

## Day in the life

Each issue of *Wounds International* features a typical day in the life of a different wound care clinician from around the world. This series looks at the variety of techniques that are required in different settings and asks clinicians about the type of conditions they work in, the types of wounds they see, and the challenges that they face when providing wound care to patients.



This issue features Carmen Alba who is Nurse Manager, Functional Unit of Wounds, Hospital Clínico Universitario, Valencia, Spain.

### Can you outline where you practise?

I work at the Hospital Clínico Universitario in Valencia, Spain, which is the referral hospital for the Health Department of Valencia-Clínico-Malvarrosa, treating a population of more than 334 000 citizens, divided into 16 primary healthcare (PHC) areas. Our wound care unit is a recently established nurse-based unit. I coordinate patients with complex wounds.

Consultations come from the different departments in the hospital, along with referrals from within any of the centres in the 16 PHC areas. My job involves evaluating patients and putting in place protocols for specific wound care, and, where necessary, contacting the different specialists at the hospital, acting as a liaison between the PHC areas and specialised care.

### What is the make-up of your team?

Currently, I am the only nurse and have one assistant nurse and one administrative assistant. Our work is carried out in conjunction with other specialists, mainly the vascular surgery department, internal medicine department, infectious diseases unit, as well as endocrinology, traumatology, plastic surgery and dermatology departments, and with the clinicians at the PHC centres.

### What types of wounds do you regularly see?

We treat all kind of wounds with diverse aetiologies at our clinic. The vast majority of them have a vascular origin (ischaemic, venous, and neuroischaemic ulcers), neuropathic or post-surgical coming from a variety of specialities, including paediatrics and, on occasion, oncological.

### What are the main types of equipment, dressings, and techniques that you use on a day-to-day basis?

We believe that success in the cicatrisation process comes from the early diagnosis of infection and trying to characterise it using biopsy cultures, quantitative cultures, or comprehensive blood tests. Our target is to reach an aetiological diagnosis, at the same time trying to avoid invasive techniques. If other diagnostic procedures are required, such as MRI, ultrasound, or angiography, we cooperate with the relevant departments.

In cases of venolymphatic pathology, it is mandatory to treat oedema immediately to speed up the healing process. All processes involving decongestion are made with low elasticity bandages during the initial stages of treatment and later we provide patients with high compression socks. If the patient is older and unable to put on the compression socks by themselves, we switch to double layer socks, which combine the different levels of pressure available (8, 19, 21 mmHg, for instance) and/or round or flat knitted garments.

We are well stocked in terms of therapeutical material in moist wound care and we can provide negative pressure therapy if needed, as well as cadexomer iodine, protease modulators, collagen dressings with gentamycine or ionic (colloidal) silver.

### What is the most unusual wound you have seen recently and how did you manage it?

It was not so much the rarity as the complexity of the wound management that was needed in the case that comes to mind. It related to a 70-year-old person with diabetes, hypertension and lymphomatoid papilloma that had been operated on some 4 years ago in the thigh. The patient's ankle brachial index (ABI) was 1.3. At first consultation, two lesions were discovered, both having been present for 1 year. The lesions affected two-thirds of the patient's left leg, one on the calf (30×10 cm) and the other on the ankle (7×7 cm). The pain experienced by the patient was recorded at 6–8 on a visual analogue scale.

There were clinical signs of infection by methicillin resistant *Staphylococcus aureus*, but the antibiotic therapy was empirical at

that time. We then adapted the antibiotic regimen based on the results of antibiogram of the biopsy culture. The wound had irregular edges, with some granulation tissue, but other necrotic areas, slough, and some residual lymphorrhagia. The per ulcer area had been damaged by the exudate, with erythema, and other lesions with haematoma aspect covered almost the rest of the leg. The abundant exudate had a fetid odour, resulting in the patient's family having to change dressings often.

Symptoms of the wounds were controlled through coordination with the input of an oncologist, who was responsible for drug prescription, adjustment of chemotherapy levels, and controlling protein supply. A weekly evaluation of the patient was also conducted by a PHC-based nurse. Wound care consisted of cleaning the wound with a chlorhexidine sponge, while per ulceral protection was provided using zinc foam. Activated carbon/coal dressings with silver, alginates, and absorbent dressings were all used.

The patient's ankle wound healed completely, while the calf wound reduced in size by 60%, with all satellite lesions healing fully. I believe that the low elasticity bandages were instrumental in the healing process and oedema control in this case.

### Do you feel your service/practice has any unique obstacles that hamper your work?

The workload is too much for one person alone. It would be wonderful to have more people, but this is just how it is right now.

### What equipment/resource/education would make the most difference to your everyday work?

I would really like to implement the use of autologous growth factors in complex wound care. I would also like to be able to work with the rehabilitation department to deliver lymphatic drainage therapy or ultrasound therapy to fragment proteins, thus enhancing lymphatic transportation. This is my dream. ■