

THE GRANULATOR

.....a less-pain academy educational initiative for wound care clinicians



SEND to a friend



FROM THE EDITOR

We are looking forward to meeting you at the **AMWA conference (BOOTHS 23-25a)** and are delighted to announce that **Tod Brindle** will be speaking at the **Mölnlycke SIG Breakfast on Thursday 25th March** and at "in booth" presentations throughout the conference. Tod will discuss an innovative strategy in the prevention of pressure ulcers.

Did you manage to listen to the latest less-pain academy live seminar? If not, all is not lost! Ask your local representative or download it from the lesspain.com website. The presentation will be podcast and is entitled **Wound Related Pain Story, Where we have come from...where we are going**, 1 CNE point can be allocated. Wendy White is a fantastic presenter and reminds us of some important considerations with regard to assessing and managing pain at dressing changes.

COMPETITION

Thank you to all those who submitted suggestions for the newsletter. We had some very innovative suggestions and as you can see "**The Granulator**" was the favourite and I congratulate **Judy Blair from the Orthopaedics Department of the Canberra Hospital**, for this suggestion. Your wound care manual is on its way.

EVENTS

	MON	TUE	WED	THUR	FRI	SAT	SUN
1	2	3	4	5	6	7	
8	9	10	11	12	13	14	
15	16	17	18	19	20	21	
22	23	24 AWMA	25 AWMA	26 AWMA	27 AWMA	28	
29	30	31		28	29	30	

MARCH 24-27 :

Mölnlycke Health Care is delighted to announce its Platinum Sponsorship of the **2010 AWMA Conference**. We look forward to seeing you in Perth.

WOUND INFECTION

Varied opinions for a common challenge

By William McGuinness, Deputy Assoc. Dean, Div. of Nursing & Midwifery, La Trobe Uni.

A wound bypasses the natural defence provided by the skin to bacterial infiltration. Effective wound management is aimed at preventing bacterial colonisation and subsequent infection. Infection of a wound is commonly cited as a factor that interferes with the normal healing cycle. Early recognition of bacterial infiltration via developing signs of infection and the implementation of preventative and treatment strategies is therefore an important component of wound management.

But what is meant by the term wound infection? How is a wound infection recognised? What management strategies are effective against different types of infection? Answering each question provides an important frame work for managing wound infections. It also highlights the differing opinions that are proffered in regard to this subject.

Definitions of wound infections are many and varied. Most authors refer to an invasion of tissue by one or more types of microorganisms with the severity of the outcomes determined by the virulence of the organisms and the immunocompromised status of the host defences (Bolton 2004). Common infecting organisms are those normally found on the skin with streptococcal and staphylococcal strains being the most represented (Frank, Wysocki et al. 2009).

Translating this theoretical concept into clinical observations, however, remains principally a subjective interpretation. A systematic review by Bruce et al. (Bruce, Russell et al. 2001) examined ninety prospective studies from twenty countries in an effort to identify common features. They identified forty one definitions for a wound infection. No signs or symptom were common to all definitions. The sign with the highest frequency was purulent discharge (54 studies) with erythema and swelling the next most common signs (8 studies). Studies that had examined the accuracy with which health care practitioners identify wound infections demonstrated a range of both false positives (identifying an infection not present) and false negatives (failing to identify an infection that was present). Further the reliability of wound cultures (swab or biopsy) was questioned with bacteria being isolated from healing wounds not exhibiting signs of infection or alternatively not isolating bacteria in wounds exhibiting early signs of infection. This is further complicated by references to different levels of bacterial infiltration within the literature. Terms such as critical colonisation, bacterial burden,

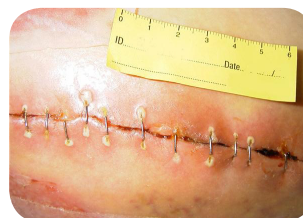
and biofilms suggest that the clinician is not only required to identify infection but also to determine if slow to heal wounds, not manifesting infection, are being hampered by an infective source. When combined it is obvious that a "gold standard" for recognising when microbes are interfering with wound healing is yet to be determined.



Infected venous leg ulcer

Whilst the evidence suggests a degree of subjectivity, observing for core or 'cardinal' manifestations of wound discharge, erythema, oedema, pain, and local heat will help early detection in acute and surgical wounds healing by primary intention (Bruce, Russell et al. 2001). In chronic wounds these manifestations may be masked by underlying pathologies (e.g. ischemia, diabetes). Additional manifestations for identifying early infections in these wounds include discolouration and increased friable granular tissue, pocketing of the wound base, increased necrotic tissue, foul odour and malaise with or without pyrexia (Bolton 2004; Santy 2008; Frank, Wysocki et al. 2009; Frankel, Melendez et al. 2009). Detailed identification criteria can be found in the consensus documents "Wound infection in clinical practice: and international consensus" (http://www.mepltd.co.uk/downloads_pub.html) and "Management of wound infections" (<http://ewma.org/english/position-documents/all-documents.html#c322>)

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Inflamed suture line



MYTHBUSTERS

Mepitel® causes hypergranulation!

- NOT TRUE!

By definition hypergranulation is an excess of tissue produced by fibroblasts aetiology unknown. Common theories are bacterial bioburden +/- infection, excessive inflammation, continued trauma, increased moisture levels, and an imbalance between collagen synthesis and degradation.

Hypergranulation may indicate oedema of the wound tissue. Managing exudate levels becomes important when using Mepitel® and it is important to ensure that a sufficiently absorbent secondary dressing (such as Mesorb®) be used and changed as required.

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PAIN AT DRESSING CHANGES IS A MAJOR CONCERN – professional recommendations for minimising pain and trauma

Pain and trauma is most often experienced at dressing changes. The main causes are dressing wound adherence and aggressive adhesives damaging the peri-wound skin.

International consensus^{2,3} has led to key recommendations for helping health care professionals minimise pain and trauma at dressing-related procedures.



Patients prefer dressings with Safetac® technology

The results of a multinational survey¹ showed an overwhelming, statistically significant preference for dressings with Safetac® technology. **93% of patients wished to continue with the dressing with Safetac® technology.** Patients prefer dressings with Safetac® technology because they are less painful at dressing removal².

Find out more about how dressings with Safetac® technology reduce pain and trauma for your patients on www.less-pain.com.

References: ¹White R. A multinational survey of the assessment of pain when removing dressings. *Wounds UK*. ²Zilmer R et al. Biophysical effects of repetitive removal of adhesive dressings on peritumor skin. *JWC* 2006.

References: ²Waltz CF, Strickland OL, Lenz ER, Delphi Technique. *Designing Nursing Tools and Procedures*. Second Edition. 1991.F.A. (Davis Company, Philadelphia). pp338-55. ³Reddy M, Keast D, Fowler E, Sibbald RG. Pain in pressure ulcers. *Ostomy Wound Manage*. 2003; 49(4 suppl): 30-5.

MEPILEX® AG – a less painful way to target bacteria

Mepilex®Ag is a novel antibacterial dressing since it combines the unique features of Safetac® technology with the bacteria reducing power of silver. Mepilex®Ag goes to work quickly, inactivating wound pathogens within 30 minutes and for up to 7 days¹. At dressing removal, Mepilex®Ag does not stick to the wound or strip surrounding skin, minimising patient pain and wound trauma. Mepilex® Ag is not for every patient but for those with wounds that don't heal normally. If the bacterial influence is too high, it needs to be reduced in order not to interfere with the wound healing.

Every part of the body deserves a less painful dressing change



TUBIFAST® GARMENTS

NOW AVAILABLE

	Sizes
Vests	6mth to 14yrs
Leggings	6mth to 14 yrs
Socks	One size fits all
Gloves	S, M, L Child & Adult



Please contact your local representative for more information.

WOUND INFECTION....cont'd

The varied definitions for wound infections and criteria for identification is further complicated when treatment strategies are examined. Approaches fall into systemic and local interventions. Systemic approaches use antibiotics and anti inflammatories to reduce bacterial counts and infiltrations. Local approaches are aimed at changing the wound environment to be less conducive to microbiological infiltration and multiplication. This is achieved by the debridement of necrotic tissue, maintaining a moist (not wet) interface and the introduction of broad spectrum antimicrobials. Common evidenced based options for the latter include ionised silver, iodine and honey. Each has been demonstrated to be effective against common infecting organisms including resistant strains such as MRS and VRE. Contemporary products have been designed to not only deliver these agents to the wound bed but also to replenish the concentration over time. This increases the efficacy of the product as the replenishment overcomes any inactivation that occurs when the active agent is mixed with wound fluid, for example ionised silver combining with chloride to become silver chloride. The slow release also overcomes any toxic effects such as those that could result from high doses of iodine. Each has advantages and disadvantages that can be found by reviewing the consensus documents listed above and manufacturers information. Wound infections are a complex complications that have yet to be defined, diagnosed and adequately managed. Until this is achieved the clinician must rely on a subjective assessment based on their previous experience and education. Vigilant aseptic techniques, regular assessment for developing cardinal signs of infection, and early elimination of pathological bacterial loads via debridement, systemic antibiotics and topical antimicrobials provide a sound foundation for contemporary management of wound infections.

Bibliography:
Bolton, L. (2004). "Surgical and Chronic Wound Infection Measurement Outcomes." *Wounds*(6). Bruce, J., E. Russell, et al. (2001). "Quality of Surgical Wound Infection Measurements." *Journal of Hospital Infection* 49: 99-108. Frank, D. N., A. Wysocki, et al. (2009). "Microbial diversity in chronic open wounds." *Wound Repair & Regeneration* 17(2): 163-172. Frankel, Y. M., J. H. Melendez, et al. (2009). "Defining wound microbial flora: molecular microbiology opening new horizons." *Archives of Dermatology* 145(10): 1193-1195. Santy, J. (2008). "Recognising infection in wounds. [Review] [29 refs]." *Nursing Standard* 23(7): 53-54. This article explores the clinical signs and symptoms that help healthcare staff recognise infection, which can be a painful, distressing and potentially life-threatening complication of wounds. [References: 29].

DO YOUR PATIENTS REQUIRE INSTRUCTIONS ON HOW TO MANAGE THE MEPILEX® AG DRESSING AT HOME?

Email: cheryl.rogan@molnlycke.com TO OBTAIN MÖLNLYCKE MEPILEX® AG DISCHARGE SHEETS.



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- Mepitel®
- Mepilex® BorderLite
- Mepiform®
- Mepilex®
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