



## Expert commentary

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On reading this article by Seckam and Cooper, we are reminded of both the traditional uses of honey in wound care over the past 2000 years, and the renewed interest in honey over the past two decades. This renewed interest has been prompted primarily by concerns around antibiotic resistance and the need for antimicrobial agents that inhibit planktonic and biofilm organisms in wounds. We note that the literature reflects increasing evidence to explain the broad-spectrum antimicrobial efficacy and cytocompatibility of honey, as well as its other bioactive properties that facilitate debridement and control malodour and inflammation. Such a combination of properties in one product makes one wonder why honey is not used more frequently and by more clinicians?

The authors suggest “some scepticism in some quarters” exists with regard to the use of honey and perhaps this is related more to practicalities in clinical practice than demands for high-level evidence. The amorphous honey formulations usually require twice-daily applications to ensure sustained efficacy. This frequency of application is not practical in most situations and comes with additional resource costs that can be inhibitive. However, the expanded range of honey formulations listed in **Table 1** may not be widely appreciated or used by some clinicians. Not only do these honey-impregnated formulations afford greater clinical choice for more wound types, but they also provide more sustainable effects (up to 3 days in wounds with low to moderate amounts of exudate).

Clinicians’ experiential knowledge can offer additional practical insights in regards to the selection of honey dressings. Recently, a patient presented at the community clinic at

which I work with an iatrogenic, deep partial thickness burn on his abdomen, extending into his umbilicus.

The burn had occurred during the surgical repair of an umbilical hernia but the causative agent was not known. Clinical indications suggested it was a chemical burn. Surgical debridement and skin grafting had been offered to the patient, but he declined; his preference was to be discharged from hospital and receive wound care from a community clinic. Prior to hospital discharge, a silver alginate dressing had been applied to the burn, which was covered in thick, white eschar. However, the dressing had adhered, causing the patient significant pain.

Following comprehensive assessment, the short-term goals of care in our clinic were debridement, infection control, and pain management. Iodine- and chlorhexidine-based products were not used due to concern that the skin preparation agent used prior to surgery – although unknown – was likely one of these agents and may have been the cause of the burn. The wound was too dry for a silver fibre or fabric product. Thus, a honey-impregnated alginate dressing was applied and found to conform well to the wound and umbilical undulations and was comfortable for the patient. Medical-tape sensitivity was also suspected, so a secondary absorbent pad was held *in situ* with an abdominal binder. Autolysis of the eschar was efficient and over the next 4 weeks the wound progressed to healing. Even the surgeon was impressed.

This scenario suggests that perhaps clinicians need to reconsider the use of honey, not only in light of new and expanding evidence, but from a pragmatic perspective when sensitivities or concerns exist in relation to other antimicrobials.