The Importance of TenderWet in the Debridement Phase

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INTRODUCTION

The presence of necrotic and fibrous tissues often impairs healing of leg ulcers. Contamination with various germs provides an ideal breeding ground for this devitalised tissue. Colonisation sometimes leads to infection of the wound, slowing or even preventing the healing process. This is why thorough cleansing of wounds and appropriate debridement are so important in wound management.

TENDERWET

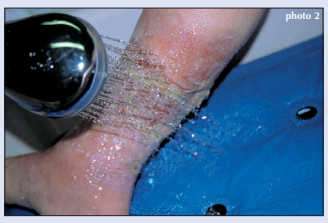
The composition of the TenderWet dressing places it in the osmotic products class. The polyacrylate contained in the TenderWet dressing has an affinity for proteins and is therefore able to absorb bacteria and debris.
This dressing also has another important function in wound management. We know that yellow or fibrinous wounds have to be thoroughly cleaned. This means that every time the dressing is changed the wound must always be thoroughly flushed or cleansed with a physiological solution along with a wound cleanser or tap water. The continuous flushing effect of the TenderWet dressing enhances the wound-cleaning effect.
In conjunction with these cleansing techniques, the moisture-regulating TenderWet dressing is in complete accordance with the principles of moist wound healing, providing an ideal environment for the wound to heal.

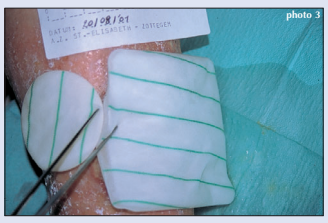
CASE STUDY

An 86-year-old insulin-dependent lady was admitted on 20/08 with a venous ulcer running almost completely around her left calf (see photo 1). She had a temperature of over 38°C and complained of severe pain when her wound was being treated.
At the base of the wound we observed a yellow fibrin layer giving off a strong smell. Wound care comprised daily application of a hydrogel with a view to dissolving the necrotic fibrin layer. A few weeks ago the clinical signs of infection appeared and the surface of the wound increased in size.

TREATMENT

An echo-doppler examination showed no marked arterial failure. In theory we should have administered compression therapy in order to reduce the oedema and support the venous circulation. However, the patient's intense pain prevented us starting this compression therapy; our initial treatment was limited to placing the patient in Trendelenburg's position in the hope of reducing the oedema. Antiphlogistics were administered for the pain.
When administering local treatment we placed the patient on a bath lift so that we could flush the surface of the wound with a shower spray (see photo 2). This removed all loose debris (dead skin cells and bacteria) and wound fluid.
A wound culture was taken as there were clear signs of clinical wound infection. While waiting for the results of the antibiogram we applied a TenderWet 24 dressing which was changed every day (see photo 3). The dressing did not stick to the wound, which is a considerable advantage.
The antibiogram showed that the wound was caused by Escherichia Coli+++. The doctor in charge of the patient prescribed intravenous piperacillin/Taxobactam, to which this germ is sensitive.
On 24-08, day 4 (see photo 4) we observed that a thick layer of fibrin was becoming detached from the base of the wound. We were able to remove this layer without anaesthetics, using tweezers. The TenderWet 24 dressing had a combined osmotic and autolytic debriding effect. All the debris had disappeared from the wound on day 8.
On 30/08, day 10 (see photo 5), we noticed that the base of the wound was starting to granulate and it was clear that the epithelialising wound healing process was beginning. Clinical signs of infection had disappeared. Wound treatment no longer caused pain, and we were able to withdraw both painkillers and antibiotics. Venous failure was treated by means of compressive bandages (we use the Pütterbinde short elastic bandage for this purpose).
In view of the large surface area we decided on 07/09 to perform a skin graft (see photo 6). The wound healed without complications. On 10/12 the patient returned for a check-up and we observed that a substantial scar had formed (see photo 7). Therapeutic pressure stockings were prescribed to support the venous circulation.





CONCLUSION

TenderWet allows us to ensure that the wound is cleaned not only safely but also actively.
Performing a skin graft on large ulcers is not always without risk. For this reason the wound must be perfectly prepared and have reached the granulation phase, while the conditions for adhesion of the skin graft must be as good as possible. This is why the use of a TenderWet dressing in the pre-surgical phase is particularly valuable.

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