.

RESULTS
At inclusion the percentage of slough was between 75-80%, 15 days later using URGOCLEAN® and after only six dressing changes the slough had reduced to 10-15%.

A reduction is wound surface area was also recorded and a reduction in pain from VAS 5 to 1.

DISCUSSION AND CONCLUSION
URGOCLEAN® significantly reduced the percentage of slough by over 80% in only 15 days.

No adherence was reported to the wound bed, dressing changes reduced from 3x per week to only 2 and the dressing was easy to apply and removed in one piece.

The patient refused to use any other dressing until the evaluation was completed.
INTRODUCTION
The composition of **URGOCLEAN®** includes a new generation of hydro-desloughing fibres with a high capacity to absorb exudate, drain and trap sloughy residues, manufactured with a soft-adherent TLC layer at the wound/dressing interface.

Due to its composition, **URGOCLEAN®** is conformable and the strength of the fibres ensure removal in one piece, even after gelling following contact with wound exudate.

METHOD
Female patient suffering with a leg ulcer situated on the lower right leg.

The duration of the wound was two weeks, prior to using **URGOCLEAN®** a silver contact layer had been used with no signs of improvement.

The patient was followed-up over an eight week period and assessed weekly.

RESULTS
It was reported at the initiation visit that the wound bed was covered in 95% of slough.

Following 8 weeks of treatment with **URGOCLEAN®** the slough had been eliminated.

The level of exudate had significantly reduced from high to low and the odour had disappeared also all signs of maceration had been controlled.

DISCUSSION AND CONCLUSION
This patient had a 17 year history of recurring leg ulcers which the patient had self managed.

Earlier the same year the patient had developed an ulcer on her left leg which was referred to the practice nurses after self treating the wound for the first six months. Over a period of nine months a “cocktail” of dressings were used alongside compression until the wound had finally healed after a total of 16 months.

On development of the second ulcer on the patient’s right leg **URGOCLEAN®** was initiated after 2 weeks, and by week 8 the wound had totally healed, no further treatment was required.

This is a great example of cost effective dressing regime.

The patient’s comfort level with the dressing was excellent, and no pain was caused at each of the dressing changes, the clinician reported the patient felt more comfortable using **URGOCLEAN®**.

**URGOCLEAN®** was easy to remove, managed exudate well and demonstrated a good healing rate.
USE OF URGOCLEAN® IN THE MANAGEMENT OF EXUDING AND SLOUGHY WOUNDS

INTRODUCTION

URGOCLEAN® is composed of hydro-desloughing polyacrylate fibres with a high level of absorption. The degree of polymerisation and the proportion of carboxylate define its properties for smooth and progressive absorption and gelification. As part of a local evaluation, URGOCLEAN® a new hydro-desloughing absorbent dressing for exuding and sloughy wounds was evaluated over a 4 week period.

The objective of this evaluation was to access the reduction in the level of exudate, pain, sloughy tissue and wound surface area in the local management of leg ulcers.

METHOD

83-year-old female patient suffering with a 4 week old traumatic wound to her lower left leg.

The wound had previously been treated with Aquacel, however the wound became sloughy and so the decision was made to change to URGOCLEAN®.

The wound was very wet with 90% slough and only 10% granulation tissue present.

RESULTS

The area of the wound measured at the initiation visit was 4.5cm x 3cm, by week 4 the wound had completely healed.

All slough was eliminated in 4 weeks.

The level of exudate had reduced from high to no exudate.

After using URGOCLEAN® for only 3 days the level of pain reduced from 5 to 3 and after a further week reduced to no pain at all.

DISCUSSION AND CONCLUSION

URGOCLEAN® healed the wound in 4 weeks.

The ability to manage exudate was reported as excellent as was the ease of product application, conformability, and the patient comfort.

No pain was experienced by the patient at any of the dressing changes.
INTRODUCTION

Traumatic wounds have a wide range of aetiologies and the importance of repairing any underlying tissue damage is essential for reducing the risk of infection and promoting good wound healing.

In cases of severe trauma, the regenerative process can be slowed dramatically and despite suturing, still require adequate time for the healing of internal structures, even after the stitches have been removed.

The presence of slough within a wound can delay healing and have a negative impact on both the patient’s quality of life and the local budget.

UrgoClean®, a hydro-desloughing dressing specifically designed for the indication of exudate and slough, provides an effective treatment for dealing with these challenging wounds.

The objective of this evaluation was to assess the reduction in sloughy tissue and wound surface area in the local management of a five month old traumatic wound using this innovative dressing, UrgoClean®.

METHOD

In December 2012, a 78 year old female patient, suffering with Chronic Rheumatoid Arthritis, presented with a non-healing, five month old traumatic wound.

The patient had originally caused the injury by falling in her conservatory and catching her leg on a metal frame. The wound was initially treated with an antimicrobial hydrofiber dressing followed by gauze and pads.

Unfortunately, the patient was admitted to hospital when her COPD deteriorated and whilst in hospital the wound was neglected. It became infected and in May 2013 she was referred to the tissue viability team.

The hospital recommended larvae therapy, however the practice nurses felt this would not be cost effective and the patient was reluctant to try this form of treatment. However, with agreement from the patient, the decision was made to trial UrgoClean®, the new hydro-desloughing absorbent dressing.

RESULTS

Treatment with UrgoClean® commenced on 9th May 2013. The wound was dressed twice a week and by 14th June 2013, five weeks later, the wound had desloughed by 50% and reduced in size by 25%.

On the 12th July 2013 the clinical team agreed that the wound had progressed sufficiently with UrgoClean® to initiate treatment with UrgoStart®, a contact layer containing a healing accelerator.

CONCLUSION AND DISCUSSION

Using UrgoClean® reduced the wound size and percentage of slough dramatically.

It had a positive impact on both the patient’s quality of life and the wound healing process. The results of this evaluation show that this dressing is highly effective and an ideal choice for the treatment of sloughy, traumatic wounds.

Week 0: May 2013

Week 5: June 2013

Week 9: July 2013
INTRODUCTION
Intravenous (IV) drug users are at high risk of developing venous insufficiency by damaging their veins through constantly injecting into them. This can also cause the formation of a thrombosis and may lead to deep vein thrombosis (DVT).

Long-term drug injection can also lead to vascular damage as a result of sclerosis and thrombosis of the superficial veins.

This particular patient group can be very challenging for clinicians, due to non-concordance and refusal to be treated.

Their clinic attendance can also be very erratic and highly disorganised.

Due to the severity of these wounds, the wound bed can become extremely sloughy and delay wound healing.

METHOD
A 34 year old female patient presented with two year-old venous leg ulcers on the right leg. She had a history of IV drug abuse for several years and a medical history of a DVT and endocarditis.

The patient’s leg ulcers were circumferential with 90% slough and 10% granulation tissue.

Previous treatment included an antibacterial hydrofiber, which had resolved the infection with the wound improving slightly to this treatment.

Unfortunately, the patient had psychologically detached herself from the ulceration, refusing to see a health professional for several weeks following its development and had left the dressing in place for four weeks.

It was decided to commence treatment with a 15cm x 20cm hydro-desloughing absorbent dressing (UrgoClean®) on the 10th April 2013. The wound was very malodorous and scored a level 6 for pain by the patient and the dressing was initially changed 3 times a week in order to manage the moderate levels of exudate.

UrgoKTwo®, a two-layer compression system, was also applied.

RESULTS
Following an initial 2 weeks treatment with UrgoClean®, the wound had reduced in size by 1cm both in length and width and the slough had reduced by 10%. A reduction in odour was also noted, which dramatically changed the attitude of the patient.

In comparison to previous dressings used, the clinician found that the UrgoClean® dressing was easier to apply & remove and did not adhere or cause pain on removal.

The patient tolerated the dressing well, felt that it was comfortable to wear and was delighted with the progress of her wound-healing. Unfortunately infection necessitated the use of an antimicrobial but once cleared, the patient insisted on having UrgoClean® reapplied and after 9 weeks from initially commencing UrgoClean®, the slough had reduced by 67%.

CONCLUSION AND DISCUSSION
With this unpredictable patient group it is important to use a dressing that is clinically effective, quick and easy to use, and has minimal impact on the patient’s erratic life-style.

The excellent results achieved with this patient’s leg ulcers, show that the innovative hydro-desloughing dressing UrgoClean®, could provide the ideal solution to a challenging wound-healing problem.
TREATING A PRE-TIBIAL LACERATION WITH URGOCLEAN® FOLLOWED BY URGOSTART® CONTACT

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INTRODUCTION
Pre-tibial lacerations are a common problem, but can become increasingly serious and more difficult to treat in elderly women over the age of 65, usually due to reduced arterial circulation and more friable skin.

On June 10th 2013, when walking on the beach, Mrs W, a 72 year old lady, tripped, fell on a fence pole submerged in a sand dune and sustained a pre-tibial laceration. She went to A&E where the wound was glued and steri-stripped and a dry dressing and bandage applied.

Following her initial treatment, Mrs W presented at her local surgery a few days later with a wound that was red and hot. The nurses felt that there had been a build up of exudate within the wound causing it to become infected and dressed it with a non-adherent dressing.

METHOD
On 24th June 2013, the wound was noted to be sloughy and inflamed so a further course of antibiotics was commenced and the antibacterial dressing Urgotul SSD was applied.

Four weeks later the infection had cleared but the wound was still sloughy. The nurses therefore decided to apply UrgoClean® for its absorbent desloughing properties. Sloughy residue within the wound effectively binds to the fibres and are then absorbed and retained by the dressing to aid slough removal.

By week 8 the slough had greatly reduced and the wound was granulating. The clinicians decided to change to UrgoStart® Contact, a dressing clinically proven to inhibit MMP hyperactivity in wounds, allowing them to progress to full healing.

RESULTS
The UrgoClean® dressing was easy to apply and removed the slough without any trauma to the wound. The subsequent application of UrgoStart® Contact dressing, increased the amount of healthy granulation tissue and effectively reduced the wound surface area. The products were easy to use at the appropriate stages of wound healing. Initially reducing the bacterial burden and the infection, then eliminating slough and finally speeding up the granulation process to healing. Each of the 3 dressings was evaluated for 3 weeks and at the end of this time, the patient felt all dressings had been comfortable and pain free at dressing change.

CONCLUSION AND DISCUSSION
Prior to sustaining the injury, Mrs W's quality of life was good with an active social life. She regularly visited friends and enjoying going on coastal walks. However, the presence of the wound meant she could no longer wear cropped trousers in good weather and had to visit the Leg Ulcer clinic to have the dressing changed, when she wanted to be out with friends. Her quality of life and well-being were severely affected.

Following her treatment at A&E Mrs W had a raised skin-flap and was extremely worried that she would be left with an unsightly scar. However, using the recommended succession of UrgoClean® and UrgoStart® Contact, the scar tissue flattened and the wound healed in a timely manner allowing Mrs W's quality of life to return to normal in a relatively short period of time.
INTRODUCTION
Some wounds can be very challenging for a variety of reasons including co-morbidities, patient concordance and the presence of slough within the wound. Chronic wounds are also known to become ‘stuck’ in the inflammatory phase of the wound healing process, resulting in a negative impact both on the patients’ quality of life and that of all those involved.

It is therefore imperative that the most effective treatment choice is made.

_UrgoClean®,_ a hydro-desloughing absorbent dressing was developed for the treatment and management of exuding and sloughy wounds. Another dressing, _UrgoStart®,_ containing the innovative protease inhibiting compound Nano Oligo-saccharide Factor (NOSF) was specifically developed for chronic wounds which are not progressing through the phases of wound healing.

The objective of this evaluation was to remove the sloughy tissue with the innovative _UrgoClean®_ dressing and progress the chronic wound from the inflammatory phase with the use of _UrgoStart®_.

METHOD
A 63 year old male patient with type II diabetes, hypertension, high cholesterol, obesity, retinopathy, neuropathy and a CVA has bilateral charcot foot which developed ulcers in September 2011. His right foot after partial amputation had healed well but the ulcer on his left foot remained unhealed. Although it had been treated with a variety of dressing regimes, including alginates, iodine and silver over the last 18 months, it remained static with no healing throughout 2012.

The patient therefore agreed to be involved in the evaluation of the _UrgoClean®_ and _UrgoStart®_ dressings.

RESULTS
For 3 months the left foot was treated with _UrgoClean®,_ initially being dressed three times a week then twice weekly until May 2013. Initially the wound measured 200mm x 100mm and there was 80% slough present. On 2nd May 2013 the wound measured 80mm x 15mm and all slough had been removed.

The _UrgoStart®_ dressing was commenced on 2 May 2013 and changed weekly. By 22 August 2013, the wound measured 6mm x 5mm and by October 24th 2013, the wound was practically healed.

CONCLUSION AND DISCUSSION
_UrgoStart®,_ a hydro-desloughing, absorbent dressing reduced the wound size, exudate levels and removed all slough present. The protease inhibitor dressing _UrgoStart®,_ moved the wound forward from the inflammatory phase and continued to reduce the wound surface area dramatically.

The use of these dressings to manage the wound had a positive impact on both the patient’s quality of life and the wound healing process confirming this dressing regime as an ideal choice for sloughy, chronic, diabetic foot ulcers.
MANAGEMENT OF SLOUGHY CHRONIC LEG ULCERS USING URGOCLEAN A HYDRO-DESLOUGHING FIBRE DRESSING

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INTRODUCTION
The modern concept of “wound bed preparation” is to correct any anomalies that might obstruct wound healing at any time. This gives particular importance to debridement and the control of wound exudate.

The prolonged presence of necrotic devitalised tissue or sloughy deposits produced by exudate is one of the main causes of delayed healing. This is due to the chronic inflammation that this triggers and the ever present risk of secondary infection.

The objective of this evaluation was to access the reduction in sloughy tissue in the local management of leg ulcers.

METHOD
Mrs B a 55 year old female with history of depressive disorder, obesity, osteoarthritis and minor anaemia.

A simple trauma to the left leg of this patient led to a chronic venous ulcer of 6 years duration. Patient health is compromised as she is a diabetic type 2, mixed anxiety with depressive disorder and neuropathy in both knees.

Sonography test confirm a tri-phasic wave sound in 2011. A variety of dressing had been used and simple retention bandages applied. Over the following month other dressing regiments were used, infection was managed when present. Throughout this time, it was clear that the dressing being used were not managing the exudates or clearing the thick layers of slough as the patient always came to the clinic with extremely wet bandages, malodour, thick layers slough were not decreasing this was causing the patient more pain and discomfort.

Previous management to prepare the wound bed had not really addressed the holistic management of the patient and ulcer, it had mainly centred on symptom control, therefore we wanted to ensure that all her needs were met.

In November 7 2012 the size of the wound was approximately 10cm length by 13.5cm width the thickness of the slough didn’t make the depth of the ulcer measurable. The ulcer was producing yellow/ green exudate swab carried out confirmed it was sensitive to antibiotic medication.

RESULTS
Having tried several other hydro desloughing dressings it was agreed UrgoClean® could be used as a trial and after the first 5 days of U UrgoClean® the result was amazing. Healthy granulating tissue was visible and exudate level decreased. U UrgoClean® was comfortable and soft with excellent gelling properties providing a moist wound healing environment, a non-woven pad of hydro-desloughing fibres arrange in parallel to the surface of the wound in a structured pattern, which gives U UrgoClean® its specific properties of trapping the sloughy residue from the wound, as well as its resistance to traction, the absorption and drainage of sloughy residue to promote the desloughing phase. It has superior vertical absorption to reduce maceration and form a cohesive soft gel ensuring easy pain free of one piece removal.

At the end of week 4 the slough has dramatically vanished, healthy granulating tissue was clearly visible.

DISCUSSION
UrgoClean® was easily applied, conformed well to the ulcer bed and patient reported it was comfortable.

UrgoClean® managed the exudate and encouraged desloughing of the wound.

The wound bed is now in the healing process and the small ulcer above the ankle is almost healed. The wound progressed to healing without any episodes of infection.

CONCLUSION:
The patient has commented that UrgoClean® is comfortable and eased her pain during dressing change the comfort and pain relief has meant a lot to her and the effective exudate management has increased her confidence when having to travel with other patients to clinic for dressing change this also made it easier for her to be with her family and grandchildren and she was able to do all her Christmas shopping, increasing her general well-being.
THE TREATMENT OF THE AUTO-IMMUNE CONDITION CUTANEOUS POLYARTERITIS NODOSA AND ITS IMPACT ON QUALITY OF LIFE

INTRODUCTION
Cutaneous Polyarteritis Nodosa (C-PAN) is an auto immune condition. It is a rare form of vasculitis relating to the small and medium sized arteries in the dermis. It can result in very painful subcutaneous nodules, increased risk of thrombi, cutaneous ulcers and tissue necrosis. When ulceration occurs they appear quickly and can present many of the challenges related to chronic wounds. These being devitalised tissue, increased exudate, increased bioburden or local infection. A major issue for these patients is the elevated levels of pain that can be associated with the lesions. Being an auto-immune condition medical management along with effective wound management therapy is required. One of the medical treatment options is Low Dose Naltrexone which modulates the immune response. Unfortunately a side effect of this medication is that it decreases the efficacy of opiates analgesia making an already painful condition difficult to manage.

A range of advanced wound care dressings comprising of a Technology Lipido-Colloid (TLC) wound contact layer are available to the clinician. The TLC layer is a wound healing matrix comprised of petroleum jelly particles and hydrocolloid particles. The combination of these substances, when in contact with the wound bed, produce a fine film that promotes an effective wound healing environment. There is evidence to indicate the TLC layer, promotes fibroblast proliferation at the wound bed, promoting the formation of robust granulation tissue. The TLC layer also promotes non adherence to the wound bed, peri wound margins and the surrounding skin. This facilitates atraumatic and painfree removal on dressing change.

METHOD
A 48 year old woman who had been living with C-PAN for 15yrs began to develop very painful vasculitic ulcers bilaterally below the knee in early 2013. These were multiple in number and ranged in size. The patient initially approached the GP and was treated by the Practice Nurse. As the wounds were not improving she was referred to the tissue viability service. The patient was seen twice by the tissue viability nurse and was prescribed a range of products that would facilitate self-management. These included, honey, iodine and silver alginate based dressings along with a silicone adhesive foam dressing. Unfortunately she found it difficult to use all these products due to her pain levels. This was as a result of the products either adhering to the wound, drying out and adhering or developing sensitivity. Pain was also experienced when removing the silicone bordered foam. The effect on her quality of life was severe. She became house bound and her dressing changes were planned well in advance to ensure her spouse was in attendance. The day following dressing change had to cleared as she knew she would not be able to function. This led to the patient using the internet to investigate other potential products that would result in reduced or pain free dressing changes due to non-adherence. After searching the patient discovered the TLC range of dressings and the evidence to support non adherence and atraumatic removal. The patient contacted the manufacturer and was visited by the Clinical Support Specialist (TVN Hon) and assessed and the appropriate TLC products suggested and supplied for the patient to use.

RESULTS
Initially the patient utilised the TLC contact layer UrgoTul®. The patient experienced pain free, atraumatic, dressing changes for the first time. This led to a dramatic improvement to her quality of life both psychologically, physically and socially. The appropriate TLC based wound care product was used at each appropriate stage of wound healing. This included an antimicrobial (UrgoTul® SSD), a hydrodesloughing dressing (UrgoClean®), a wound contact layer (UrgoTul®) and finally a silicone bordered, TLC coated absorbent foam dressing (UrgoTul® Absorb Border). The patient reported that this silicone bordered dressing despite being held securely by the border, was able to be removed from periwound skin without ‘pulling’ and pain experienced with the previous silicone dressing. At present all wounds have healed effectively with exception of one small area.

DISCUSSION & CONCLUSION:
By utilising the range of dressings available with the TLC component not only were the objectives for each stage of wound healing met effectively, with the facilitation of robust granulation formation, but the patient experienced atraumatic, painfree removal. This led to the dramatic improvement in her quality of life and also that of her partner. It also meant that the patient did not have to choose between taking her LDN to manage her autoimmune condition or omit it,leading to increase in C-PAN symptoms, but being able to take opioid based analgesia.
Introduction

UrgoClean is a polyacrylate dressing that desloughs wounds and absorbs exudate. The dressing is coated with Technology Lipido-Colloid (TLC) which stimulates fibroblast activity and collagen production, and therefore speeds healing.

Following a robust evaluation in 2012 UrgoClean was added to the Trust formulary and alginate and hydrofiber dressings were removed. Despite involving clinicians across the Trust, the author felt staff would struggle, as seven products were replaced with two. However staff have never voiced any concerns and UrgoClean has become one of the most used dressings in the organisation.

After three years one may question whether anticipated healing outcomes and cost savings are being realised. Do staff still have confidence in the product?

This poster explores the longer term impact of a change in formulary, the views of those who have direct experience of the dressings and determines benefits or drawbacks to the organisation.

Method

The process for assessment of the efficacy of UrgoClean was:

- Review of patient experiences
- Staff questionnaire
- Cost analysis

Results

Patient Experience

UrgoClean is widely used across the Trust, it is easy to apply and acceptable to patients. It is still used on a range of acute and chronic wounds, with good effect. A total of 2285 UrgoClean dressing were used in the Trust during the last year. Staff report positive feedback from patients and the impact of the dressing remains visible as illustrated in the case study below.

After revascularisation of this foot, John developed a reperfusion injury and extensive ulceration of the lower leg. The wound was slow to heal and covered with a layer of thick slough.

UrgoClean was applied to remove slough, control exudate and promote healing. Within 7 days there was a reduction in the level of slough and good evidence of granulation tissue.

Staff Questionnaire

Initial evaluation identified the difference UrgoClean makes to wounds. As demonstrated in the tables the staff questionnaire revealed that UrgoClean was still used appropriately on all wound types and found to be equivalent or more effective than alternative dressings.

<table>
<thead>
<tr>
<th>Dressing Type</th>
<th>Staff finding UrgoClean Equivalent or Better</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alginate</td>
<td>70%</td>
</tr>
<tr>
<td>Hydrofiber</td>
<td>82%</td>
</tr>
</tbody>
</table>

Cost Analysis

Analysis of usage and spend revealed a cost saving of £5524.50 against the alginate or hydrofiber dressing previously used in the Trust.

Discussion

Formulary changes pose a risk for tissue viability nurses. In the current economic climate, change is seen as a cost saving exercise, rather than a quality initiative.

Conclusion

The analysis suggests the removal of alginate and hydrofiber dressings has not had any negative effects on patients, staff or the Trust, whilst the addition of UrgoClean has resulted in better wound management and healing outcomes for patients. This review has proved useful allowing the tissue viability team to see the true impact of a change in formulary and will be used in future to assess the long term impact of dressings introduced to the Trust.