Standing on the shoulders of giants

Wound management, research and education is the business of thousands of professionals across Europe. Nurses in every European hospital need to know about reliable strategies for determining whether their patients are at risk of pressure damage, and cost-effective interventions to prevent pressure damage. Surgeons are faced every day with choices about surgical site preparation, closure techniques, dressings and management of problematic wounds. These decisions require integration of information from research, clinical expertise, patient preferences and the availability of resources. For many decisions there is a shortage of good quality evidence from research and in this situation we need to learn from our own clinical experience and that of others. Sharing experiences by publications such as the EWMA Journal is one approach, face to face, at conferences, such as the forthcoming EWMA / GNEAUP in Granada is another.

The conference will bring together basic scientists, health service researchers, expert clinicians, educators, managers and company representatives. Getting together allows us to get feedback on our work, to identify potential links for collaboration and is an opportunity to share what we have been doing in each of our own areas of interest. So many of the problems we face, be they in research, practice or education, have already been identified and solved by others, so why not learn from them rather than reinventing the wheel. We increase the efficiency of all our endeavours by learning from others’ experience. If wound management is a science, and I passionately believe that it is, then the knowledge underpinning it is formed by the firm foundations provided by the works of others, such as the pioneering works of Gamgee, Nightengale, and Winter, to name but a few.

For the science of wound management to realise improvements in patient outcomes, it needs firm foundations. We must build upon firm science – not what we’d like to hear, but evidence from robust experiments and observational studies. To ensure that decision makers of the future have at their disposal the sum of all relevant information, we need to commit to sharing our experiences, whether they be exciting, encouraging or ‘negative’. Without this, data indicating that therapeutic strategies are not beneficial, are harmful, or are associated with particular side-effects, may not get into the public domain. The healthcare literature contains a number of examples where treatments have been implemented because the science seems to fit rather than the clinical evidence, which shows evidence of no benefit, or even harm (e.g. debriefing people after trauma compared with no debriefing results in increased psychiatric morbidity). In order to avoid this mistake in wound management, we need to develop a culture where research results are published regardless of their findings. A number of developments makes this easier than ever before:

1. prospective registration of clinical trials on http://www.clinicaltrials.com,
2. the Database of Individual Patient Experiences (DIPEx) at http://www.dipex.co.uk, and
3. electronic journals such as BioMed Central (http://www.biomedcentral.com/) where space limitations do not restrict publication of the results of studies according to their results.

We all strive for improvements in wound management, and are seeking to make this a reality by undertaking research, developing practice, and educating the clinicians of tomorrow. We humbly remember that any contribution we make pushing back the boundaries of understanding in wounds is due in part to work done by pioneers in surgery, nursing, public health, health services research, and basic sciences. In the words of Sir Isaac Newton ‘if I have seen further it is by standing on the shoulder of giants’. We are currently standing on the shoulders of giants, hopefully one day the same will be said of our contribution to wound management.

E. Andrea Nelson

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Mölnlycke
Safetac
Health Related Quality of Life Measurement

INTRODUCTION
The ways in which we evaluate the effects of health care interventions are continually developing. It is now common practice for research funders to ask that a systematic review of all the available high quality studies be undertaken to ensure that any proposed investigations build upon existing evidence. The methods used in these investigations are also developing, with increasing integration of patient-based assessments as well as clinical results and laboratory data. Measuring how patients feel about a health problem and the treatments used is no longer regarded as ‘soft data’ i.e. that which is inaccurate and unreliable. The importance of measuring the impact of ill-health and treatment is not simple, but, as clinical challenges include ‘care’ as well as ‘cure’, it is increasingly important that our evaluations of interventions are informed by patients’ views.

DEFINITIONS
Jenkinson and McGee\(^1\) state that while there is no agreed single definition of Health related quality of life (HRQoL), the definitions available include general health, cognitive function, mental health, emotional health, subjective well-being, life satisfaction and social support. This is, in part, derived from the World Health Organisation’s (WHO) definition of health; ‘Health is a state of complete physical, mental, and social well-being and not merely absence of disease’\(^2\) (WHO 1984). Health related quality of life attempts to incorporate both personal health status and social well-being in assessing health.

FROM FOCUSED TRIALS TO POPULATION STUDIES
Assessing the health of particular populations, such as people with skin conditions, can provide information on their health profile and their possible health needs. Such information may be used to determine whether these groups are being well served by current health provision, whether additional services are needed, and at whom they should be targeted. This is particularly important in assessing the burden of illness associated with non-fatal health conditions where considerable morbidity is masked by low mortality. Some HRQoL measures, e.g. the SF-36, have been used on sufficiently large numbers of people so that the results are available for the ‘norm’ values for populations according to age and gender. This allows comparison to be made between populations under study with age and sex matched populations.

Randomised controlled trials (RCTs) are used to evaluate the effect of health care interventions, whether they be drugs, devices, surgical treatments, or new methods of service delivery, such as clinic versus home care for leg ulceration. In some trials, the researchers and clinicians are interested mainly in survival, and the trial is designed to follow-up participants until death. Increasingly, however, the aim of the researchers is to improve the quality of life as well as the length of survival. This has arisen from the finding that patients may find treatments unacceptable, due to side effects, and withdraw from active treatment. In addition, some treatments may not improve survival but have the potential to improve the quality of life remaining. Much of the activity in health care provision is not designed to extend life but to reduce pain and improve quality of life, e.g. joint replacement, cataract removal, and many areas of wound care.

Finally, the use of HRQoL in trials gives us information on the impact of treatment on quality of life, so that if two therapies have similar levels of effectiveness and cost, but have different effects on quality of life, then this important finding can inform the choice of acceptable interventions.

Jenkinson and McGee\(^1\) point out that the increased use of HRQoL measures in trials needs to be balanced by critical appraisal of their use. Guidance on their appropriate use in trials can be found at the end of this article.
ESSENTIAL ASPECTS OF QUALITY OF LIFE MEASURES

Validity
A valid measure is one that measures what it claims to measure. Ideally one would be able to compare a HRQoL measure with a ‘gold-standard’ measure, but this is not usually available and therefore one examines the validity indirectly, by referring to face validity, content validity, criterion validity and construct validity.

Face validity refers to whether a measure contains items that appear appropriate to that which is being measured. It also requires that the items/questions are easily understood and not ambiguous.

Content validity refers to the choice of items/questions in the measure. These are generally developed after searching the literature, and from in-depth interviews of the general public or people with health problems. It is important that concerns of import to many people are included at the expense of rarer concerns, for example if pain is commonly reported on interviews of people with leg ulcers, then a couple of items on this would be included. Weightings are usually applied to items in the measure in order to give more weight to some items such as ‘I worry about my ulcer all the time’ rather than ‘I sometimes worry about my ulcer’.

Construct validity refers to the construction and testing of hypotheses associated with the health condition using the measure. For example, the construct validity of the SF-36 has lower scores (worse health) for older people, and those with illnesses, than for younger people, or those without illnesses.

Criterion validity refers to the ability of an instrument to correlate with other measures used to assess the same people. The presence of a ‘gold standard’ is rare in this area of research. One approach is to record the progress of a health condition, e.g. healing of a chronic wound, and record the concurrent change in the HRQoL measure. There should be agreement between subjective health reports and the HRQoL measure.

Reliability
Measures should be reliable over time, such that they produce similar results when administered on two or more occasions, given that the health of the respondent has not changed. The HRQoL measure, usually a self-administered questionnaire, should be so simple to understand on initial presentation that there is no learning effect thus avoiding a potential change in response unrelated to changes in health condition. This is called test-retest reliability.

The internal reliability (also referred to as internal consistency reliability) is commonly measured using the Cronbach alpha statistic (for items with more than two available responses) or the Kuder-Richardson (KR-20) test for items with only two available responses. The Cronbach alpha is a measure of correlation above that which would be expected by chance. The principle behind these tests is that there should be a high correlation between the results within a questionnaire if all the questions are investigating one area of interest. High values of Cronbach alpha (0.9 - 0.999) may indicate high internal consistency, but might also mean that the same question is being asked more than once.

Sensitivity
A sensitive measure is able to detect change in the target condition. This is also called responsiveness. There are a number of statistical approaches to determining the responsiveness of a measure. These measure, for example, the size of the difference detected by a measure in relation to the variability of the measure. Jenkinson and McGee offer a critique of the methods used. Generic measures of HRQoL may not be able to detect changes in health status in older people associated with, for example, the healing on a wound. This may be because the global assessment of health is relatively unaffected by one discrete health condition. In this situation, therefore, it may be necessary to use both a generic HRQoL measure, to capture changes in overall health, and a condition-specific one, to chart changes in quality of life related to one specific condition.

Generic measures
These measures can be used across a wide range of illness populations as well as healthy populations. Two of these measures have been regularly used in wound care research – The Nottingham Health Profile (Franks et al 1999, Hunt et al 1985) and the SF-36.

The Nottingham Health Profile, a short, self-administered questionnaire, has been used in studies of the general population, in leg ulcer trials, and in many other chronic health problems. The tool is intended to measure perceptions of ill health on six dimensions; pain, physical mobility, emotional reactions, sleep disturbance, social isolation and energy. Jenkinson and McGee report that the measure is good at identifying people with chronic illnesses and distinguishing between different conditions. It has also been translated and therefore can be used in international/trans-cultural trials.

The tool was designed to assess the severe end of ill health and therefore some people measure ‘zero’ when their health is affected a small amount. This ‘floor effect’ means that the tool may not be able to detect changes in health status at the less severe end of ill health.

The SF-36 was developed during the RAND corporation study of the relationship between Health Insurance provision and medical outcomes. This tool had to
be relevant and easily understood by the general population as well as by patient groups. The SF-36 contains eight ‘dimensions’ and a single question referring to the perceived change in health condition over the past year. The dimensions are:

- Physical functioning
- Role limitation due to physical problems
- Role limitation due to emotional problems
- Social functioning
- Mental health
- Energy/vitality
- Pain
- General health perception

More recently, a 12-item questionnaire has been developed, SF-12\(^9\) that produces scores for the same eight dimensions. Comparison between the SF-12 and SF-36 show considerable accuracy, so the SF-12 may be useful in studies where a short, reliable and valid generic health measure is required.

**Disease specific measures**

These quality of life measures are designed specifically to target a particular patient group, such as people with leg ulcers\(^10\). There appears to be a real gap in the assessment of the impact of acute and chronic wounds on quality of life, and reliable tools are badly needed. The development of a disease-specific HRQoL measure with rigorous measurement properties, outlined above, is time consuming, but evaluation of health technologies and methods of delivering care are in danger of ignoring the voice of patients if we cannot reliably collect this information.

**USING REPORTS OF HRQoL**

It is clear that quality of life measures are becoming more widely used and will be included in more trials and, consequently, will appear more in the research literature. The inclusion of these reports will not, on their own, lead to useful information for health care providers and clinicians; the information derived from the measure must also be meaningful, as well as valid and reliable. Fitzpatrick et al\(^11\) undertook a systematic review of the literature on HRQoL measures and have suggested eight requirements for judging the appropriateness of outcome measures in clinical trials. These include:

1. Is the content of the measure appropriate to the questions that the clinical trial is intended to address?
2. Does the instrument produce reliable results (results that can be reproduced and are internally consistent)?
3. Is the measure valid (does it measure what it claims to measure)?
4. Is the measure responsive (does it measure changes over time that matter to patients)?
5. How precise are the scores on the measure (is it easy to administer and process)?
6. How interpretable are the scores on the measure?
7. Is the measure acceptable to patients (is it to too long, potentially distressing)?
8. How feasible is the measure (is it easy to administer and process)?

Jenkinson and McGee\(^1\) suggest that papers that do not attempt to address these issues must be regarded as potentially flawed. This approach to demanding clearer reporting of the methods in trials mirrors the demand for clearer reporting of systematic reviews\(^12\) (QUOROM) and randomised controlled trials (CONSORT)\(^13\).

**CONCLUSION**

The funds available to purchase health care are always likely to be limited and, therefore, the pressure on getting the best health for the population within a limited budget will increase. Evaluating the quality of life of populations, as well as the longevity, allows us to compare outcomes across health conditions and between competing interventions. Valid and reliable tools for measuring condition-specific quality of life are urgently needed in wound management.

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Johnson & Johnson
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The use of Compression Therapy in the Treatment of Venous Leg Ulcers: a recommended Management Pathway

ABSTRACT
Management guidelines have identified compression therapy as the cornerstone in the treatment of venous leg ulcers. An international panel has recently designed a practical and easy-to-use management pathway (management algorithm) focusing on the role of compression therapy in venous leg ulcer therapy. The panel's objective was to provide physicians, nurses and other healthcare professionals with a useful tool in the management of venous leg ulcers. It is hoped that this practical and straightforward approach will ensure that the findings are widely disseminated and implemented. The algorithm is based on a comprehensive, qualitative review of the literature and, where data are lacking, consensus from a panel of international leg ulcer specialists based on their clinical experience.

INTRODUCTION
The appropriate management of venous leg ulcers is a continuing challenge to healthcare professionals, despite the publication of numerous useful management guidelines and systematic reviews.1-8 Approximately 1-2% of the general population suffer from a poorly healing ulcer of the lower extremity in their lifetime.9 More effective management strategies are required which are based on the results of randomised, controlled trials, improved organisational structures and multi-disciplinary co-operation. In addition, it is vital that any evidence-based recommendations are widely disseminated and easily implemented to maximise benefits to patients.

Compression therapy remains the cornerstone of therapy in venous leg ulcers10 and this document provides an up-to-date, qualitative overview of the literature and expert consensus on the use of compression therapy in the treatment of venous leg ulcers. This work was carried out by a distinguished international, multi-disciplinary group and aims to continue and expand on the excellent work reported in previous guidelines, in particular the RCN and SIGN guidelines.1,2

The main outcome of this co-operation was to produce a management pathway (management algorithm) designed for easy implementation by physicians, nurses and other healthcare professionals. The algorithm is based on the best quality data reviewed in the current literature, and where this was not available, on consensus opinion from experts in the field. These findings have already received additional input from other healthcare professionals at a recent international symposium. It is hoped that this algorithm will be a useful tool in improving the management of venous leg ulcers.

METHODS
A literature search using MEDLINE and EMBASE was carried out from 1966 and from 1974 respectively using the keywords: compres-

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These recommendations were compiled by an international expert panel, with complete editorial freedom. All panel members have collaborated on this project without remuneration. A small, unrestricted educational grant was provided by Smith & Nephew Medical Ltd and used by the panel for co-ordination and communication.
sion therapy/treatment, venous leg ulcers, clinical paper/article/trial or review, and selecting human, priority journals. Relevant journals and conference proceedings from the past five years were manually searched and reviewed for relevance. Existing guidelines such as the RCN and SIGN guidelines provided valuable information. The panel members also contributed additional papers. An experienced clinical researcher in the field provided a large number of publications in non-English language journals. Nearly 150 papers were selected for detailed review and were graded using a hierarchy of evidence, tool-based on an example by Guyatt et al. (Figure 1). These papers provided the evidence base for the algorithm. A full list of references reviewed is available on request.

The panel drafted a management algorithm that was discussed at a meeting in September 2001, and the algorithm was subsequently presented for comment at an international symposium during Innovations in Wound Care Week in Cardiff UK.

Definitions
There remains some debate on the definitions of certain aspects of compression therapy. For the purpose of designing the management algorithm, the panel agreed on a number of terms (Figure 2). Elastic compression (long-stretch) bandages exert high compression during rest and exercise whereas inelastic (short-stretch) bandages produce passive compression mainly when the calf muscle contracts, increases in volume and creates pressure against the bandage. At rest, inelastic compression bandages exert pressure dependent on the tension used during application.

MANAGEMENT ALGORITHM
The panel designed a management algorithm based on a review of the available literature and expert consensus (Figure 3). In order to ensure ease of use and effectiveness, the algorithm has been kept as simple and straightforward as possible. The algorithm can be broken down into four stages: Assessment, Diagnosis, Recommendations for treatment, and Outcomes.

Assessment
Accurate assessment is necessary to ensure the correct aetiology of the ulceration and to exclude those patients with arterial disease for whom compression is dangerous. There are a number of non-invasive methods used to confirm venous disease when a patient presents with suspected venous disease. Methods of assessment include:

- Hand-held, continuous-wave Doppler ultrasound measurement of ankle brachial pressure index (ABPI). This is regarded as the most reliable way of detecting arterial insufficiency, however, in patients with diabetes Doppler waveform analysis and toe pressure measurements are the more reliable methods.
- Duplex ultrasonography, that measures blood flow velocity through a vessel, is the primary method of identifying venous obstruction or abnormal venous reflux.
- A number of plethysmographic methods, including air and photo plethysmography, which may be used to assess venous function.

A number of other investigations should take place to exclude other disorders such as rheumatoid arthritis, diabetes, renal failure, anaemia, tumours and autoimmune disorders.
Diagnosis
Following assessment, the patient with a leg ulcer can be assigned to one of five groups. In brief, patients with a venous leg ulcer require compression therapy, those with an arterial leg ulcer or with a significant arterial component require referral to a vascular specialist. Patients with mixed arterial and venous ulcers require reduced compression therapy with referral to a vascular specialist, particularly if there is pain at rest. Patients with ulcers from other sources require disease-specific treatment and compression therapy for oedema control.

There remains some debate on the definition of arterial insufficiency by ABPI and the scope of the mixed arterial/venous ulcer groups was agreed based on the panel’s clinical experience rather than demonstrated in the literature.

Recommendations for treatment
This algorithm focuses on the appropriate use of compression therapy in the treatment of venous leg ulcers. It is widely accepted that sustained compression provides the mainstay of treatment in venous leg ulcers. This should be supported with adjunctive medical and surgical therapy, appropriate dressings and patient education.

Sustained compression is provided by multi-layer elastic or inelastic bandage systems. There is now considerable evidence to show that this form of sustained high compression improves ulcer healing and provides quality of life and cost benefits. Three systematic reviews have shown that compression therapy does increase the healing rate of venous leg ulcers. Multi-layer high compression bandaging improves healing of venous leg ulcers when compared with single layer, low compression bandaging although there is little reliable evidence, to date, of large, randomised, controlled trials which directly compare 4-layer compression to 3-layer or 2-layer bandaging. To date, there is insufficient data to suggest a difference in benefit in terms of ulcer healing between elastic and inelastic compression.

These multi-layer bandage systems are complemented by reduced compression systems (15-25 mmHg) for those patients who cannot tolerate high compression systems, and compression stockings. Intermittent pneumatic compression (IPC) is a useful adjunct to multi-layer compression and has been shown to improve ulcer healing rates when used with multi-layer compression.
Medical and surgical treatment: There are a number of adjunctive medical therapies that are currently in use without unequivocal support in the literature. Discussion of these therapies lies beyond the scope of this paper. There is also increasing realisation that chronic wounds, such as venous ulcers, benefit from an overall approach aimed at optimising the wound bed. This approach, termed wound bed preparation, includes a number of aspects critical to wound care, such as elimination of excessive exudate and bacterial burden, debridement and elimination of necrotic tissue, angiogenesis and the formation of a wound matrix that promotes re-epithelialisation.

There is also emerging evidence that skin substitutes may be beneficial in the treatment of hard to heal venous leg ulcers (especially in those with duration >1 year) when used in conjunction with multi-layer compression bandaging. Other biological agents, such as growth factors and protease inhibitors are currently being evaluated for their efficacy in the management of venous leg ulcers.

Many patients with leg ulcers suffer pain that can adversely affect quality of life and may influence speed of healing. Reduced compression should be used until pain and oedema resolves and then high compression bandaging can be introduced. In most cases, appropriate dressings or oral analgesics can effectively manage pain although skin grafting may be required in cases of intractable pain.

Appropriate dressing selection: Patients with leg ulcers are prone to contact sensitivity particularly from wool alcohols, topical neomycin, framycetin, cetylstearyl alcohols and rubber mixes which are present in many dressings, ointments and creams. Emphasis should be placed on allergen avoidance to allow optimal wound healing. However this remains a difficult management issue in individual patients.

Education: Factors that encourage ulcer healing, such as improved nutritional status, appropriate bandage use and mobility, are dependent on patient involvement. Education to improve patient understanding of the condition will aid compliance to therapy.

Mobile and immobile patients: Reduced mobility and reduced ankle function, as well as other factors such as ulcer size and duration, have been shown to independently affect healing rates. As inelastic bandages lose pressure when leg oedema is reduced, multi-layer (elastic) compression is recommended as first-line therapy for immobile patients with venous leg ulcers. However, these recommendations are based on expert opinion rather than being demonstrated conclusively in the literature at this stage.

Elastic stockings can be used as second-line therapy in mobile patients, particularly those that are young and working, who are unable or unwilling to tolerate multi-layered compression.

Reasons for referral: Patients should be referred for specialist opinion in a number of cases (see ‘Reasons for referral’ box). If a patient is unable to tolerate compression a specialist may be able to identify the reason for the problem, and then take the patient through a process to temporarily reduce compression, control pain, educate patient in the importance of sustained compression, and then re-instate treatment.

During acute infection patients with venous leg ulcers may require reduced compression for a period of time. The level of compression should be tailored according to symptoms such as the level of pain.

Outcomes
The panel has recommended a definition of failure to heal as no reduction in ulcer size in 1 month. Patients with ulcers <10 cm² who have failed to achieve complete healing in 3 months should be referred to a specialist for re-evaluation including diagnosis and re-assessment and evaluation for surgical correction of any venous abnormality. Patients with ulcers >10 cm² are likely to take a long time to heal and skin grafting may be required.

Following healing of the ulcer, steps must be taken to minimise the risk of recurrence by using compression hosiery and maintaining education and support to the patient. Control of oedema by elevation and use of compression hosiery for life may be required. Compression hosiery should be applied at the highest level of pressure subject to patient compliance and dexterity.

Conclusions
This new algorithm, based on a comprehensive review of the literature and expert consensus, confirms the role of sustained compression (elastic and inelastic) as first-line therapy for venous leg ulcers.

Reduced compression and compression hosiery are useful alternatives in those patients with additional arterial disease or who cannot tolerate multi-layer bandaging. Intermittent pneumatic compression is a valuable adjunctive therapy in the treatment of venous leg ulcers although there is a need for further evidence-based findings on these techniques.
In addition, there is a need for further randomised, controlled trials on the other medical and surgical therapies to be used in conjunction with compression therapy.

It is hoped that this algorithm provides a useful working tool for primary care physicians and nurse practitioners to provide appropriate care based on the latest findings in the literature.

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The Professional Role and Competence of Tissue Viability Nurses in Finland

SUMMARY
In Finland the post of Tissue Viability Nurse (TVN) is unspecified. Despite this, in hospitals and health care centres, there are nursing professionals working who are responsible for the development of wound care practice. These nurses are called TVNs. The aim of this study was to describe the professional role, as well as the competence of TVNs in Finland. The data of the study was collected in Spring 2000 by survey. The questionnaires included structured and open-ended questions. The open-ended questions were analysed by content analysis. Statistically data was inspected by SPSS 10.0. The TVNs were predominantly specialised nurses, with considerable working experience (mean 16.5 years), but the time in the post of TVN was not that long. For over half of the TVNs it was under 6 years. The role of the TVN was described in four categories: general, special, independent sphere of action, and co-operation. Accordingly, the study of the role of TVNs included the role of Clinical Nurse Specialist (CNS).

It was found that the role of the clinical practitioner was dominating while the role of research had a minor part. The professional education for TVNs needs to be developed so that the theory and clinical practice of wound care can be integrated.

During the past five years wound-care has become an important issue in Finnish health care. One reason for this is that modern wound-care products are available in all parts of the country. Another reason is that the number of wound patients has increased, especially in primary health care. At the same time, in nursing, there has been a debate on the role and competencies of Clinical Nurse Specialists, who are working, for example, among diabetes, asthma and rheumatoid arthritis patients. Their role is defined. Also the need for TVNs has been recognised and in many hospitals and health care centres there are nurses working as professionals who are responsible for the development of wound care. Despite this, the professional competence, role, duties and responsibilities of TVN are still unofficial and undefined. The aim of this study was to describe the professional competence and role of TVNs in Finland. The principal for the study was the Finnish Wound Care Association, which, in co-operation with Mikkeli and Oulu Polytechnics, has developed specialist education in Wound Management in Finland. The part time courses in Wound Management for registered nurses have been implemented since autumn 1999. The courses last one year and incorporate 800 hrs of student work.

The survey of TVNs was implemented in Spring 2000. The purpose of the study was to describe the working history, educational background, role and preconditions of those nursing professionals who are working as TVNs in Finland.

The research questions were:

- What is the educational background and working history of nursing professionals who are working as Tissue Viability Nurses?
- What does a TVN’s work involve?
- What kind of support do TVNs get from their superiors?
- What kind of preconditions do TVNs expect from their work to be able to further develop their professional competence and skills?

The data was collected by survey with structured and open-ended questions. The structured questions considered the TVN’s age, sex, workplace, basic education, nursing speciality, work experience and time in the post of TVN in years. The open-ended questions included questions on the TVN’s role and the improvements that they have
made during their TVN career. The open-ended questions considered the received and expected support from their superiors. The questions were also formulated to include the references used by the TVNs and the expectations for further education.

The coded questionnaires were sent to administrative nurses in all university and central hospitals, five district hospitals and 31 wards or home care units in primary health care in Finland. The administrative nurses were asked to give the questionnaires to the TVNs in their organisation. This way the nursing professionals who were nominated as TVNs were recognised for the study.

After three weeks, those organisations that had not returned the survey were sent a repeat survey. In total 123 questionnaires were sent, of which 84 were returned. The data was statistically analysed by SPSS 10.0 for Windows. The open-ended questions were analysed by content analysis. The main categories were formulated according to the research questions and the sub-categories were developed inductively from the data. All categories were coded as a variable in SPSS. The total number of variables was 115. Statistically data was inspected with frequencies, percentages and means.

Figure 1 shows the numbers of sent and received questionnaires from different provinces of Finland.

The study covered TVNs in the whole of Finland, and 68% of questionnaires sent out were completed and returned. The results of the study will be presented according the research questions.

EDUCATIONAL BACKGROUND AND WORKING HISTORY OF TVN

Most of the TVNs were female (81 of 84). Only three of them were male. The average age of a TVN was 43 years with the youngest being 26 years old and the oldest 58 years old. The educational background of TVNs showed that 40 were Specialised Nurses and those mainly having specialised in surgical or surgical-medical nursing. Twenty-four TVNs were registered nurses, seven were public health nurses and twelve were practical nurses. Only one of the TVNs had university education, an MNSc. The TVNs worked in both specialised and primary sectors with 46 being specialised (46) and 38 in primary health care. In specialised care most of the TVNs (48) worked in surgical departments. Two TVNs were working in paediatric units and two in intensive care units. Most TVNs had been qualified for many years, the average being 16.5 years. The time period in the post of TVN was less than six years in over half the cases.

Some TVNs reported that they had had further wound care education mainly from one or two day seminars, which were arranged by the Finnish Wound Care Association. In addition, the manufacturers of wound care products were reported to be providers of education. Five of the TVNs had studied Wound Management at polytechnic level.

One third of TVNs reported that they had not been formally appointed the post of TVN. To quote an example:

“I just got the tasks because of my own interest.”

The nomination for the post of TVN was in most cases through a ward sister. In ten cases the nominator was an administrative nurse or medical doctor. In five cases the tasks of TVN were included as a part of infection control.
ROLE OF TVN

The role of the TVN was described in four categories: 1. General, 2. Special, 3. Independent sphere of action, and 4. Co-operation.

1. The general sphere of action included eight categories to describe the work of a TVN. (Figure 2)

The work of TVNs was mostly very practical and included treatment of wounds and decision-making on wound care products. The TVNs stressed their wound assessment skills. Also education of the nursing staff was an important area in the TVNs' work. Some of the TVNs had participated in organising regional network education for the treatment of leg ulcers and had lectured in nursing schools. The role of patient education was not as dominant as expected. It was merely mentioned and not described in detail. Research and developmental activities were mainly described as being pilot case studies of wound-care products. Only one TVN described having participated in a multi-scientific research project on wound management. Consulting was done internally and outside the TVNs' own organisations and TVNs reported an increased amount of telephone consulting.

2. The special sphere of TVNs was described through 10 sub-categories, which are listed in table 1.

3. The independent sphere was divided into six subcategories including decision-making on the wound-care products, educating the patients, educating the patients’ relatives, educating the nursing staff, developing wound-care instructions, and patient education material.

4. TVNs co-operated a great deal with other health professionals, especially with doctors and nurses in the clinic or ward where they worked. Also, co-operation with other TVNs and nurses in home care units was reported. The main form of co-operation was consulting and advising on treatment of wounds and selection of wound-care products.

The TVNs described many improvements that they had made. On a general level, they reported that the attitude toward wound management has become more positive in wards and clinics where they work. They also described very concrete and practical improvements, which had been made, like changes in wound treatment routines, better
the study covered TVNs working in specialised and professional development of TVNs. The study was qualitative, Finland. It also described the preconditions for the professional role and competence of TVNs have been developed. The repetition of the survey enables the following up of the development of TVNs’ educational background, nomination, role and preconditions for their work. The questionnaires can also be translated into other languages to allow transnational comparison of the role and competence of TVNs.

Based on the results of the study it can be recommended that the role and competence of TVNs be defined nationally. The educational criteria of TVNs should also be defined nationally. If TVNs are aiming to achieve the position of CNS (Clinical Nurse Specialist) it is extremely important that the competence and skills required, as well as the qualifications needed, are defined. Specialised education combined with solid working experience in wound-care should qualify a TVN. In the United Kingdom, TVNs are normally educated in universities7,8.

In Finland the aim is to educate TVNs in polytechnics on a post-graduate qualification course for RNs. The first courses for TVNs have already been implemented and the feedback from the students has been very positive.

This was the first survey of TVNs in Finland. Based on the results of this study, questionnaires for the professional role and competence of TVNs have been developed. The role within the educational strategy on theTVN. Journal of Tissue Viability 1998, 8. 9-11.

References
7 Waterlow, J.A. A regional study days. The role within the educational strategy on the TVN. Journal of Tissue Viability 1998, 8. 9-11.

TVNs reported that they used references from the national multi-professional journal “Haava” (Wound), leaflets and material produced by product manufacturers, and basic nursing study books. Only nine of the TVNs reported that they read international professional journals and publications on wound-care. All TVNs wished for further education with seminars and study visits mentioned most frequently. Specialist education was reported as being expected in the future.

DISCUSSION AND CONCLUSIONS
The study described the role and competence of TVNs in Finland. It also described the preconditions for the professional development of TVNs. The study was qualitative, however, the number of TVNs participating in the study was not very high and this limited the general conclusions that could be made from the results. On the other hand, the study covered TVNs working in specialised and primary health care across the whole of Finland. TVNs from 50 different hospitals and health care centres participated in the study. This increases the reliability of the study1.

The study showed that the competence of TVNs varies considerably. Educational background was very varied and few TVN had formal qualifications in wound-care. According to the study, a Finnish TVN has the role of Clinical Nurse Specialist including clinical practice, education, consulting, research and administration3,4. The role of clinical practice was dominant, but also the roles of educator and consultant were very clearly defined in the study. The role of research was minor. One reason for this might be that the TVNs had been appointed because of their clinical experience, rather than any research-based qualifications.

Figure 3: Reported improvements by Tissue Viability Nurses described by categories in percentages (n = 145)
Coloplast
Better Outcomes
Convatec
Versiva
A Review of Advances in Fungating Wound Management since EWMA 1991

INTRODUCTION
This review includes advances in the topic of fungating wound management, and their status in terms of evidence-based practice. They were accessed from published research findings. The mainstays of the management of fungating wounds comprise treatment of the underlying tumour; symptom control; local wound management and supportive care to the patient and family. The review is presented in chronological date order. Where there was more than one publication on a topic the articles were grouped. Overall there were a small number of publications, which were diverse in both content and the discipline of the authors.

METHOD
A key word search was conducted of the following databases: BioMed CancerLit; BioMed CINAHL; BioMed MEDLINE; and internurse.com; together with a scan of recent wound care and palliative care journals. This search updated a comprehensive literature search undertaken in August 1999 prior to submission of the author’s PhD thesis on the palliative management of fungating wounds. The review does not constitute a systematic review but covers key published work on this topic since 1991.

CONTENT OF THE REVIEW
Fungating Wounds
- a Research Priority for Palliative Care
A key advance since the retrospective survey conducted by Thomas is the selection of the topic as a research priority in a Delphi study. The aim of the study was to identify ten research priorities for the five major disciplines involved in the specialty. The topic of fungating wounds reached the final round of research priorities identified by the Palliative Nursing Group and was defined as follows:

“... Compare a selection of treatments and dressings available for fungating wounds in terms of preventing and controlling odour, patient comfort, control of bleeding, infection, exudate ...”
(Cawley and Webber 1995 Table 5 p. 106)

The Management of Malodour
Malodour is a key, distressing feature of advanced malignant wounds and one that is difficult to control. A further advance is therefore the literature review of the use of metronidazole in the treatment of malodorous malignant wounds by Hampson. A number of limitations were identified of current approaches to managing odour, the evidence base for these approaches, together with suggestions for problem-solving research. For example, Hampson found that the data specifying the chemical nature of wound malodours are limited and contradictory with no cause and effect relationship established. Overall the conclusion was drawn that the justification for prescribing metronidazole is mainly anecdotal and therefore further research and changes in practice are needed.

The Management of Cutaneous Pain
The management of pain requires identification of the receptors responsible for the pain so that appropriate analgesia may be prescribed. Topical opiates are increasingly being used to palliate nociceptive pain and stinging from damaged and ulcerated skin. Their effects have been evaluated in a series of uncontrolled case studies. Clearly the findings from such case studies need to be treated carefully and not transferred directly to another patient with painful lesions before an accurate diagnosis of the individual’s problem is made. There is however increasing theoretical understanding of opiate sensitive pain. This theoretical understanding together with the appropriate treatment can be transferred, or generalised, from one patient to another as opposed to a direct trans-
fer of treatments between patients with no theoretical explanation of why this may be appropriate.

The Application of Honey for Debridement and the Management of Malodour

Recent laboratory studies demonstrate the antibacterial activity of honey from the Leptospermum species in Australia and New Zealand. The clinical advantages of using honey for fungating lesions appear to include clearance of infecting microbial strains, removal of necrotic tissue and malodour, and an anti-inflammatory action with reduced oedema. At present in the UK honey for medical purposes is not widely available. However the accumulating evidence to support its use in the treatment of haemorrhagic lesions associated with meningococcal septicaemia and chronic wounds, including fungating wounds, may change this situation.

Pilot Study of a Malignant Cutaneous Wound Staging System (MCW)

The potential advance of this study is a staging system and therefore a common language for exchanging clinical information, and for the longitudinal evaluation of outcomes. The study objectives were to determine the colour, size, hydration and general appearance of malignant wounds; the effectiveness of using digital imagery to quantify wound characteristics; and the feasibility of a staging system. The staging system presents a four-stage progression of a malignant lesion with progressive destruction of the basement membrane, including the symptoms that need to be managed. The authors concluded that photography is an effective method of data collection, outcome measurement and longitudinal evaluation. In addition they considered that although the study was limited (N = 17 wounds, 13 subjects) the characteristics of malignant wounds could be classified into four distinct stages, which are summarised as follows:

Stage 1: Closed wound/intact skin
Stage 1N: Closed wound/superficially open/hard and fibrous
Stage 2: Open wound/dermis and epidermis involved
Stage 3: Open wound/full thickness skin loss of subcutaneous tissue
Stage 4: Open wound/invasive to deep anatomic structures

Further testing of this staging system is needed however. For example the findings of the author’s study indicate that all four of the above stages may be found concurrently on a single patient with a rapidly changing, progressive pattern of disease, which may limit the utility of the system.

An Evaluation of the Palliative Management of Fungating Malignant Wounds, within a Multiple-Case study Design

This project focused on the palliative management of fungating malignant wounds. Individual experiences, from forty-five participants, of living with a fungating wound were followed in a multiple-case study design. The study evolved through three principal phases: quasi-experimental design, emergent collaborative design, and emergent theory-driven evaluation. The radical departure from the initial research approach was in response to the methodological problems encountered in a study of individuals with uncontrolled disease.

The study had a dual focus. The first was methodological and the second concerned the generation of explanations for dressing performance and the management of fungating wounds. The methodological aspect included the development of the TELERT™ system of treatment evaluation, as a method of measuring dressing performance against goals of optimal practice in fungating wound management. The system of reasoning was developed as an analytic strategy for abstracting general issues from individual case study data to construct explanations. The latter were generalised beyond the individual cases with the use of theory.

Two forms of explanation for fungating wound management were constructed. These include explanations of the individual experiences of living with a fungating wound and knowledge of the elements of fungating wound management. The impact on the individual of a fungating wound was explained in terms of the stigma attached to public disability and a general revulsion in society for uncontrolled body fluids. A pivotal relationship emerged between exudate and the other wound management problems, including the psychosocial aspects. A final critical explanation was developed for the qualification of the currently accepted moist wound healing theory to explain the phenomenon of exudate management in fungating, and possibly other exuding chronic wounds.
The potential advances from this study are therefore a methodology for those complex situations where the control of variables is not possible but where specific and rigorous evidence, capable of generalisation, is needed. In addition the explanations of dressing performance indicate where there are anomalies in dressing performance for exudate management for fungating wounds, particularly the impact of low moisture vapour loss from current dressings on the accumulation of exudate under the dressing. They therefore form a basis for new approaches, including product development, for exudate management.

A Topical Palliative Treatment for Skin Metastases from Breast Cancer

Miltefosine (ASTA Medica) is a palliative, topical cytostatic treatment for skin metastases from breast cancer, currently undergoing clinical trials. Tewogt et al.17, for example, conducted a phase II trial of topically applied miltefosine solution to patients with breast cancer and skin metastases. Thirty-three patients entered the trial and were evaluated over 8 weeks. A response rate of 43% for thirty evaluable patients of which 23% was complete and 20% was partial. Toxicity included localised skin reaction controlled with a paraffin-based skin cream17. Further trials are ongoing with a view to obtaining a license. The potential advance of Miltefosine is an application that may check tumour progression through the skin without the side effects associated with systemic anti-cancer agents.

Ethnographic Study of the Dying Process

Lawton’s study within a hospice setting gives a profound insight into the loss of ‘self’ associated with the destruction of the body through invasive disease. Lawton18 viewed hospices as institutions in which a particular type of bodily deterioration and decay is set apart from mainstream society. She observed that most symptoms requiring ‘control’ appeared to share a distinctive feature in common: they were associated with, or caused, a rupturing and breakdown of the surfaces of a patient’s body. As a consequence, fluids and matter normally contained within the body were leaked and emitted to the outside, often in an uncontrolled and ad hoc fashion (p. 128). Lawton’s contribution to the topic of fungating wound management includes a critical insight into the reaction of individuals and society at large to the consequences of disfiguring illness18.

Survey of Dressing Usage for Malignant Wound Management

Wilkes et al.19 used a modified version of Thomas’2 survey instrument to determine what nurses use to dress malignant wounds. The survey is the first part of a three-phase study and adds an international perspective to research on the topic, as it is conducted in New South Wales, Australia. The second phase will explore decision-making in relation to wound care with expert palliative care nurses. The third phase will determine how patients cope with fungating wounds through qualitative interviews. The researchers present evidence of the complexities faced by nurses in selecting dressings. Additional qualitative data reveal major unsolved issues that include odour management and meeting the costs of dressings. The researchers also concluded that there are no clear recommendations to guide nursing practice19. This study advances knowledge of the outstanding problems in malignant wound management and provides a framework that may contribute guidelines for best practice.

Wound and Symptom Self-Assessment Chart (WoSSAC)

Naylor et al.20 published the above tool in the Handbook of Wound Management in Cancer Care. The Handbook is in itself a useful resource in meeting the goals of evidence-based clinical practice. The self-assessment tool was developed by one of the authors for a degree dissertation but has not been validated. The tool is comprehensive and includes self-assessment of a number of symptoms such as pain and bleeding, together with issues concerning the intrusion of dressing changes and the level of social support given. In addition the respondents are asked to quantify feelings of shame, guilt, embarrassment, appearance and impact on relationships with a partner. These psychosocial aspects may be derived legitimately from the literature and located in accumulated professional experiences of helping patients with advanced wounds, such as fungating wounds. However it may be inappropriate to assume that such highly personal feelings are generalisable to a population of patients. In effect the questions impose on the patient attitudes that Lawton18 identified as prevalent in society at large, that may culminate in a loss of ‘self’ in the face of disfiguring illness. Although this tool may in the future constitute an advance in the assessment of fungating wounds it would have been better not to publish it before validation, particularly before its acceptability to respondents is demonstrated.


dash
SUMMARY AND CONCLUSIONS

In this review an advance in fungating wound management was the priority accorded to the topic in a Delphi study of research priorities in cancer and palliative care. The literature review on metronidazole challenged current approaches to the management of odour and suggested new lines of inquiry. The theoretical work on the antimicrobial action of honey, together with clinical insights from Dunford et al on the debriding and dedodorising effects of honey from the Leptospermum species indicated potential problem-solving research for this distressing problem. The studies on the analgesic properties of topical opiates contributed theoretical and case study evidence of a useful symptom control measure for cutaneous pain. Clinical trial data for a topical palliative treatment, Miltefosine, show a promising advance in terms of an agent to check skin metastases from breast cancer. The author’s study contributed a novel approach to generating clinical evidence of fungating wound management, together with explanations of dressing performance and the qualification of moist wound healing theory to accommodate exudate management in fungating wounds. Lawton’s ethnography into the dying process in a hospice explained current attitudes towards illness, which can lead to the loss of ‘self’ in the face of the kind of bodily deterioration evidenced in fungating wounds. A staging system and a self-assessment tool for malignant cutaneous wounds have the potential to foster a common approach to describe fungating wounds, evaluate progression, and interventions. However limitations in the application of both instruments were found. The replication of Thomas survey by the Australian authors increases understanding of this topic at an international level.

The main stays of the management of fungating wounds are anti-cancer treatments, symptom control, local wound management and supportive care. Lawton’s study indicated that body boundaries could be reinstated by effective symptom control. Since 1991 there has been a lack of advances in clinical management options, particularly with regard to wound dressings. In a free paper to the EWMA 1991 conference the author concluded: “...the examples given demonstrate the inability of dressing materials to conform to the shape of the body and to absorb exudate effectively...” (Grocott 1991) p 88-91.

The following key conclusion was drawn in the qualitative evaluation study (Grocott 1999): “...a pivotal relationship between dressings and exudate was found, which accounted for a significant number of problems identified for fungating wound management, including the psychosocial impact of living with an uncontrolled wound...” (Grocott 1999) p 223.

Key advances in the management of exudate from 2001 onwards may be derived from a collaborative project into the objective assessment of dressings for chronic wound exudate management. The Engineering and Physical Sciences Research Council are funding the project.
Pegasus
Arjo
Tailored Care
Wound Management in Home Care in Italy

BACKGROUND
When the Nurses Association for the Study of Skin Wounds (A.I.S.Le.C) was founded in 1995, it set its objectives as promoting the quality of care through extensive research using data from Italy and abroad. AISLeC has trained over 7000 health professional in seven years of work and three studies have been conducted involving a total of 1760 colleagues and 8240 patients from 297 wards. From these studies we’ve been able to see if the position of the patients was changed at regular intervals while confined in bed, be it by their own power or assisted by health professionals. We checked if anti-pressure sore beds were used and which medications were used. We also evaluated the level of assistance given to patients in home care treatments. We have looked at mobilisation and the use of assistance for preventive treatment of pressure ulcers in home care.12.

These studies have enabled us to inform the Italian people and the Italian Health Ministry about this important problem and to improve quality assurance.

PREVALENCE OF PRESSURE ULCERS
In Italy in 1984, 8.6% of hospital patients had pressure sore lesions3. This caused their hospital stay to increase by 69 days and it also increased the cost by 7 million liras per lesion4. The total cost of medical care for these problems was more than 5000 billion lira. AISLeC research has also demonstrated that the prevalence of pressure ulcers in Italian hospitals was increasing; 50% more patients in hospital had pressure sores in 1994 than in 1984 (from 8.6% in 1984 to 13.2% in 1994)1. This continues to increase, and the study conducted in 19972 has shown the prevalence of pressure sore lesions to be 18.3% for those in the hospital setting and 32.19% for those in the home care environment.

When we consider other skin lesions, we have a similar incidence to the rest of the developed world. We know from the literature on this topic that vascular lesions afflict 1% of the adult population5. Among those less than 40 years old the prevalence is low, but it increases with age, reaching its peak among those in the age group 70 to 90 years with a female to male ratio of 3:1. These figures are comparable to those found in Italy.

It has been stated that the “skin care” problem will literally be “a demographic time bomb”6 for industrialised countries, because of the ageing population. The over-65 age group (presently 20%) will double in the forthcoming years putting great emphasis on skin care. These figures motivated us to conduct this study.

Research objective: To promote quality assistance in home care for wounds and skin care.

Rationale for the study:
- Poor knowledge of professional healthcare givers about pressure ulceration
- High costs for administration care and population
- Lack of studies on this matter in home healthcare
- The desire of the Italian health administration to improve home healthcare

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(14 hereof University
courses on wound-care)
President of AISLeC
(Nurses Association for
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From 1995 Honour
member of AIUC (Italian
Ulcer Society)
EPUAP Trustees Member
of Commission Research
of Italian Nurses Council
Coordinator in nursing
research projects (three of
these multicentered with
30, 35 e 22 Hospitals)

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S. Bonelli
M. Bergognoni
A. Calosso
P. Deriu
E. Zanetti
M. Bonvento
A. Cavicchioli
**Purpose of the project:**
To estimate the size of the chronic skin lesion problem and report how personnel responsible for providing home health care assistance perceived it.

**Description of the project:**
The project was to:
- determine the prevalence of cutaneous lesions
- determine which medical treatment and procedures were used
- determine how detailed nurses’ knowledge was on the topic of chronic wounds, the different types of skin lesions and their management

**Methodology**
Much of home health care in Italy is delivered by lay carers, therefore we decided to divide the work into two parts.

In the first part, nurses were asked about the organization of homecare assistance and about the carers’ knowledge of the state of health of their patients.

After the first survey was completed the carers were given material regarding epidemiologic research. In addition, a copy of the Norton Score, the NPUAP evaluation scale on wounds, together with other instruments were handed out to everyone to facilitate the comparison of this data with that of previous studies.

**Outcomes of the project:**
- Instructions for health personnel on how to administer the medical treatments by means of workshops and wound healing courses
- Publication of the results: posters/articles in seminars and conventions
- A technical report for the Ministry of Health and Public Health Authorities from the region and province

Bibliographical references have been used to support the protocols (AHCPR’s guidelines and classification of NPUAP).

The data from the study has been compared with the two preceding AISLeC studies (1994 and 1996). In this study the following areas were examined: pressure ulcers, vascular lesions and foot lesions in home care.

**Results:**
The study involved 57 public health districts that offered home health care. They were from 23 public health departments of the 250 in the country of Italy. The sample was made up of 2,665 patients selected among a total of 17,621 patients receiving medical care. The criteria for selecting the patients were based on the number and frequency of the home care visits (minimum one home care visit every 15 days).

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>F %</th>
<th>M %</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-44</td>
<td>38.8</td>
<td>61.2</td>
<td>2.62</td>
</tr>
<tr>
<td>45-54</td>
<td>50</td>
<td>50</td>
<td>2.74</td>
</tr>
<tr>
<td>55-64</td>
<td>51.8</td>
<td>48.2</td>
<td>6.43</td>
</tr>
<tr>
<td>65-74</td>
<td>57.0</td>
<td>43</td>
<td>19.45</td>
</tr>
<tr>
<td>75-84</td>
<td>66.9</td>
<td>33.1</td>
<td>35.89</td>
</tr>
<tr>
<td>&gt;84</td>
<td>74.79</td>
<td>25.21</td>
<td>32.83</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65.43</strong></td>
<td><strong>34.57</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

Table 1. Age and gender of patients.

Two out of three patients were women and more than 67% of all the patients in the study were over 74 years old, see table 1.

The risk of developing pressure sore lesions was used as the basis for evaluating the patients. This, as in the preceding studies promoted by the Association, was done using the Norton Score. Essentially, the results have confirmed the previous results: over 50% of surveyer home care patients were found to be ‘at risk’ of developing ulcers (from the present study 53.28% were at risk and in the 1996 study 55.3% were at risk).

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Patients</th>
<th>% Patients “at risk”</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-44</td>
<td>30/19</td>
<td>61%</td>
</tr>
<tr>
<td>45-54</td>
<td>29/59</td>
<td>49%</td>
</tr>
<tr>
<td>55-64</td>
<td>51/117</td>
<td>44%</td>
</tr>
<tr>
<td>65-74</td>
<td>144/380</td>
<td>38%</td>
</tr>
<tr>
<td>75-84</td>
<td>342/709</td>
<td>48%</td>
</tr>
<tr>
<td>&gt;84</td>
<td>475/696</td>
<td>68%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1071/2010</strong></td>
<td><strong>53%</strong></td>
</tr>
</tbody>
</table>

Table 2. Number of patients at risk of developing pressure sore lesions and their corresponding age groups.
There were also large numbers of patients with open wounds. Tables 3, 4 and 5 document the prevalence of pressure sores, leg ulcers and foot ulcers.

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>PSL</th>
<th>% PSL</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-44</td>
<td>15/67</td>
<td>22</td>
</tr>
<tr>
<td>45-54</td>
<td>24/70</td>
<td>34</td>
</tr>
<tr>
<td>55-64</td>
<td>34/164</td>
<td>21</td>
</tr>
<tr>
<td>65-74</td>
<td>96/496</td>
<td>19</td>
</tr>
<tr>
<td>75-84</td>
<td>207/915</td>
<td>23</td>
</tr>
<tr>
<td>&gt;84</td>
<td>284/937</td>
<td>34</td>
</tr>
<tr>
<td>Total</td>
<td>662/2665</td>
<td>25</td>
</tr>
</tbody>
</table>

Table 3. Number of patients with pressure sore lesions and their corresponding age groups. (PSL = pressure sore lesion)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>LU</th>
<th>% LU</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-44</td>
<td>2/67</td>
<td>3</td>
</tr>
<tr>
<td>45-54</td>
<td>10/70</td>
<td>14</td>
</tr>
<tr>
<td>55-64</td>
<td>23/164</td>
<td>14</td>
</tr>
<tr>
<td>65-74</td>
<td>134/496</td>
<td>27</td>
</tr>
<tr>
<td>75-84</td>
<td>196/915</td>
<td>21</td>
</tr>
<tr>
<td>&gt;84</td>
<td>170/837</td>
<td>20</td>
</tr>
<tr>
<td>Total</td>
<td>535/2665</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 4. Number of patients with leg ulcers (LU) and their corresponding age groups.

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>FL</th>
<th>% FL</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-44</td>
<td>2/67</td>
<td>3</td>
</tr>
<tr>
<td>45-54</td>
<td>5/70</td>
<td>7</td>
</tr>
<tr>
<td>55-64</td>
<td>12/164</td>
<td>7</td>
</tr>
<tr>
<td>65-74</td>
<td>76/496</td>
<td>15</td>
</tr>
<tr>
<td>75-84</td>
<td>104/915</td>
<td>11</td>
</tr>
<tr>
<td>&gt;84</td>
<td>102/837</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>301/2665</td>
<td>11</td>
</tr>
</tbody>
</table>

Table 5. Number of patients with foot lesions and their corresponding age groups. (FL = foot lesions)

Therefore, overall, 56.2% of the subjects examined had skin ulcers.

In evaluating pressure sore lesions and comparing the home care setting to the hospital setting, we can see that the presence of low-grade lesions (stage 1 and stage 2) was reported as 50%, as in the 1996 study. We also found an increase of 50% in stage 3 and an increase of 100% in stage 4 lesions when comparing the two settings, home care and hospital.
For wound treatment at home, hydrocolloid dressings are most frequently used (20%). It is noticeable that antiseptics were used more often in home care than in hospital care (54% of 15%). Topical antibiotics were used more often in home care than hospital care (61% of 5%), see table 9.

### Types of medical treatment

<table>
<thead>
<tr>
<th>Types of medical treatment</th>
<th>Number of applications</th>
<th>% of applications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low adhesion medication</td>
<td>142</td>
<td>7.9</td>
</tr>
<tr>
<td>Membrane / films</td>
<td>74</td>
<td>4.1</td>
</tr>
<tr>
<td>Hydrogel</td>
<td>151</td>
<td>8.4</td>
</tr>
<tr>
<td>Hydrocolloid</td>
<td>361</td>
<td>20.1</td>
</tr>
<tr>
<td>Alginates</td>
<td>76</td>
<td>4.2</td>
</tr>
<tr>
<td>Foams</td>
<td>84</td>
<td>4.7</td>
</tr>
<tr>
<td>Cavity medications</td>
<td>59</td>
<td>3.3</td>
</tr>
<tr>
<td>Topical antibiotics</td>
<td>98</td>
<td>5.4</td>
</tr>
<tr>
<td>Antiseptics</td>
<td>276</td>
<td>15.4</td>
</tr>
<tr>
<td>Fibrinolytic / Proteolytic</td>
<td>220</td>
<td>12.2</td>
</tr>
<tr>
<td>Compounds</td>
<td>32</td>
<td>1.8</td>
</tr>
<tr>
<td>Other</td>
<td>223</td>
<td>12.4</td>
</tr>
<tr>
<td>Total</td>
<td>1796</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 9. Types of medical treatments used

We have obtained a lot of clinical data from this epidemiological study, and all public health departments in the country and regional departments of health have been informed of the results. The Health Ministry was also informed.

Last February the Italian Health Ministry presented a new health program for the next three years, and we persuaded the Ministry to include pressure sores and chronic leg ulcers as one of the most important chronic problems in the upcoming years. Currently, this is being discussed in the Italian Parliament and we are waiting confirmation that this area will be treated as a priority.

This is one of the most important goals that Italian nurses have achieved from the research work done in Italy and it is hoped that it will result in improvement of wound management for over one million people.

### References


The most common locations where lesions developed were the sacrum, heel and trochanter, see table 6.

<table>
<thead>
<tr>
<th>Location</th>
<th>n/N</th>
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<tr>
<td>Sacrum</td>
<td>337/662</td>
<td>51</td>
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<tr>
<td>Heel</td>
<td>86/662</td>
<td>13</td>
</tr>
<tr>
<td>Trochanter</td>
<td>101/662</td>
<td>15</td>
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</tr>
<tr>
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<tr>
<td>Other</td>
<td>73/662</td>
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Table 6. Pressure sore lesion locations

The physiopathology of the lesions of the lower limbs has also been evaluated, see table 7.

<table>
<thead>
<tr>
<th>Type of lesion</th>
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<tr>
<td>Venous lesion</td>
<td>245</td>
<td>45</td>
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<tr>
<td>Arterial lesion</td>
<td>66</td>
<td>12</td>
</tr>
<tr>
<td>Mixed lesion</td>
<td>138</td>
<td>24</td>
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<tr>
<td>Other</td>
<td>68</td>
<td>13</td>
</tr>
<tr>
<td>Missing</td>
<td>31</td>
<td>6</td>
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Table 7. Types of lesions of the lower limbs

It is interesting to note that the percentage of cases in the “Mixed lesion” class is greater than that reported in the literature while the percentage of cases in the “Venous lesion” class is lower.

The Wagner staging method was used to classify foot lesions. This revealed that more than 65% were stage 1 and 2 lesions, see table 8.

<table>
<thead>
<tr>
<th>Stage</th>
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</tr>
<tr>
<td>2</td>
<td>124</td>
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<tr>
<td>5</td>
<td>21</td>
<td>6</td>
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</tbody>
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Table 8. Wagner staging of foot lesions

Of those working in Home Care, 45% stated that they had a protocol for the prevention and management of wounds.
Mölnlycke
Mepilex Border
WOUND HEALING IN MOORISH SPAIN

SETTING THE SCENE
In 711 the Moors crossed from North Africa and invaded Gibraltar. They spread rapidly as far as Southern France, but driven back the army of Charles Martel. Ultimately, they consolidated their empire within most of the Iberian peninsula (See Figure 1). Over the next few centuries, Moorish culture flourished. During this time, universities were founded in Toledo, Cordoba and Seville as well as buildings such as the Great Mosque in Cordoba and the Alhambra Palace in Granada being erected. Cordoba was possibly the most important city of the Western Caliphate. There was a population of a million people, twenty-seven free schools and fifty hospitals. The library contained an amazing 200,000 books. The Christian re-conquest of Spain started in 1085 with the capture of Toledo, but took until 1492 to complete with the fall of Granada.

ISLAMIC MEDICINE
Islamic medicine was based on Greek medicine, especially the teachings of Galen, a physician who was born around 129 AD and wrote around 600 medical textbooks. Today, Galen's work is seen as seriously flawed, for example, his concept of 'laudable pus' which dominated wound management for centuries (see Box 1). Much of Galen's work was translated into Arabic, often with the translators' own commentary added to the text. Al-Razi or Rhazes in Latin (865-925) is early example, but the most famous was Ali Ibn Al-Husain-al-Sina (Avicenna to the West) (980-1037) who wrote the Canon Medicina, which was seen as the foremost medical textbook in the Middle East, North Africa and Europe up until the 17th Century (Guthrie, 1945). These translations were widely used to inform medical practice across the Arab world and often translated into other languages such as Hebrew and Latin. Figure 2 is an illustration of open-air pharmacy taken from a 15th century Hebrew edition of Avicenna's Canon.

Avicenna recommended the use of white lead ointment for both burns and pressure ulcers. In addition, he advised that covering the bed with salix leaves and preventing the patient from sleeping on his/her back for those with pressure ulcers (Kanal, 1973).
He had several interesting remedies for suppurating wounds such as copper ore, copperas and arsenic. If this was not effective then he suggested trying cautery and then applying an ointment made of verdigris, wax and oil. For wounds with tissue loss where the skin edges could not be approximated or where there was pus or necrosis, Avicenna advised that they should be allowed to dry up with the use of astringents. However, if the wound was clean, then the growth of granulation tissue should be encouraged.

DOCTORS OF MOORISH SPAIN

Many doctors trained in Cordoba, perhaps the most famous of them was Abu-Al-Jarrah-Al-Zahrawi (936-1013), known in Latin as Albucasis. He was a surgeon of some renown whose surgical textbook provided the foundation of surgery in Europe (Hamarneh & Sonnedecker, 1963). It was entitled Al-Tasrif and comprised 30 treatises one of which was completely devoted to different types of dressings, bandages, plasters and compresses. The most fre-

Figure 2
An Open-Air Pharmacy from a 15th Century Hebrew Edition of Avicenna’s Canon
quently described treatise is the 30th which described all aspects of surgery including the use of cautery, the treatment of fractures and dislocations, many types of operations and included 200 illustrations of surgical and dental instruments. This was the first textbook to include illustrations of this nature and their use in a wide variety of operations (Campbell, 1926). Figure 3 shows some of the instruments used for cautery as shown in an 18th Century edition of Al-Tasrif.

Albucasis was much influenced by the work of Rhazes and, therefore, Galen as can be seen by comparing the description below with Box 1. Azmi (1984) described a surgical wound dressing used by Albucasis to apply to a surgical wound healing by second intention. It comprised packing the wound with frankincense, aloes and dragon’s blood, binding the wound up and covering it with a pad soaked in either olive oil and wine or oil of roses and water. The purpose of the dressing was to reduce swelling. After 3 days it was removed and the wound formented (cleaned) with plenty of oil and water. The wound was then redressed with Palm ointment and basilicum ointment until it healed.

Bishop (1959) writes of Albucasis’ concern to prevent the wounds being exposed to the air. He proposed that wounds should be covered in cotton soaked in oil of roses alone or with wine. If the wound had been exposed to the air, then an ointment should be applied until suppuration appeared. An alternative, if the wound was bleeding, was to apply a powder made from incense, dragon’s blood and quicklime.

Pharmacists were not available in Moorish Spain and so Albucasis had to make up all his own medicaments. The Al-Tasrif contained detailed directions for the making a wide variety of medicines. The ointments he recommended for application to a wide variety of wounds all had the same type of base—a mixture of hog lard and fowl and animal fats (Hamarneh & Sonnedecker, 1963).

Ibn Zuhr (Avenzoar in Latin) (1091-1161) was the most famous of a dynasty of physicians from Seville. He believed in the importance of observation and wrote up a number of interesting case histories including the healing of a rupture by rest and a diet of bread and boiled sparrows (Guthrie, 1945). Avenzoar believed that God is the Ultimate Healer who would guide the hand of the physician and this was often quoted in his writings (Azar, 1998). It can, perhaps, be seen as forerunner of the famous quote of Ambrose Pare: “I dressed the wound, but God healed it”. God certainly did not get a great deal of help from the physicians of these times!

It was not just Arabs who were distinguished physicians, but also Jews, the most famous being Maimonides (1135-1204). He was born in Cordoba, but ultimately was banished and traveled to Morocco and then Cairo. He wrote a variety of books including a work on poisons, especially those relating to bites from a variety of animals, the worst being the bite of ‘a fasting man’. The treatment comprised keeping the wound open and removing the poison by sucking, cupping, scarification or cauterisation. If the bite was in a limb, then a tight bandage should be applied above the site of the wound (Guthrie, 1945). It is interesting to note that Maimonides wrote in Arabic and his work was only later translated into Hebrew and also Latin.

CONCLUSIONS
The doctors described within this paper illustrate the flowering of Arabic medicine over a period of three centuries. They also explain the link between ancient concepts of medicine of the Greek and Roman times and mediaeval Europe and beyond. Although most of the concepts of wound healing and wound management that were practiced then have been discarded today, they still make fascinating reading.

References
Bishop W.J. (1959) A History of Surgical Dressings. Robinson & Sons Ltd, Chesterfield
Campbell D. (1926) Arabian Medicine, Cambridge University Press, London
Johnson & Johnson
Promogran
It is a somewhat daunting task to take over the presidency from Prof. Christine Moffatt later this year. Christine has navigated EWMA skilfully through the difficult transition from a publishing house-linked, largely UK-based society to a fully fledged independent association with roots across Europe. During her term of office the society has gained financial security and has developed its own independent voice through its in-house publication, the EWMA Journal. Now, twice yearly, ten thousand copies of the journal are circulated, free of charge, across Europe providing EWMA with a powerful communication tool. The success of the EWMA Journal has been mirrored by the development of the EWMA web site and the popularity of the society's conferences in Stockholm, Dublin and, in May of this year, Grenada.

EWMA is now a far more pan-European Society and through the efforts of Christine and other Council members, EWMA now has established links with a number of major national wound care associations and societies within and outside of the European Union. These links bode well for the long term viability of the association and should allow the society to develop a politically more effective voice on both national and European stages. As part of this drive to become an all inclusive umbrella organisation, the society has also established links with a number of non EU states offering them support and advice on establishing their own wound care associations. Christine has visited a number of these groups and has been able to bring several of these new societies into EWMA “family”.

Through these initiatives and by working with other more established European wound management groups, an understanding of the differing health care systems has developed within EWMA and the issue of reimbursement has come to the fore. Clearly this is an important issue for the society to address and Christine, working with Prof. Peter Franks and others, has established a cost-effectiveness panel as part of the EWMA structure. This, along with the educational development project chaired by Madeleine Flanagan and Finn Gottstrup, has been a major development for EWMA under Christine’s presidency.

Finally, Christine realised how important it was for the society to be independent if it were to have an effective voice on wound care provision and, for that reason, she established an industry liaison group; a group on which I have worked with her. The aim of this group was to respond to the requirements of industry but to be independent from it. I believe that the recent success of the society in establishing corporate sponsorship has been founded on the good relations established within this group and this is in no small part due to Christine’s hard work.

Although Christine retires as president this year, her role with the society will continue. She will take over as the immediate past president and will continue to influence the development of EWMA over the next few years. I look forward to taking over from her after the Grenada conference. During her three years as president, Christine has established EWMA across Europe and she leaves it a much stronger organisation than before. Thank you, Christine for your hardworking and successful years as president.

Peter Vowden
Since the last issue of this Journal, Lohmann & Rauscher has joined the EWMA Corporate Sponsorship Programme at level B. The B Sponsorship Programme allows companies to connect themselves with EWMA’s existing activity without having to commit fully to all projects and activities.

A warm welcome to Lohmann & Rauscher from the EWMA council and we hope to see Lohmann become even more involved with our organisation in the future.

Welcome to Wolfgang Vanscheidt

In this issue EWMA would like to welcome an international opinion leader, Professor Wolfgang Vanscheidt to the EWMA Council. Professor Vanscheidt was unanimously co-opted at the latest EWMA council meeting, and we are very pleased that EWMA will now benefit from Wolfgang’s vast expertise within wound healing.

Professor Vanscheidt is a professor of Dermatology and works as the medical director of the Porten-Clinic-Group in Germany. He is also qualified in phlebology and allergology and was appointed vice-head of the department of Dermatology at the University of Freiburg.

His interest and focus is mostly on pathogenesis and therapy of venous leg ulcers, pathophysiology of the chronic wound and pharmaeconomy of wounds.

Furthermore, Wolfgang Vanscheidt is president of the German Wound Healing Association DgFW, and, in this role, he will be able to develop the future co-operation between EWMA and Germany. EWMA considers this a very important step towards uniting European wound healing practice.

We extend a warm welcome to you Wolfgang from the entire EWMA council.

New Corporate Sponsor for EWMA

Since the last issue of this Journal, Lohmann & Rauscher has joined the EWMA Corporate Sponsorship Programme at level B.

The B Sponsorship Programme allows companies to connect themselves with EWMA’s existing activity without having to commit fully to all projects and activities.

Use the Journal to profile your company

The EWMA Journal is a bi-annual European informational source within woundhealing and Management. The 10,000 copies are distributed free of charge to all members of organisations co-operating with EWMA. This makes the Journal a unique communication channel from which your company could benefit greatly.

If you are interested in more information on rates and possibilities please contact

Congress Consultants
Martensens Alle 8
DK-1828 Frederiksberg C
Denmark
Tel: +45 7020 0305
Fax: +45 7020 0315
e-mail: congress@congress-consult.com

Please observe that the deadline for next issue is September 20th!
On page 41 in the fall issue 2001 of this Journal you can find an overview of papers published in 2001 on prognosis and diagnosis of various wound types. As a follow up this issue will focus on treatment studies.

**Burns**


**Diabetic foot ulcers**

**Leg ulcers**


**Pressure ulcers**


**Traumatic wounds**


**Surgical wounds**


KIKUHIME
Subbandage Pressure Measuring Device

- POWER button. HOLD function displays steady measurement value.
- Handy size, 9 x 6 x 2 cm. Fits easily into the breast pocket. Light-weight, only 90 g.
- Attachment clip with drop-preventing strap.
- Syringe and valve for calibration.
- Extended battery life. (Approx. 5 years for measurements of 20 times/day).
- A low priced device.

This device has been produced with the advice of scholars at Graduate School of Hokkaido University, Biomedical Systems Engineering, System- and information Engineering.

Practising nurses

KIKUHIME is an instrument that helps nurses to make a correct compression bandage. The nurse is placing the pressure-sensing pad on the leg, then applying the compression bandage. The subbandage pressure is now displayed on a small liquid crystal display screen. The nurse is able to see the results during the process and therefore able to alter the bandage technique in response to the results.

KIKUHIME fits easily into the pocket. Always available when needed and easy to handle. KIKUHIME is the ideal and precise measurement device at a low price.

The above picture is from the Danish Magazine SÅR no. 4. 2001.
Smith & Nephew
Kommer fra
Congress Consultants
‘Evidence-based’ are the words on everyone’s lips and undoubtedly evidence-based medicine, evidence-based practice or evidence-based decisions are here to stay. But what does it mean and how do I use it? is also the question asked by many.

This book has been born out of a successful series of articles, *Users’ Guides to the Medical Literature*, which were published in JAMA between 1993 and 2000. This Users’ Guide is written in two parts and primarily targets clinicians and medical educators.

**Part 1** sets out to cover the basics of what every clinician should know about Evidence-Based Medicine (EBM) in terms of basic concepts and core knowledge. It aims to be as simple and succinct as possible.

**Part 2** goes into greater detail exploring these basic concepts and applying clinical research to patient problems. It is suggested that readers dip into this section of the book to target specific areas of interest.

A strength of the book is the use of clinical scenarios to illustrate their approach to using evidence to help make decisions in real-life, complex clinical situations. They emphasise throughout the maxim that evidence alone is never enough, the whole clinical picture needs to be considered.

The style of writing is simple and the text is peppered by examples thus helping the reader understand the points being made. All sections are well referenced for anyone who wishes to explore any subject in even greater detail. Part 2 is very detailed and is best approached, as the authors suggest, as targeted reading. A condensed version of the full manual, containing all of Part One of the larger book, and the critical sections of Part Two (including the full CD from the manual) is also available (Paperback – 376 pages, Publisher American Medical Association; ISBN: 1579471919. cost £25.00 at Amazon).

The book is well laid out, readable and presents the key concepts of this substantial subject in an accessible way. Evidence based healthcare is relevant to nurses, doctors, dentists, health care managers and commissioners, and the professions allied to medicine (physical therapists, speech and language therapists etc.) and all will find useful material in this book.

Sally Bell-Syer
Research fellow, Department of Health Sciences, University of York, York YO10 5DD.
## Conference Calendar

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## Ewma Conference History

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The scientific programme of the 11th Annual Meeting of ETRS held in Cardiff in September was the best yet according to comments made by attendees. Keith Harding, our new president, and colleagues should be congratulated for their hard work. A stimulating session on impact of ageing, chaired by Niall Dickson of the BBC, was held at the opening of the meeting. Another unique aspect of the meeting was the in depth review of healing in different organs by experts from throughout the world.

Next Joint conference will be held in Baltimore, USA (28 May – 1 June 2002). Baltimore is an excellent venue for the meeting and we are confident that there will be a good attendance by members of the ETRS; similar to the support the Wound Healing Society members gave the last joint meeting in Bordeaux.

The new World Union of Wound Healing Society is beginning to become a working organisation through its working parties. The educational group had its first meeting in conjunction with the European Wound Management Association meeting in Dublin in May under leadership of Gary Sibbald of Toronto and this was attended by members of wound healing societies from Australia, Canada, Denmark, France, Germany, New Zealand, UK and USA.

The industrial liaison committee headed by Keith Harding had an introductory meeting at the ETRS meeting in Cardiff with members of Industry outlining plans of the new World Union as well as encouraging industry to actively join the corporate side of this new organisation.

The developing country working party headed by the editor sponsored a practical wound management meeting in Tanzania, Africa in conjunction with the International Skin-care Nursing group.

This four day meeting in which Terence Ryan of Oxford as well as Kent Jonssen, a general surgeon and Salathiel Mzezawa, a plastic surgeon both from Harare, Zimbabwe made major contributions to the practical management of trauma and wounds which was well received by the audience of African dermatology assistants, doctors and nurses. Both surgeons from Zimbabwe have attended to our annual meeting in Malmo, Sweden. Dr Mzezawa is currently involved in research on HIV and healing of clinical wounds. Wound management is a major problem in developing countries, particularly resulting from trauma and this meeting was just the beginning of future programmes that are needed.

Dr George W. Cherry

Chairman Wound Healing Programme, Dept. of Derm. Oxford University, UK.
Secretary/treasurer of the European Pressure Ulcer Advisory Panel (EPUAP).
EWMA Past President and Recorder.
Honorary professor to the Trauma Centre Postgraduate medical College and 304th Hospital Beijing, China.
Editor of ETRS Bulletin.
ETRS Past President.
Organizer of the Oxford European Wound Healing Summer School.
Founder, member and Secretary of the European Pressure Ulcer Advisory Panel (EPUAP).
ARCHIE COCHRANE
The Cochrane Collaboration is named in honour of Archie Cochrane, a British medical researcher. Archie Cochrane is best known for his influential book, Effectiveness and Efficiency: Random Reflections on Health Services published in 1972. The principles he set out so clearly were straightforward: he suggested that, because resources would always be limited, they should be used to provide equitably those forms of health care which had been shown, in properly designed evaluations, to be effective. In particular, he stressed the importance of using evidence from randomised controlled trials (RCTs) because these were likely to provide much more reliable information than other sources of evidence.

In 1979 he wrote, “It is surely a great criticism of our profession that we have not organised a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomised controlled trials.” His challenge led to the establishment, during the 1980s, of an international collaboration to develop the Oxford Database of Perinatal Trials. This database was the forerunner of the Cochrane Library.

In 1987, the year before Cochrane died, he referred to a systematic review of randomised controlled trials (RCTs) of care during pregnancy and childbirth as “a real milestone in the history of randomised trials and in the evaluation of care”, and suggested that other specialties should copy the methods used. You can find out more about Archie Cochrane at: http://www.cochrane.de/cochrane/archieco.htm

THE DEVELOPMENT OF THE COCHRANE COLLABORATION
The Cochrane Collaboration was developed in response to Cochrane’s call for systematic, up-to-date reviews of all relevant RCTs of health care. Cochrane’s suggestion that the methods used to prepare and maintain reviews of controlled trials in pregnancy and childbirth should be applied more widely was taken up by the Research and Development Programme, initiated to support the United Kingdom’s National Health Service. Funds were provided to establish a ‘Cochrane Centre’, to collaborate with others, in the UK and elsewhere, to facilitate systematic reviews of randomised controlled trials across all areas of health care.

When ‘The Cochrane Centre’ was opened in Oxford, in October 1992, those involved expressed the hope that they would be contributing to a collaborative international response summarising the best available evidence of the effects of health care interventions. This idea was outlined at a meeting organised six months later by the New York Academy of Sciences. In October 1993 – at what was to become the first in a series of annual Cochrane Colloquia – 77 people from eleven countries co-founded ‘The Cochrane Collaboration’.

THE TEN PRINCIPLES OF THE COCHRANE COLLABORATION
The Cochrane Collaboration has evolved rapidly since it was inaugurated at the first Colloquium, but its basic objectives and principles have remained the same. It is an international organization that aims to help people make well-informed decisions about health care by preparing, maintaining and ensuring the accessibility of systematic reviews of the effects of health care interventions. The Collaboration is built on ten principles:
Collaboration
by internally and externally fostering good communications, open decision-making and teamwork.

Building on the enthusiasm of individuals
by involving and supporting people of different skills and backgrounds.

Avoiding duplication
through good management and co-ordination to maximise economy of effort.

Minimising bias
through a variety of approaches such as scientific rigour, ensuring broad participation, and avoiding conflicts of interest.

Keeping up to date
through a commitment to ensure that Cochrane Reviews are maintained through identification and incorporation of new evidence.

Striving for relevance
through promoting the assessment of healthcare interventions using outcomes that matter to people making choices in health care.

Promoting access
through wide dissemination of the outputs of the Collaboration, taking advantage of strategic alliances, and by promoting appropriate prices, content and media to meet the needs of users worldwide.

Ensuring quality
through being open and responsive to criticism, applying advances in methodology, and developing systems for quality improvement.

Continuity
through ensuring that responsibility for reviews, editorial processes and key functions is maintained and renewed. (This ninth principle was added in October 1998)

Enabling wide participation
in the work of the Collaboration by reducing barriers to contributing and by encouraging diversity. (This tenth principle was added in October 2000)

THE COCHRANE WOUNDS GROUP
The Wounds Group helps prepare, maintain and disseminate reviews to answer questions around the prevention and treatment of wounds and their complications, e.g. infection and scarring. There are completed reviews on the following topics:

- Antibiotic prophylaxis for mammalian bites
- Beds, mattresses and cushions for pressure sore prevention and treatment
- Compression for preventing recurrence of venous ulcers
- Compression for venous leg ulcers
- Disposable surgical facemasks for preventing surgical wound infection in clean surgery
- Electromagnetic therapy for treating pressure sores
- Electromagnetic therapy for treating venous leg ulcers
- Intermittent pneumatic compression for treating venous leg ulcers
- Laser therapy for venous leg ulcers
- Oral zinc for arterial and venous leg ulcers
- Patient education for preventing diabetic foot ulceration
- Pentoxifylline for treating venous leg ulcers
- Pressure relieving interventions for preventing and treating diabetic foot ulcers
- Removal of nail polish and finger rings to prevent surgical infection
- Skin grafting for venous leg ulcers
- Therapeutic ultrasound for pressure sores
- Therapeutic ultrasound for venous leg ulcers
- Topical agents or dressings for pain in venous leg ulcers
- Topical negative pressure for treating chronic wounds

Reviews are underway in the following topic areas:

- Anti-microbial prophylaxis for colorectal surgery
- Community clinics versus home management for leg ulcer treatment
- Double gloving for reducing surgical glove perforations
- Dressing and topical agents for burns
- Dressings and topical agents for preventing pressure sores
- Dressings for pressure sores
- Dressings for venous leg ulcers

COCHRANE COLLABORATIVE REVIEW GROUPS
Cochrane reviews (the principal output of the Collaboration) are published electronically in successive issues of The Cochrane Database of Systematic Reviews, as part of the Cochrane Library. Preparation and maintenance of Cochrane reviews is the responsibility of international collaborative review groups. The members of these groups – researchers, health care professionals, consumers, and others – share an interest in generating reliable, up-to-date evidence relevant to the prevention, treatment and rehabilitation of particular health problems or groups of problems.
Sally Bell-Syer
The Cochrane Wounds Group has two part-time staff; studies of interest. They set out how the reviewer will find and synthesise the evidence of the coordinating editor, Professor Nicky Cullum. There is an international panel of editors who help to ensure that the output of the group is of high quality and relevant to the needs of people making decisions about wound management. The vast majority of people preparing Cochrane Reviews are doing it in their own time or have been able to build some time into their study or work for preparing a review. Occasionally there are funds available to help people prepare Cochrane Reviews and these tend to target areas in which people find it particularly difficult to prepare a review, e.g. in developing countries. The Cochrane Wounds Group is fortunate in having funding from the Theatre Nursing Trust to help UK-based theatre nurses buy some time out of practice to prepare a review. Contact Roz Thompson if you are a theatre nurse interested in finding out more about this funding (e-mail: mrt4@york.ac.uk, fax: 01904 321383, tel: 01904 321351).

You can keep up to date with the Wounds Group by looking at our website www.cochranewounds.org

THE COCHRANE COLLABORATION LOGO

The Cochrane Collaboration logo illustrates a systematic review of data from seven randomised controlled trials (RCTs), comparing one health care treatment with a placebo. Each horizontal line represents the results of one trial (the shorter the line, the more certain the result); and the diamond represents their combined results. The vertical line indicates the position around which the horizontal lines would cluster if the two treatments compared in the trials had similar effects; if a horizontal line touches the vertical line, it means that that particular trial found no clear difference between the treatments. The position of the vertical line to the left of the vertical line indicates that the treatment studied is beneficial. Horizontal lines or a diamond to the right of the line would show that the treatment did more harm than good.

This diagram shows the results of a systematic review of RCTs of a short, inexpensive course of a corticosteroid given to women about to give birth too early. The first of these RCTs was reported in 1972. The diagram summarises the evidence that would have been revealed had the available RCTs been reviewed systematically a decade later: it indicates strongly that corticosteroids reduce the risk of babies dying from the complications of immaturity. By 1991, seven more trials had been reported, and the picture had become still stronger. This treatment reduces the odds by 30 to 50 per cent of the babies of these women dying from the complications of immaturity.

Because no systematic review of these trials had been published until 1989, most obstetricians had not realised that the treatment was so effective. As a result, tens of thousands of premature babies have probably suffered and died unnecessarily (and needed more expensive treatment than was necessary). This is just one of many examples of the human costs resulting from failure to perform systematic, up-to-date reviews of RCTs of health care.


As a part of the new EWMA strategy, we have, within the last year, worked hard to create closer bonds between the national wound healing and management organisations. Through co-operating with EWMA the national organisation receives a large number of benefits including:

- The members of the organisation register as EWMA members at conferences
- The members will receive the EWMA Journal
- A quarter page or half a page in the EWMA Journal for association data or national news
- Link at EWMA web-site
- Invitation for EWMA co-operating association workshop at the annual EWMA conference
- 1-2 free invitations for the annual EWMA Conference
- Participation in the European Curriculum Group, developing guidelines for education within the wound management area
- Co-operative status in relation to EWMA research funding
- The organisation is free at any time to co-operate with other wound management associations
- EWMA expects no financial obligations from the co-operating association

On the following pages you will find a presentation of some of the organisations which have agreed to co-operate with EWMA. Others will be presented in the following issues of the EWMA Journal.

We are very happy that so many within such a short time have agreed on the need for closer co-operation within Europe. We are also convinced that the number will keep rising, and that we are all well on our way to create a truly European forum for the improvement of wound management.

We hereby hope that more associations will see the opportunities and contact us, so that we can all benefit from the synergy that is being created around EWMA.

Christine Moffatt, EWMA President

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**Corporate B**

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Fax: +49 (0) 2634 99-1205
## Co-operating Organisations

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The sixth National Conference of the Finnish Wound Care Society was held from the 7th to the 8th of February 2002 in Helsinki Finland. The conference theme was "Local Wound Management and Advances in Wound Management Products". With almost 600 delegates attending the conference it is clear that there is a growing national interest in this speciality.

As in previous years, the programme was coordinated by the executive committee of the Finnish Wound Care Society. The programme consisted of lectures, free paper presentations, workshops and an exhibition.

The Deputy Mayor for Social Affairs and Public Health for Helsinki, Mr Timo Honkala gave the welcoming address at the Conference's opening ceremony. In his address Mr Honkala reminded delegates that Helsinki celebrated its 450th anniversary in 2000 and was, at the same time, one of the European Cities of Culture. He also mentioned a recent study by the French economical journal L'Expansion in which Helsinki was rated as the 7th happiest city in the world.

Mr Honkala also reported on the recent research into the health of the citizens of Helsinki. In Helsinki the average age of people with diabetes type II is 67 years. The number of patients is predicted to grow from 16,000 today to 30,000 in 2010. An important statistic to note is that 67% of the total costs for diabetes care goes on the treatment of complications like foot ulcers.

Each day of the two-day conference was divided between lectures, free paper presentations and workshops. Delegates voted the lecture “Sugar in wound management” by MD Jyrki Kössi as the most interesting lecture of the conference. Traditionally sugar was used in healing wounds, but the practice is all but forgotten nowadays. MD Kössi has successfully used sugar paste in treating patients presenting with badly healing wounds with a lot of necrotic tissue and leakage. The successful treatment is safe and well tolerated. The material cost of the treatment is very low, but carries an extra work cost due to the need to change dressings.

Among the other interesting lectures were topics on the physiology of wound healing; wound assessment and documentation; selecting the appropriate wound dressing; antiseptic and antimicrobial products; and when to consult the wound management specialist. The lecture on the effects of tobacco smoking on wound healing reported an increased risk of infections and a decrease in the tissues' ability to heal. In the ensuing discussion the importance of informing the patient preoperatively was addressed.

The free papers presented three research studies:
1. EPUAP’s Pan-European Pressure Ulcer Study (PEPUS)
2. The Finnish Wound-Care Society’s study on the availability of wound management products
3. The Central Hospital of Päijät-Häme’s study comparing closed orthopaedic wound cover materials.

The four workshops were very well attended and focused on the following topics:
1. How to clean wounds
2. Selecting the right treatment
3. How to use wound dressings, and
4. How to use Doppler and apply bandages.

The exhibition gave an excellent view on wound management materials and equipment as well as nutritional products on the market.

The delegate’s encouraging feedback gave new topics for the next conference to be held in February 2003.

The conference dinner was closed with singing and dancing. Wearing appropriate colours, the executive committee of the Society performed its brand new creation "Pink, Red, Yellow and Black, the Wound Song". The delegates enjoyed karaoke singing and lively discussions into the late night. Overall it was a very successful conference and enjoyed by all.
PRESENTATION OF A NON-PROFIT ASSOCIATION IN PROGRESS

Swedish Wound Healing Society (Svenskt Sårläkningssällskap) is Sweden’s national organisation in the subject area of wound and wound management/treatment. SWSH is a non-profit association that aims to widen knowledge on the subject area, and to contribute to enhanced competence, to actively support research and to ensure scientific development in the area of wound healing. Furthermore, one of SWHS’s objectives is to arrange for a standardisation and consensus in the treatment and evaluation of patients with different types of wounds.

A chronic wound is often a multidisciplinary problem, especially as chronic wounds even kills elderly people who has either one or more other diseases. Furthermore, it is important that the main illness is treated parallel with the treatment of the chronic ulcer. In order to obtain a good and effective result from the treatment it is essential to identify the causes and to give the patient diagnosis of the ulcer and not to forget preventive activities. Treatment needs to be consequent and that the patients are observed even after the treatment has ended. It is central to diffuse knowledge on how to treat chronic and acute ulcers cost-effectively to both counties and municipalities.

History
In 1994 Swedish Wound Healing Society was founded by five specialists with different research and occupation areas, namely:

- Dermatology/venerology
  - Docent Carita Hansson, Göteborg
- Diabetology/endocrinology
  - Prof. Kerstin Brismar, Stockholm
  - Docent Jan Åpelpqvist, Lund
- Geriatric/gerontology
  - Docent Vivianne Shubert, Stockholm
  - Nurse Barbro Hemgren and Prof. Finn Gotttrup attended the first meeting.

All the founders have a solid research background. They are known internationally in their research areas and have a long clinical experience with patient with different types of wounds. Besides from national and international tasks, the board members are also invited speakers at different scientific conferences and have established international contacts through these conferences. Today, specialists in general medicine, in surgery, plastic surgery, and infections have become members of the association.

To develop the group in a multi-scientific context other people working with wounds and similar professions has been invited to become members. The group of members include researchers, foot therapists, charge nurses, nurses and people with a general interest in the subject area. Through membership the wound industry is involved, which makes it possible for them to exhibit their products in connection with symposia.

Additional development
– a part of the association’s activities
Based on science and profound experience, SWHS has since 1995 been actively focusing on developments. Each year since 1995, the association has arranged a symposium, which took place in November/December. International researchers have been invited as speakers.

Themes for the symposia arranged by the association
1995 Venous leg ulcers
1996 Chronic wounds– pressure ulcers
1997 Diabetic foot ulcers
1998 Differential diagnosis at leg and foot ulcers
1999 Alternative wound management
2000 Chronic wounds – nutrition and infection
2001 Circulation and pain

Literature
In addition to the work in the association, the board members are often engaged as speakers and participate in regional meetings. The book, scientific articles, consensus, wound healing programme, directions in the subject area of wound management, which the members have written, have also contributed to the development of the wound management area. This kind of publication has enhanced the quality of both the documentation and treatment of patients with wounds and wound related problems. However, there is still a lot of work to do.
A COMMUNICATION FROM
THE NORWEGIAN WOUND HEALING
ASSOCIATION

NIFS
Norsk Interessefag-
gruppe for Sårheling

Norwegian Wound Healing Association

Administrative areas:
Wound groups, contact persons, web site
Swedish Wound Healing Society has since the beginning urged for exchange of information and contributed to the creation of different networks called “sårvårdsgrupper” in which the association has contact persons who serve as the association’s right hand-man. The contact persons, who live in different areas of the country, are offered education and are kept informed about wound related areas at an additional annual education meeting. The education meeting takes place in spring in connection with the association’s annual meeting. This education has provided a basis for a number of regional wound healing groups/wound healing teams/wound healing centres.

Swedish Wound Healing Society’s website
http://www.saralakning.com
SWHS has its own website with information about the association but also a calendar on national and international meetings and conferences.

Members
Swedish Wound Healing Society is growing and the number of members is increasing year by year and today the association has 540 members.

The Wound Healing Organisation for Patients and Relatives
This organisation is a non-governmental organisation for patients with different types of wounds. The objective is to support, inform, and educate patients, relatives and hospital staff. Another objective is to affect politicians, decision-makers and to inform the public. SWHS supports the organisation and has participated in their meetings.

NIFS GOAL SETTING / AGENDA 2001-2003
Consolidation
■ To establish a countrywide network based on the NIFS members. The members will report their local needs to NIFS – NIFS will subsequently lend its support.
■ To continue cooperation with institutions with mutual interests.
■ To establish new relations with national and international groups, such as ETRS and EWMA.
■ To recruit new members and future candidates for the board and other relevant committees.

Distributing information and knowledge on wound healing
■ A general medical record of the different types of wounds is being prepared in collaboration with the medical professions.
■ Guidelines for treatment of the different types of wounds are under preparation in collaboration with the medical professions.
■ Postgraduate courses in diagnostics and treatment of wounds will be arranged.
■ A list of available lecturers throughout the country will be monitored and kept up-to-date.
■ A NIFS Internet Homepage will be created for easy access to information on our activities, with direct links to the relevant organizations.

Research
■ To establish contact with Norwegian research institutions and groups engaged in studies of processes related to Wound Healing.
■ To continue the programme of establishing scholarships for NIFS members involved with Wound Healing.

Introduction of NIFS to the authorities and to future members
■ The SÅR Journal will continue to serve as the vehicle in which to manifest the professional commitment to problem wounds in Norway and Denmark.
■ Education grants for NIFS members will be established.
■ Authorities and political bodies will be made aware of pertinent aspects of wound treatment problems, epidemiology and research via letters and published articles.
■ NIFS will be promoted by presentations in the media.

Guidelines for treatment of the diabetic foot
The WHO guidelines for treatment of the diabetic foot have been translated and worked out for Norwegian health personnel by an interdisciplinary group. The pamphlet is distributed without cost through NIFS and the Norwegian Diabetic Association.
The AIUC board is continuing to progress the development of educational activities in Italy and its co-operation with the European Wound Management Association will bring a vital, new lift to both societies for an enthusiastic program of scientific exchange.

The Portuguese Wound Management Association (A.P.T.F.) was born due to the need felt by the health professionals in the treatments of wounds and has as its main aim the training and diffusion of news services within this area.

The Danish Wound Healing Society was established during a meeting of doctors and nurses on the 12th of February 1992. Developments since then have shown that there is a major need for organisation and multidisciplinary build up of the wound area in order to help patients as well as the society.

In Denmark, this has resulted in the creation of several groups of wound-interested personnel and the establishment of the Copenhagen Wound Healing Center.

The Society has expanded from the start and presently the membership is now 1000 persons from the Danish Health Care system. For these reasons we have celebrated the 10th anniversary of our organisation by holding an extended meeting consisting of an international one day pre-conference workshop on Multidisciplinary Concepts in Wound Healing and two and a half day Nordic 10th Anniversary Symposium.
In 1994, in order to highlight the importance of the problem of chronic wounds, and specially pressure ulcers, the Grupo Nacional para el Estudio y Asesoramiento en Úlceras por Presión y Heridas Crónicas (GNEAUPP) (Spanish Pressure Ulcers and Chronic Wounds Advisory Panel) was created. This is an interdisciplinary society with more than 1500 health care professionals. The aim of the GNEAUPP is to focus on the promotion of evidence-based comprehensive approaches for the prevention and treatment of chronic wounds involving different types of disciplines.

Every two years the GNEAUPP organizes a national meeting about pressure ulcers and chronic wounds and is involved in other European organisations like the European Pressure Ulcers Advisory Panel (EPUAP) and the European Wound Management Association (EWMA). The GNEAUPP has published several guidelines:

- The prevention of pressure ulcers
- The staging of pressure ulcers
- The treatment of pressure ulcers
- Obtaining samples from chronic wounds
- Epidemiological indicators

GNEAUPP has funded several research projects about pressure ulcers and is developing a white report about pressure ulcers in Spain.

The GNEAUPP has its own website: www.gneaupp.org, it produces a newsletter and publishes a scientific journal, Gerokomos-Helcos, in conjunction with the Sociedad Española de Enfermería Geriátrica y Gerontológica (Spanish Geriatric and Gerontologic Nursing Society).

The evolution of Wound Care in Spain has produced an increase of research activities in fields like clinical, epidemiological and basic sciences.

Previous meetings and conferences:
1. Meeting 1996 Logroño 700 Delegates
2. Meeting 1997 Barcelona 1200 Delegates
3. Meeting 1998 Logroño 1300 Delegates
First Summer school 2000 La Rioja
Second Summer school 2001 La Rioja

LYMPHOEDEMA
Do your patients suffer from this swelling of the limbs and body?

The Lymphoedema Support Network provides support and up-to-date information about lymphoedema to patients and health care professionals.

For further information please contact The Lymphoedema Support Network.

The Leg Ulcer Forum
A national forum to advance clinical practice for the management of patients with leg ulcers and associated conditions through the education and support of all relevant professionals.

The Leg Ulcer Forum Secretariat
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Hartford
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www.legulcerforum.com
The Wound Management Association of Ireland (WMAI) is organising all categories of health area staff: doctors, nurses, therapists etc. in both Southern and Northern Ireland.

Bernadette Kerry
Chairperson

Correspondence to:
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Altnagelvin Hospital
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BT47 6SB
Londonderry
Northern Ireland

The Wound Management Association of Slovenia (WMAS) is working on creating a constitution for our association and keeping the multidisciplinary teams together. We have defined our main goals as: cooperation with educational institutions and professional associations in Slovenia and abroad, cooperation with the ministry of health and setting national standards in assessment of wounds. The priority is good quality and cost effective studies, in order to obtain evidence which can convince our country that we need materials for managing wounds on prescription.

We have contacted the ministry of health to let them know, what we are trying to do and to get their support.

24th of October was a big day for us – WMAS became legal. We are sending you a picture of our logo and our first president, who is a plastic surgeon assistant Toma Jane, dr. of medicine and the lady vice-chairman is Vanja Vilar, RN, ET. We are very satisfied with our achievements so far. Our only regret is that a group of surgeons insists on leadership in the area because we objected when they suggested to make an association of their own. It is very important for all parties to work together in this field and we hope that the two organisations will be able to work together in the future.

Hypocrates said: «Healing is a matter of time, but it is also a time of opportunity.»
We want to get our opportunity!

With best regards,

Dragica Tomc, RN, ET
for Wound Management Association of Slovenia
**European Wound Management Association**

**EWMA** was founded in 1991 at a conference in Cardiff to address clinical and scientific issues associated with wound healing represented by medical, nursing, scientific and pharmaceutical interests.

The objectives agreed upon then were as follows:

- To promote advancement of education and research into epidemiology, pathology, diagnosis, prevention and management of wounds of all aetiologies.
- To hold conferences on aspects of wound management throughout Europe.
- To provide grants and bursaries to EWMA members
- To hold multi-centre, multi-disciplinary training courses on topical aspects of wound healing.

**EWMA** has since worked to fulfil these objectives and, at the same time, searched for new ways to help the promotion of a truly international forum for wound management.

At present **EWMA** is enjoying an ever-increasing number of members; participants in the annual conferences; co-operating organisations; promising projects, and a warm support from the industry.

Ten years after its foundation, it is not too much to say that the **European Wound Management Association** has truly become the international forum envisaged in Cardiff.

There is, however, still potential for improvement, and we hope that many will join **EWMA** and thereby help the organisation and the whole wound management area.

The rate for a one year full membership is £15.

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**Membership application**

Surname: ____________________________

First name(s): ______________________

Profession:  
- [ ] Physician  
- [ ] Surgeon  
- [ ] Dietician  
- [ ] Nurse  
- [ ] Pharmacist  
- [ ] Other

Work Address: _______________________

Address for Correspondence (if different from above): _______________________

Tel: _______________________________

Fax: ______________________________

E-mail: ____________________________

Payment accepted in pound sterling only, drawn on UK bank. I enclose a cheque of £15. Please indicate cheque no.:

Please make cheques payable to: European Wound Management Association

Or

Please debit my account by £15:  
Credit Card type: (Delta, Master Card or Visa)  
Credit card no: ______________________

Expiry Date: _______________________

Exact name and initials on the credit card:

Please return form and enclose cheque to:

**EWMA**  
PO Box 864,  
London SE1 8TT,  
United Kingdom
3 Editorial

Scientific Articles

5 Health Related Quality of Life Measurement
E. Andrea Nelson

Clinical Articles

9 The use of Compression Therapy in the Treatment of Venous Leg Ulcers – a recommended Management Pathway
Michael Stacey et al

15 The Professional Role and Competence of Tissue Viability Nurses in Finland
Salla Seppänen

21 A Review of Advances in Fungating Wound Management since EWMA 1991
Patricia Grocott

27 Multi-center Research on Wound Management in Home Care in Italy
A. Bellingeri

32 Wound Healing in Moorish Spain
Carol Dealey

36 Thank you Christine Moffatt

37 Welcome to Wolfgang Vanscheidt

38 Treatment studies from 2001

41 Book Review
Guide to the Medical Literature. A Manual for Evidence-Based Clinical Practice
Sally Bell Syer

Conferences

42 Conference Calendar
42 Ewma Conference History

43 The 11th Annual Meeting of the European Tissue Repair Society
September · 2001 · Cardiff · UK
George W. Cherry

Organisations

44 The Cochrane Collaboration
47 European Co-operation
48 Co-operating Organisations
55 EWMA Information