

P 169

THE MANAGEMENT OF A PATIENT WITH PAINFUL PRESSURE NECROSIS AND EXPOSED TENDONS

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Introduction: This study reviews the case of Mr P, an 81 year old man with a large area of necrosis on the back of his right hand due to a failed venflon insertion for antibiotic therapy. He also had a necrotic left heel as a result of pressure damage. Initially, both of these areas were softened with a 1st generation hydrogel, and then further debrided with larval therapy. Although initially this was found to be efficient, as the tendon that was now exposed in the right hand became dried, the larvae failed to thrive. Tendon tissue is susceptible to dehydration and during exposure quickly loses its viability which inhibits cell proliferation. These effects are counteracted by keeping the exposed tendon segments moist (Abrahamsson SO. 1991)

Wounds with exposed tendon, bone present a difficult treatment challenge, particularly when, as in this case, the wound is also associated with pain. It is vital that exposed tendons maintain a moist environment to prevent desiccation and to allow movement for exercising.

Method: ActiFormCool, a 2nd generation hydrogel, was selected for pain relief and to maintain moisture balance (Hampton S. 2004). The wounds were assessed for pain, using a Pain VAS and were photographed at every dressing change in order to monitor the healing rates.

Results: The exposed tendon remained clean and the wound healed without problem. ActiFormCool provided the ideal wound healing environment whilst still providing pain relief that no other dressing was able to deliver

This paper will describe the care and outcomes for this gentleman

P 170

AN INVESTIGATION INTO PATIENT ADHERENCE USING A NEW TWO LAYER BANDAGE SYSTEM

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Aim: To investigate patient adherence using a new two layer compression system.
Methods: Thirty patients with venous disease were recruited to a pilot open, single centre, cohort, outcomes study for 6 weeks. In addition to self-reports of adherence, wound and skin characteristics were recorded at each visit together with primary dressings and treatment of surrounding skin. Patients were asked to evaluate the comfort level associated with the system, whilst nurses were asked to rate the new system on three key parameters: ease of application, conformability and ease of removal.

Results: At each visit over ¾ of the patients reported wearing the compression system for 75% of the time and were considered by the nurses to be 'fully adherent' for 80% of the time. Of the 134 eligible patient weeks, 69.4% recorded the system as either 'very comfortable' or 'comfortable', 15.7% reported 'fair/unsure' and 14.8% reported 'uncomfortable' or 'very uncomfortable'. Of a possible 121 nurse evaluations, 85.1% recorded conformability as 'easy' and 67.7% indicated that the system was 'easy to remove'. The data report a wide range of dressings were used in conjunction with the system. Patients presented with varying skin conditions associated with venous disease; main treatments for surrounding skin were emollients and steroids.

Discussion: Patients were recruited from a specialist wound clinic and community leg ulcer clinics. These data suggest that patients can adhere successfully to this system in a range of settings. More research is needed to evaluate the optimal combination of primary dressing and skin treatments.