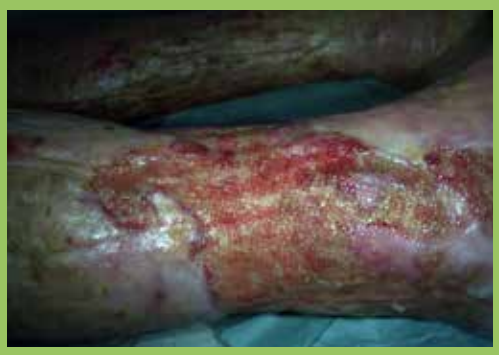
INTERNATIONAL
CASE STUDIES

Case series evaluation:
ADAPTIC TOUCH® in conjunction with negative pressure wound therapy

CASE STUDIES SERIES 2015



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Using ADAPTIC TOUCH® in conjunction with negative pressure wound therapy

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INTRODUCTION

Negative pressure wound therapy (NPWT) has become more accessible and is frequently used in the management of a variety of wounds, including acute and chronic wounds[1]. At a basic level, NPWT provides a sophisticated, sterile, closed dressing that allows a moist healing environment. Its use supports healing by:

- Increasing local blood flow
- Reducing oedema
- Stimulating formation of granulation tissue
- Removal of infectious material and wound fluids
- Drawing the wound edges closer together[1].

NPWT is often used to treat chronic wounds, especially those that have not responded to alternative treatments, as a bridge to surgical closure or to progress the wound to healing by secondary intention[2]. It is of particular use in patients for whom surgery is not an option, due to comorbidities or because they are not concordant with surgical intervention[2]. NPWT has been shown to be cost-effective in several types of hard-to-heal wounds, including diabetic foot ulcers, surgical and traumatic wounds, and burns[1]. The benefits of NPWT (Box 1) can be supplemented by the selection of an appropriate wound contact layer for use under the wound filler or NPWT dressing.

WOUND CONTACT LAYER SELECTION IN NPWT

A wound contact layer should be used in NPWT to:

- Protect fragile wound structures
- Help minimise trauma and the potential for bleeding at dressing removal in patients with increased risk of bleeding
- Facilitate future dressing removal
- Cover skin grafts
- Cover retention structures[2].

The wound contact layer can also be used to bolster the benefits of NPWT — for example, use of an antimicrobial dressing can help manage infected wounds. After a thorough, holistic assessment of the patient, the clinician should choose the most appropriate primary wound dressing based on the needs of the patient and wound (Box 2, p2).

Box 1: Benefits of negative pressure wound therapy[2]

- Maintains a moist wound environment
- Draws wound edges together
- Removes exudate and infectious material
- Reduces oedema
- Promotes perfusion
- Promotes formation of granulation

Patient comfort

Effectively managing patient pain is a fundamental part of ensuring high-quality treatment, particularly in chronic and difficult-to-heal wounds[3]. During NPWT, adhesive film dressings are generally used to fix the wound dressing to the site and provide an adequate seal with the periwound skin for negative pressure to be generated. NPWT dressings require replacement every 48–72 hours (infected wounds may require more frequent dressing changes); occasionally, dressing removal may be uncomfortable for the patient[3]. By taking care to select appropriate non-adherent, fenestrated dressings, discomfort associated with dressing removal can be reduced[4].

ADAPTIC TOUCH® (Systagenix, an Acelity company) (Box 3, p2) is a non-adherent, flexible, open-mesh primary wound contact layer composed of cellulose acetate coated with a soft-tack silicone that may assist dressing application[5]. The dressings may be used in the management of wounds healing by secondary intention, including dry to heavily exuding, partial- and full-thickness wounds. Silicone is chemically inert[6], meaning that ADAPTIC TOUCH is atraumatic to the skin and wound, and minimises patient discomfort when used as a wound contact layer under NPWT to protect fragile wound structures.

Box 2. Properties of an ideal primary dressing for use with negative pressure wound therapy

- Can be placed under the NPWT wound filler to protect vulnerable structures
- Lets exudate easily pass through into the canister
- Easy to use and apply
- Minimises patient discomfort during the use of NPWT
- Does not adhere upon removal
- Does not cause trauma to the wound or surrounding skin on removal

Exudate management

Wound exudate can slow or even stop proliferation of key cells for the growth of healthy tissue, and can result in maceration of tissue[7]. A fenestrated wound contact layer should be placed underneath the wound filler not only to protect vulnerable structure (e.g. exposed blood vessels, organs or tendons and prevent disruption of the wound bed), but to also allow the passage of exudate into the canister[8]. When applied as a wound contact layer, ADAPTIC TOUCH conforms to the wound and lets exudate pass freely through its advanced mesh design into a secondary dressing[9]. This mesh design minimises the risk of exudate pooling and helps reduce the likelihood of tissue maceration and, because of the pore size, the potential for granulation tissue in-growth may be less than with other, similar products[7].

ADAPTIC TOUCH in practice

In a series of international case studies, ADAPTIC TOUCH was used as an alternative to traditional wound contact layers under NPWT to benefit patients with a range of wound types[10]. Over the course of those treatments, clinicians reported that ADAPTIC TOUCH was easy to use and remove, did not adhere, and did not cause patients pain during wear or upon removal.

In the five case studies that follow, similar results were seen over a variety of complicated wounds:

- A case of painful Fournier's gangrene, where the combination of ADAPTIC TOUCH and NPWT allowed the wound to be prepared for surgical closure
- A dehisced abdominal wound with putrefaction of flesh, which achieved 82% reduction from baseline over the 4-week study
- Maintenance of and improvement in a non-healing wound that allowed the patient time to embrace concordance with the recommended treatment decision
- A breast abscess in which undermining began to resolve in just 7 days
- A venous leg ulcer of 5 years' duration began to move towards healing (achieved 50% granulation tissue formation in 4 weeks).

By following the practical tips for using ADAPTIC TOUCH (Box 4, p3) — along with product instructions for use and local guidelines — the clinicians were able to enact a straightforward procedure that achieved the management goals for each wound. Furthermore, the dressing was shown to allow exudate to pass freely into the canister, without adhering or causing pain. Based on these outcomes, an NPWT protocol that incorporates ADAPTIC TOUCH should be explored for patients with fragile wound structures that are suitable for negative pressure therapy.

Box 3. Evidence for ADAPTIC TOUCH®

ADAPTIC TOUCH® has been evaluated in a number of *in vivo* and *in vitro* studies and has been shown to:

- Have sufficient tack for the dressing to remain in place during application, while still allowing atraumatic removal[11,12]
- Allow free passage of exudate through the mesh to the secondary dressing[11]
- Be easy to handle and apply[10].

Box 4. Tips for using ADAPTIC TOUCH® with negative pressure wound therapy

- Select a size of ADAPTIC TOUCH® that is appropriate to the wound size.
- If more than one piece of ADAPTIC TOUCH is required, ensure dressings overlap, to avoid secondary dressing adherence to the wound.
- Before application, prepare the wound bed according to appropriate wound care protocols.
- If need be, cut the dressing to size using sterile scissors before removing the release papers.
- Place gently on wound bed.
- Cover the dressing with an appropriate negative pressure wound therapy secondary dressing according to the wound type, wound position, exudate level and condition of surrounding skin.
- Ensure the primary dressing is removed. If the primary dressing appears dry at dressing change, wet with sterile saline before removing.

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CASE 1: FOURNIER GANGRENE WITH FOUR WOUND AREAS

INTRODUCTION

Mr SP is a 62-year-old male who was fit, healthy and active before admission for recent pain in the groin area and development of an abscess over 3 days. He also had noted sore and inflamed inner thighs before admission. The scrotal abscess ruptured with discharge on the third day, and the patient underwent emergency surgery and surgical debridement for Fournier gangrene.

The initial tissue viability assessment occurred 2 days post-surgery in the intensive therapy unit. There were five wound areas:

- Right groin, 20cm long x 2.5cm wide x 5cm deep
- Right thigh, 21cm x 2.5cm x 4cm
- Left groin, 20cm x 7cm x 4cm
- Left thigh, 26cm x 5cm x 4cm
- Scrotum, 12cm wide x 5cm long.

TREATMENT

Due to the location of the wounds and intense pain, intravenous (IV) morphine and medical nitrous oxide/oxygen were required to allow the initial review to take place. Because of this pain, along with increased oedema, it was decided to proceed on all but the scrotum wound with negative pressure wound therapy (NPWT) in vacuum mode at -125mmHg, with ADAPTIC TOUCH® (Systagenix, an Acelity company) as the wound contact layer, along with V.A.C.® GranuFoam™ (KCI, an Acelity company). A thin hydrocolloid border was applied to assist adherence of the drape and to protect the skin. Dressing change was scheduled for 3 days later. The patient was also started on IV antibiotics; signs and symptons of infection were managed per local protocol throughout.

First dressing change: Due to the location of the wounds around the genitalia, the oedema and the position of the dressing needed to achieve a good seal, the patient was in significant pain and was given IV pethidine and midazolam, as well as medical nitrous oxide/oxygen. Neither ADAPTIC TOUCH nor GranuFoam adhered to the wound bed upon removal, and the wound was cleansed with saline before inspection and re-dress. All four wounds treated with NPWT had reduced in depth by about 20% (no changes in length and width), with good infill of healthy-looking granulation tissue and reduction of periwound erythema. Exudate levels were low and slough had reduced. To ensure rapid wound-size reduction while maintaining a protective barrier (particularly important due to *Candida* infection around the scrotum), the decision was made to continue the dressing regimen.

Second dressing change: At the assessment and dressing change, the same cleansing and sedation regimens were followed. The wound bed was much cleaner, 'beefy' red granulation was present,

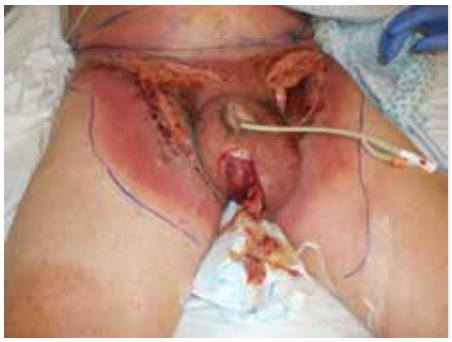


Figure 1: Baseline

Figure 2: First dressing change

Figure 3: Second dressing change

periwound erythema had resolved, cavity depth had reduced, and there was evidence of epithelialisation at the margins. Exudate levels remained low, and ADAPTIC TOUCH continued to not impede its passing into the canister. Due to the wounds' progress and to continue healing, the dressing regimen was continued, with the next change scheduled for 3 days later.

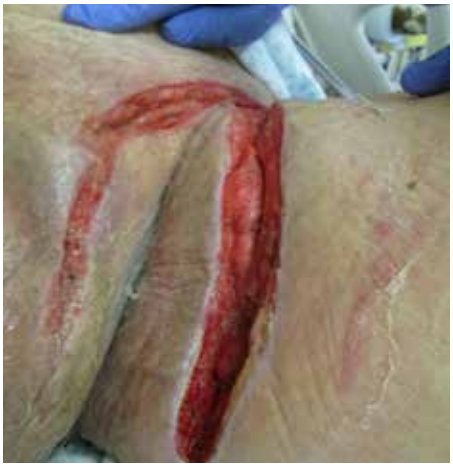
Third dressing change: Sedation and cleansing were carried out as at previous dressing changes. Exudate volumes had reduced by over 50% and were minimal, and there was visible epithelialisation at the margins. Granulation tissue was clean, and the four wounds had reduced in size:

- Right groin, 17cm long x 1.8cm wide x 3cm at deepest point (63% reduction from baseline)
- Right thigh, 17.2cm x 2cm x 2.8cm at deepest (54% reduction)
- Left groin, 16.8cm x 4.8cm x 2.7cm at deepest (61% reduction)
- Left thigh, 21.2cm x 3.6cm x 2.6cm at deepest (62% reduction)

The dressing regimen was continued, to be removed in the operating theatre in 1 week, when the wounds would be surgically closed.

DISCUSSION

ADAPTIC TOUCH was found to be easy to apply, conforming easily to the anatomical areas involved. The dressing did not adhere to the wound bed, nor did it interfere with the use of NPWT. Because of the rapid healing, the dressing regimen was continued up until surgical closure to further enhance epithelialisation and the growth of healthy granulation tissue.



Figures 4a–c: Third dressing change

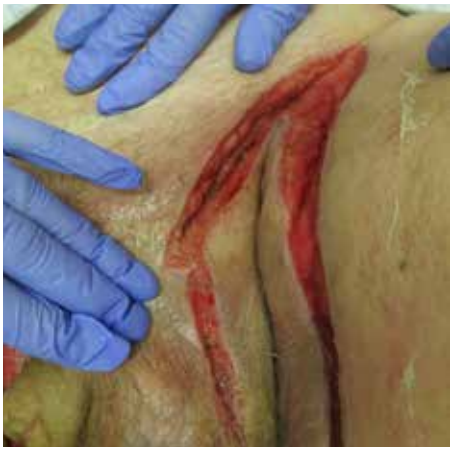


Figure 4b

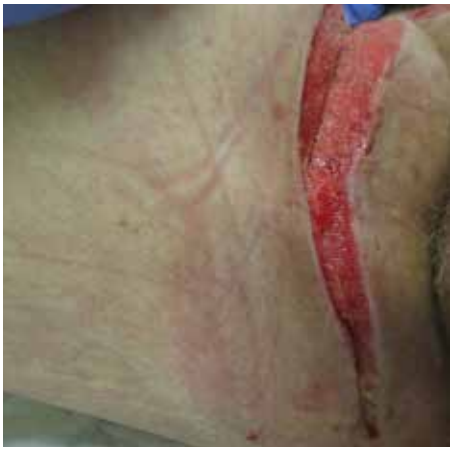


Figure 4c

CASE 2: DEHISCED ABDOMINAL WOUND WITH PUTREFACTION OF FLESH

INTRODUCTION

Ms BB is a 65-year-old female with type 2 diabetes, morbid obesity, hypothyroidism and hypertension who presented with a necrotic abdominal wound. She was taking metformin, doxycycline, levothyroxine, lansoprazole, atorvastatin, ferrous fumarate, amlodipine, amitriptyiline, candesartan, furosemide and calcium resonium.

She had initially presented in accident and emergency that day, 3 weeks after a blunt trauma wound due to a fall, which had resulted in strong odour, mild cellulitis, and necrotic tissue that was very soft on palpation with 'putrefied' flesh beneath. The patient had been treated in the community with two courses of oral antibiotics, but at this time required emergency surgical debridement. It was found after excision that fat had liquefied and gas gangrene was present. She was put on insulin due to unstable blood glucose after the procedure.

V.A.C. VeraFlo™ (KCI, an Acelity company) negative pressure wound therapy (NPWT) with irrigation (30ml saline for 10 minutes every 3.5 hours at -125mmHg) was initially used for 5 days to cleanse the putrefied flesh in the wound, while generating the benefits of NPWT. After cleansing was complete, the wound, located on the left side of the abdomen (along the transverse plane from the umbilical to the lateral margin), measured 50cm long x 11cm high x 3.5cm deep. The patient had pain in the left iliac fossa and corresponding deep red erythema in that area. The patient was transitioned to NPWT to granulate the wound and prepare for closure; signs and symptoms of infection were managed per local protocol throughout.

TREATMENT

Due to the location of the wound and its size, the decision was made to proceed with NPWT at -125mmHg, with ADAPTIC TOUCH® (Systagenix, an Acelity company) as the wound contact layer, along with V.A.C.® GranuFoam™ (KCI). Cleansing was done with saline, a thin hydrocolloid was applied to protect the periwound area and aid drape adherence (due to moisture on the skin). Dressing changes were scheduled for every 3 days, with review every 7 days.

Week 1 review: Cleansing and hydrocolloid application were performed. Pain level was improving, particularly in the left fossa, and the patient rated wound-related pain as 2 out of 10 on the visual analogue scale (VAS). ADAPTIC TOUCH was easy to remove, without adherence to the wound bed, and the patient rated dressing-change pain as a 3. The wound was 75% clean granulation tissue, with 25% soft slough dispersed throughout. Erythema had

Figure 1: Baseline

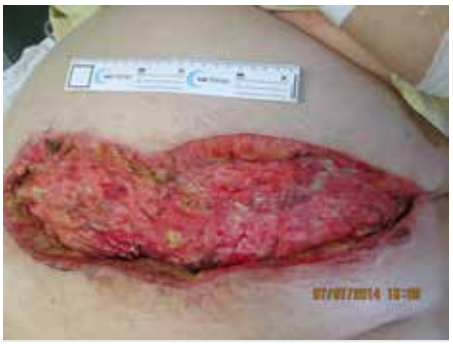


Figure 2: Week 1 review

Figure 3: Week 2 review

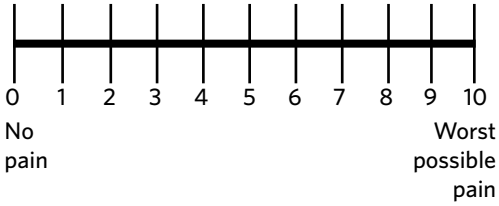


Figure 4: Visual analogue scale for pain

reduced, exudate levels were moderate, and the wound measured 47cm x 10cm x 3cm at the deepest point (27% reduction from baseline). Because the wound was responding well to treatment, the dressing regimen was continued unchanged. The patient tolerated application of the new dressing well; the foam and ADAPTIC TOUCH slid into place easily.

Week 2 review: The cleansing and change regimen proceeded as previously described. Exudate levels were still moderate, but erythema had resolved. Good infill of healthy, nonfriable granulation tissue was present. The wound was showing signs of contraction, measuring 46cm x 7cm x 2.5cm (58% reduction from baseline). The patient rated wound-related pain as 1 on the VAS and dressing change pain as 2, and did not require sedation. Because ADAPTIC TOUCH continued to protect the new granulation tissue and easily conformed to the wound with no adherence, and because the wound continued to progress but was still too large for surgical intervention, the dressing regimen was continued unchanged.

Week 3 review: The dressing cleansing and change routine was carried out. There was an increased amount of slough over 45% of the wound bed; the wound was not infected, but the patient had generally declined over the 72 hours before the review due to respiratory issues and increased oedema due to significant systemic changes that were, at the time of review, beginning to respond to treatment. Exudate volume was low, and epithelial tissue and contraction had increased. The wound measured 46cm x 6cm x 2cm (71% reduction from baseline). To continue managing the size of the wound, the dressing regimen was continued using a portable NPWT unit, to allow more physiotherapy and independent mobility to aid respiratory issues.

Week 4 review: Cleansing was carried out; hydrocolloid was not needed on the periwound area. Exudate levels were low, the slough build-up from the previous week had lifted, and there was epithelial migration, with many areas now level. The wound measured 45cm x 5cm x 1.5cm (82% reduction from baseline). The patient rated wound-related and dressing-change pain as 1 on the VAS. To move the wound towards a size appropriate for surgical grafting, the dressing regimen was continued unchanged.

Figure 4: Week 3 review

Figure 5: Week 4

DISCUSSION

The patient requested at week 3 to see the wound for the first time, and she remarked that she was surprised at how it looked and how well healing was going. She was highly satisfied with her care and the ADAPTIC TOUCH dressing used with NPWT. From the clinician perspective, the dressing worked well and let exudate pass into the canister, and there were no concerns that ADAPTIC TOUCH or the foam would adhere.

CASE 3: MAINTENANCE AND IMPROVEMENT IN A NON-HEALING WOUND

INTRODUCTION

Mr PK is a 72-year-old male with type 1 diabetes, ischaemic heart disease, hypertension, hyperlipidaemia, peripheral vascular disease and lower-limb ischaemia, and psychosocial issues with self-neglect. He was on insulin, aspirin, metformin, diuretics, angiotensin receptor blocker, atorvastatin, gabapentin and nicotine patch. He had a history of leg ulceration over 5 years before presenting with a venous leg ulcer (VLU) and diabetic foot ulcer (DFU).

TREATMENT

After transfer from another hospital, the wounds were presenting with graft dehiscence (and pressure ulcers) after a right femoral crossover graft that had not re-perfused adequately. The patient refused to consider amputation, so the VLU and DFU had been treated with larval debridement. He developed *Pseudomonas* colonisation after the first round and underwent subsequent larval and surgical debridement.

After review with surgeons, he was still not prepared to undergo amputation. When he was referred back to the tissue viability team, the right posterior aspect over the gaiter area exhibited superficial tissue loss of 2.5cm x 1.5cm with a granulating wound bed; the right lateral malleolus had purple/black deep tissue injury 1.5cm x 1.5cm (caused by ischaemia and diabetes); and the right lateral aspect of the heal had eschar measuring 6cm x 3cm. The extent of debridement on the dorsum of the right foot was 24cm x 11cm, with a wound bed comprising 30% granulation tissue, 20% slough and 50% necrosis with exposed tendons and deteriorating toes. The necrotic tissue was malodorous.

ACTISORB® Silver 220 was woven between the toes due to moisture and odour from necrosis, and held in place by a thin hydrocolloid strip. To prevent further limb deterioration and reduce the frequency and discomfort of dressing changes, the decision was made to initiate negative pressure wound therapy (NPWT) over the dorsum of the right foot.

The wound was cleansed with saline, and a thin hydrocolloid was applied around the periwound margin to aid drape adherence. ADAPTIC TOUCH® (Systagenix, an Acelity company) was used as the wound contact layer to protect the tendon and base of the wound and V.A.C.® GranuFoam™ (KCI) as a secondary dressing, because standard dressings were not controlling exudate. NPWT was applied at -125mmHg. Reviews were scheduled daily; signs and symptoms of infection were managed per local protocol throughout.

First dressing change: The dressing change routine was carried out as described above. The wound's overall appearance was cleaner, with reduced slough and increased contraction. The wound measured 21cm x 8cm (36% reduction from baseline). Some necrosis had lifted, allowing purulent discharge to be released from behind the exposed tendon. The vascular surgeon who reviewed was 'very happy' with the progress. Exudate levels were high, but ADAPTIC TOUCH did not interfere with its passage to the canister. Dressing removal caused no trauma and did not exacerbate pain levels: the patient rated

Figure 1: Baseline

Figures 2a–b: First dressing change

Figure 2b

both wound-related and dressing-change pain as 8 of 10 on the visual analogue scale (VAS) and was given top-up oral morphine and medical nitrous oxide/oxygen for dressing change. For symptom management and because the limb showed slight signs of improvement, the regimen was continued with dressing change scheduled in 72 hours.

Second dressing change: Routine dressing change revealed the wound bed status to be generally static, and the fourth toe on the right foot was showing signs of becoming ischaemic. However, there was a reduction in the purulent discharge behind the tendon, and overall exudate levels had reduced to moderate. A swab found the wound was still free from the previous *Pseudomonas* infection. There was a slight reduction in the width of the wound across the toes (0.4cm), and some granulation had begun to appear over the tendon. Overall, the wound measured 20.7cm x 7.6cm (40% reduction from baseline), and the wound comprised 35% granulation, 30% slough and 35% necrosis. The patient appeared more tolerant during dressing change: wound-related pain was rated 7 and dressing-change pain 6 on the VAS. To continue to protect the wound from further deterioration and, if possible, encourage reperfusion, the dressing regimen was continued.

Third dressing change: Due to increased pain in the toes, dressing change was performed early to let the vascular surgeon review the wound. Wound bed dimensions were static, but exudate levels had further reduced in volume. The patient reported that pain felt more controlled at dressing change, although pain ratings had not changed. Ischaemic discolouration was noted in the great toe; however, the patient was still refusing to consider the possibility of amputation. Because ADAPTIC TOUCH appeared to protect the exposed tendon and was encouraging some growth of granulation tissue, and because the dressing regimen was offering symptom control, it was continued.

Fourth dressing change: This was carried out as per the routine. Some tendon was further covered by granulation tissue, exudate levels had further reduced and there were no signs of infection. Wound size had decreased to 20.3cm x 7.2cm (45% reduction from baseline). However, the toes had further deteriorated and, after long discussions with the vascular and tissue viability teams, the patient decided to undergo below-knee amputation. The dressing regimen was discontinued.

DISCUSSION

The patient is still in hospital and, after amputation, is a much more positive man. Although amputation was the best choice for this non-healing wound, using ADAPTIC TOUCH and NPWT helped avoid rapid wound deterioration and reduce dressing-change pain, until the patient could be concordant with amputation. He is now pain-free and understands how ill he could have become, appreciating that the dressing regimen gave him time to make the 'right' decision. Despite his many comorbidities and the severity of his symptoms, the combination of ADAPTIC TOUCH, V.A.C. GranuFoam and NPWT maintained the wound area and even imparted some improvement in a wound where healing was not the end goal. The ADAPTIC TOUCH and V.A.C. GranuFoam dressings were found to be easy to use, with good conformability and no adherence on dressing change.

Figures 3a–b: Second dressing change

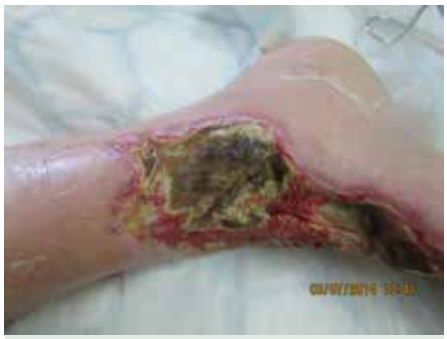


Figure 3b

Figure 4a: Fourth dressing change

Figure 4b: Fourth dressing change

CASE 4: RECURRING STRESS-RELATED ABSCESS OF RIGHT BREAST

INTRODUCTION

Ms HA is a 55-year-old female with raised BMI and a past history of stress-related abscesses over the body, resulting in an abscess to the right breast. A recent previous large abdominal abscess (April 2014) had been treated with surgical debridement and negative pressure wound therapy (NPWT). She was on medication for long-term depression.

The patient presented for emergency admission for a ruptured stress abscess on her right breast, which required urgent surgical debridement for necrotising fasciitis. The procedure left a large cavity from significant breast tissue removal, including the nipple and areola. The wound measured 25cm wide x 10cm long; depth could not be measured due to pain levels. Cellulitis and significant erythema were present around the periwound margin. The wound bed comprised 60% necrosis, 20% slough and 20% granulation tissue. There was suspected undermining that could not be explored due to pain.

TREATMENT

Because the patient had previously responded well to NPWT and was eager to heal the wound quickly, an NPWT regimen beginning with irrigation (30ml saline for 10 minutes every 3.5 hours at -125mmHg) was initiated. V.A.C. VeraFlo™ (KCI, an Acelity company) was used to remove the necrotising fasciitis and prepare the wound bed. After 1 week, the wound measured 21cm wide x 7 cm long; the overall dimensions with undermining were 28cm wide x 20cm long. The wound bed comprised 90% healthy granulation tissue and 10% slough. Exudate levels were low.

To address the extensive undermining, NPWT at -125mmHg, with ADAPTIC TOUCH® (Systagenix, an Acelity company) as the wound contact layer, along with V.A.C.® GranuFoam™ (KCI) was applied. Medical nitrous oxide/oxygen was administered due to pain. Dressing changes were scheduled every 72 hours.

First dressing change: The wound was cleansed with saline. Exudate levels were low, erythema at the periwound margin had resolved, and the wound bed was predominantly healthy granulation tissue, with areas of loose slough scattered over 5%. The wound measured 20cm x 6.5cm (12% reduction from baseline) and the undermining area 27cm x 19cm (8% reduction from baseline). No sedation was required as pain had greatly improved — the patient rated both wound-related pain and dressing-change pain as 3 of 10 on the

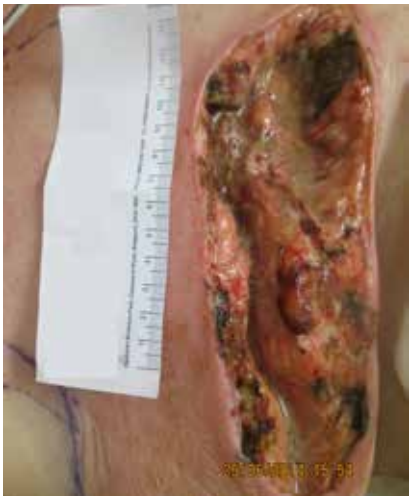


Figure 1: Initial presentation

Figure 2: Second dressing change

visual analogue scale (VAS). To continue to reduce the wound size and encourage the growth of healthy granulation tissue, the dressing regimen was continued unchanged.

Second dressing change: Cleansing was performed. Exudate levels had reduced and were still low. The wound bed comprised 98% granulation tissue and 2% slough. There was further contraction and evidence of epithelialisation. The wound measured 18cm x 6cm (27% reduction from baseline) and the undermining 26.5cm x 18.5cm (12% reduction from baseline). Pain was 1 of 10 on the VAS. The dressing regimen was continued unchanged.

DISCUSSION

After 1 week, the patient was discharged to the care of community nurses to continue the dressing and NPWT regimen. Although the patient did not return for formal assessment, the wound was reviewed twice more (Figure 3 and Figures 4a–b). Throughout treatment, the wound showed good progress towards healing, and ADAPTIC TOUCH was easy to use, with no adherence to the wound bed and virtually pain-free for the patient.

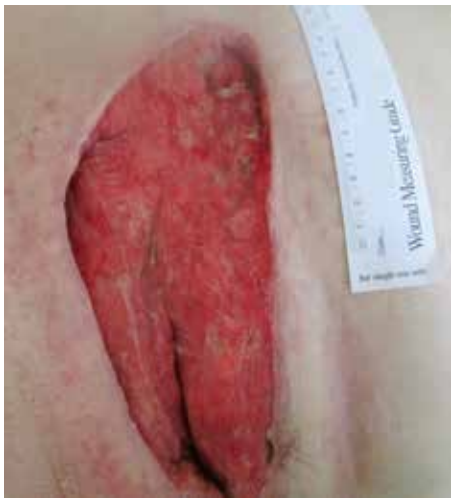


Figure 3: Third dressing change

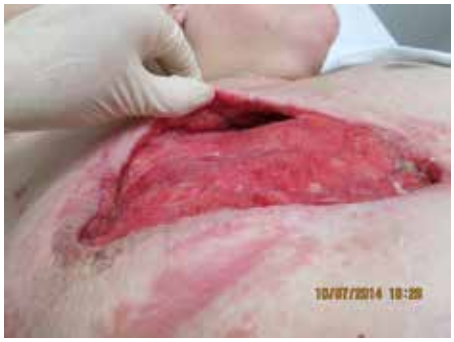


Figure 4a: Fourth dressing change

Figure 4b: Fourth dressing change

CASE 5: VENOUS LEG ULCER OF 5 YEARS' DURATION

INTRODUCTION

Ms VM is a 74-year-old female with hypertension (being treated with antihypertensive agents), anaemia and a history of venous leg ulcers (VLUs) in both legs. She presented with a VLU on the lateral right lower leg that had occurred after a trauma in the home. The 10cm x 12cm wound was not progressing — it was 5 years old — despite the use of appropriate compression systems and the wound bed was lightly exuding.

TREATMENT

The patient was very practical-minded about treatment, but did not want to tolerate pain at dressing removal. To progress the wound towards healing and minimise pain, NPWT at -125mmHg, with ADAPTIC TOUCH® (Systagenix, an Acelity company) as the wound contact layer was applied. Two-layer compression was used over the dressing and NPWT. Dressing changes were scheduled for every 3 days, with weekly review.

Week 1 review: The wound was free from infection, but exudate levels were high. Granulation tissue had increased slightly, although wound size remained the same. The patient rated both wound-related and dressing-change pain as 3 of 10 on the visual analogue scale (VAS). ADAPTIC TOUCH was easy to use and did not cause bleeding upon dressing change. The treatment regimen was continued unchanged.

Week 2 review: Granulation tissue coverage had again increased, and the wound was free from infection. Exudate levels were still high, and wound size was unchanged. The patient rated pain a 3 on the VAS. Because the wound was responding after 5 years, ADAPTIC TOUCH was easy to use, and the patient was highly satisfied with the low pain level, the treatment regimen was continued.

Week 3 review: Granulation tissue had increased and now covered between 25 and 50% of the wound, which was unchanged in size. Exudate levels were now moderate, and the beginnings of epithelialisation at the wound edges was observed. The patient rated pain 2 on the VAS. Because results continued to be positive all around, the treatment regimen was continued unchanged.

Week 4 review: Granulation tissue continued to increase, to about 50% of the wound, and the wound size had reduced to 10cm x 10cm (17% reduction from baseline). Exudate levels were moderate, and pain was still a 2 on the VAS. Although the case study period had ended, the treatment regimen was continued.

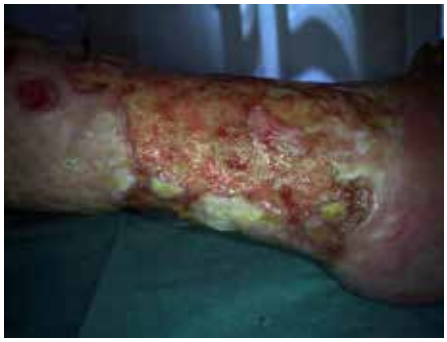


Figure 1: Baseline

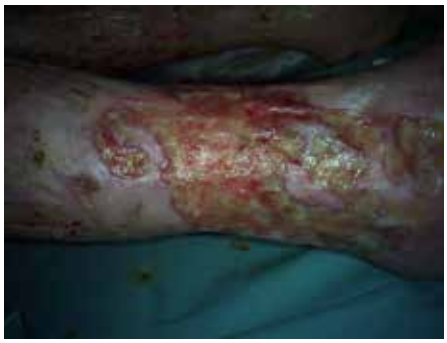


Figure 2. Week 1 review

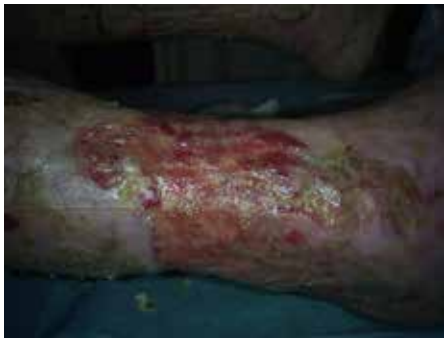


Figure 3. Week 2 review

DISCUSSION

This case study demonstrated how the combination of ADAPTIC TOUCH and NPWT could kickstart healing in a previously recalcitrant wound. ADAPTIC TOUCH was easy to use and place, did not adhere to the wound bed and let exudate pass through to the canister. The patient was highly satisfied, as she saw progress towards healing and did not experience high levels of pain as part of treatment.

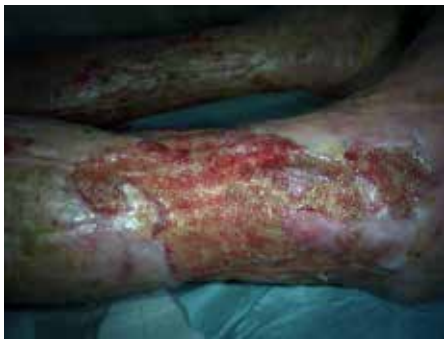


Figure 4: Week 3 review

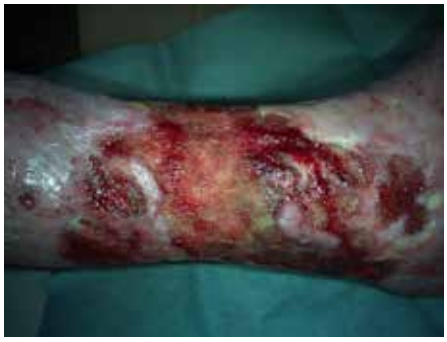


Figure 5: Week 4 review

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