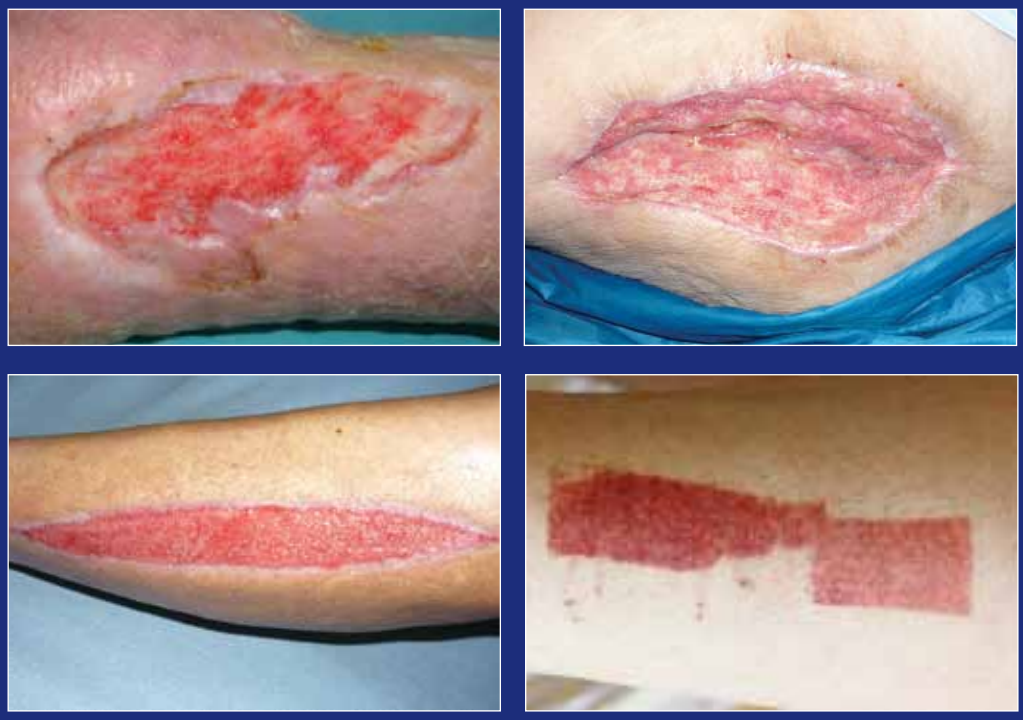
INTERNATIONAL
CASE STUDIES

USING ADAPTIC TOUCH® Non-Adhering Silicone Dressing: **CASE STUDIES**

CASE STUDIES SERIES 2013



Wounds INTERNATIONAL

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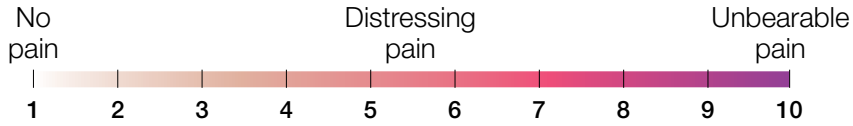
ABOUT THIS DOCUMENT

This document contains a series of case reports describing the use of ADAPTIC TOUCH® Non-adhering Silicone Dressing (Systagenix) in patients with a range of wound types. All patients were treated for a minimum of 2–4 weeks and the decision to continue with ADAPTIC TOUCH® was based on continual assessment. A formal assessment was performed weekly, although in some cases dressing changes were carried out more frequently.

All patients were assessed for:

- **clinical signs of infection/critical colonisation**
- **signs of improvement, including granulation extent and reduction in wound size.**

A pain assessment was carried out at the initial examination using a visual analogue scale (VAS) where 1 = no pain and 10 = unbearable pain.



Photographs were taken weekly in the majority of cases to document wound progression. Relevant additional wound treatments, such as compression therapy, antibiotic therapy, analgesia, etc were reported.

The clinicians undertaking the study were also asked to rate the dressing (from highly satisfied to dissatisfied) and to comment on the ease of use.

In addition, clinicians were offered the opportunity to check the protease activity in the wound using a WOUNDCHEK™ Protease Status test (Systagenix).

The weekly assessment outcomes are cited for each case where:
↓ = reduction ↑ = increase — = no change.

ADAPTIC TOUCH® Non-Adhering Silicone Dressing: case studies

ADAPTIC TOUCH® Non-Adhering Silicone Dressing is a soft tack silicone dressing that has an advanced mesh design and is highly conformable. The mesh design minimises the risk of exudate pooling, maceration and secondary dressing adherance to the wound[1-3]. Exudate is able to pass freely through the mesh. ADAPTIC TOUCH® is associated with patient comfort and minimal pain at dressing removal[1,2].

This document contains a number of case studies that describe how ADAPTIC TOUCH® can be used as an alternative to traditional wound contact layers under negative pressure wound therapy (NPWT) to benefit patients with a range of wound types. One of the cases describes a novel approach to managing skin graft donor site wounds using ADAPTIC TOUCH®.

What is ADAPTIC TOUCH®?

ADAPTIC TOUCH® is a non-adherent, flexible, open-mesh primary wound contact layer composed of cellulose acetate coated with a soft tack silicone to assist dressing application[4]. The dressings may be used in the treatment of wounds healing by secondary intention, including dry to heavily exuding, partial and full-thickness chronic wounds (Box 1). In addition, it can be used in the management of traumatic wounds such as skin tears. As the silicone is slightly 'tacky' this may help to maintain the position of the dressing.

Non-adherent dressings can be useful in patients with fragile or friable skin. Adherence of dressing materials to the skin can disrupt the formation of new cells and cause distress to patients, leading to stripping of the epidermal layer[5]. Non-adherent dressings are gentle on the skin. Silicone is chemically inert[6], meaning that ADAPTIC TOUCH® is suitable for use in patients with a high risk of sensitivity, such as those with leg ulcers. ADAPTIC TOUCH® offers atraumatic dressing removal and is suitable for use, under medical supervision, with negative pressure wound therapy (NPWT).

How does ADAPTIC TOUCH® work?

When applied as a primary contact layer, the dressing conforms to the wound and allows exudate to pass freely through its advanced mesh design into a secondary dressing[3]. This mesh design minimises the risk of exudate pooling and helps reduce the likelihood of tissue maceration, while ensuring a reduced risk of secondary dressing adherence to the wound.

Evidence for ADAPTIC TOUCH®

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

- retain its position on the wound bed when the secondary dressing is removed[1,4]
- have sufficient tack for the dressing to remain in place during application, while still allowing atraumatic removal[1,2]
- allow free passage of exudate through the mesh to the secondary dressing, thus minimising tissue maceration[3].

BOX 1: INDICATIONS FOR ADAPTIC TOUCH®

For the management of:

- dry to heavily exuding wounds, such as:
  - venous leg ulcers
  - pressure ulcers
  - diabetic foot ulcers
- traumatic and surgical wounds
- donor sites
- 1st and 2nd degree burns

BOX 2: PRECAUTIONS AND CONTRAINDICATIONS FOR THE USE OF ADAPTIC TOUCH®

- ADAPTIC TOUCH® is not indicated for patients with a known sensitivity to silicone or cellulose acetate fabric or for surgical implantation.

Tips on using ADAPTIC TOUCH®

- Prior to 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 secondary dressing according to the wound type, wound position, exudate level and condition of surrounding skin.
- Select a size of ADAPTIC TOUCH® that is larger than the wound to ensure the dressing can be applied to intact skin surrounding the wound margins.
- If more than one piece of ADAPTIC TOUCH® is required, ensure dressings overlap, to avoid secondary dressing adherence to the wound. Overlap should be minimised to prevent occlusion of holes.
- Dressing change frequency is determined by exudate levels and condition of the wound and surrounding skin.
- ADAPTIC TOUCH® can be left in place for several days, while the secondary dressing can be changed more frequently as required.
- If the primary dressing appears dry at dressing change it may be saturated with sterile saline solution prior to removal.
- ADAPTIC TOUCH® will not unravel or shed fibres.

ABOUT ADAPTIC TOUCH®

- For further information about ADAPTIC TOUCH® please go to: www.systagenix.com/adaptictouch

Ease of use

The ease of handling of ADAPTIC TOUCH® has been evaluated and compared with other commercially available non-adherent contact layers by a group of 13 clinicians[7] that had never worked with ADAPTIC TOUCH® before. It received the highest number of positive responses and the lowest number of negative ones, demonstrating that it was considered easy to handle when compared with dressings the clinicians were familiar with handling.

References

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5. Dykes PJ, Heggie R. The link between the peel of forces of adhesive dressings and the subjective discomfort in volunteer subjects. *J Wound Care* 2003; 2(7): 260-2
6. Thomas S. Soft silicone dressings: frequently asked questions. *World Wide Wounds*. Available online at: http://www.worldwidewounds.com/2003/october/Thomas/Soft-Silicone-FAQ.html
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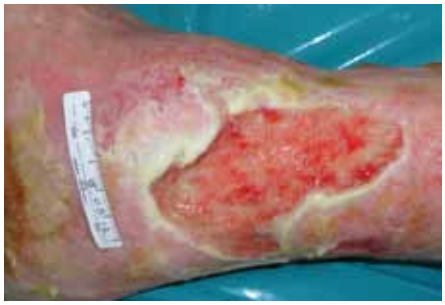
Case 1

Background
Mr A was a 76-year-old man with a longstanding venous leg ulcer on the medial aspect of the lower right leg, measuring 45cm^2. The wound had been present for 15 years and had occurred spontaneously as a result of underlying venous disease, confirmed by routine vascular assessment techniques, including Doppler ultrasound. On examination the wound bed was composed of around 25% granulation tissue, wound edges were oedematous and the surrounding skin was red and macerated. Previous treatments had included moist wound dressings and elastic compression bandages. Mr A also had systemic sclerosis.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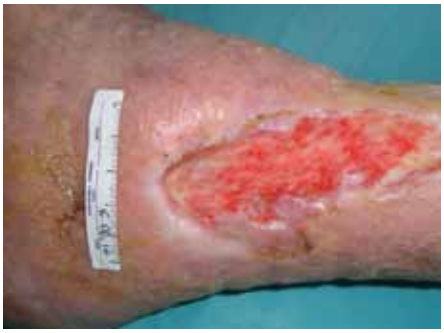

Week 4

Figures 1-2: The size of the wound decreased over the course of the study period and the contact layer aided comfort at removal.

Treatment
A WOUNDCHEK™ Protease Status test indicated low protease activity. The decision was taken to treat the wound with negative pressure wound therapy (NPWT) because it was large, hard to heal and had not responded well to standard treatment. It is the clinic's standard practice to use a wound contact layer under the foam dressing when using NPWT, so ADAPTIC TOUCH® was applied as a primary contact layer. The portable NPWT device (V.A.C.Via™; KCI) was used so that the patient remained mobile. Pressure was set at -125mmHg and an inelastic compression bandage system was applied toe to knee. The dressing was changed twice weekly in the community, and reviewed formally in clinic weekly.

Week 1: Seven days later, the wound dressing was removed and the wound was cleansed. ADAPTIC TOUCH® was easy to remove and had adhered only slightly to the wound bed. The patient reported a little pain before dressing removal, which reduced during removal. The wound bed showed 25-50% granulation tissue, the wound edges were less oedematous and the surrounding skin was healthier in appearance. Exudate levels were moderate. The treatment regimen was continued.

Week 2: Improvement was noted. The wound bed had decreased in size (42cm^2) and the edges were continuing to improve. Exudate levels remained moderate. ADAPTIC TOUCH® was easy to remove and had not adhered to the wound bed. The patient reported only mild discomfort prior to and during dressing removal. NPWT was continued with ADAPTIC TOUCH® as a primary contact layer under the foam interface layer. Inelastic compression bandages were applied toe to knee.

Week 3: Granulation tissue had again increased and the wound had reduced in size (40cm^2). Exudate levels were the same. ADAPTIC TOUCH® was easy to remove and did not adhere to the wound bed. The treatment regimen was continued.

Week 4: All clinical indicators suggested a positive response to treatment. Healthy granulation tissue in the wound bed had increased significantly (50-75%) and the wound had reduced again in size to 36cm^2. Exudate levels were low. The patient reported minimal pain when ADAPTIC TOUCH® was removed.

Assessment	Week 1	Week 2	Week 3	Week 4
Patient pain scores before and during dressing changes (VAS 1-10)	3, 2	2, 2	2, 2	1, 1
Protease activity	Low	n/d	n/d	n/d
Wound size	↓	↓	↓	↓

Outcome
This challenging recalcitrant wound, which had been treated over many years with different products, decreased in size at each assessment. Dressing removal was easy and did not cause trauma to the wound bed. Pain experienced by the patient decreased over the course of the study and no increase in pain was reported at dressing changes. Clinical staff rated the contact layer satisfactory or highly satisfactory in terms of ease of application and removal.

By: Marco Romanelli, Consultant Dermatologist, University of Pisa, Italy

Case 2

Background
The patient was an 87-year-old woman with osteoarthritis. She had fallen in the garden, fractured her left hip and had a total hip replacement, but the surgical wound had failed to heal. An abscess had formed and the resulting cellulitis had required intravenous antibiotic therapy. The wound was approximately 95cm^2 nine days after surgery (Figure 1). It had been treated with negative pressure wound therapy (NPWT) (V.A.C.® Therapy; KCI) with Mepitel® (Mölnlycke Healthcare) non-adherent dressing as the wound contact layer. The patient had experienced considerable pain during dressing changes and was anxious and disinclined to continue with NPWT. She was given morphine sulphate (Oramorph) 5–10mg prior to dressing removal.

Treatment
A WOUNDCHECK™ Protease Status test indicated protease activity was not elevated. The wound continued to be treated with NPWT (V.A.C.® Therapy; KCI). Because of the patient's severe pain, ADAPTIC TOUCH® was chosen as a wound contact layer. Also for the patient's comfort, the NPWT pressure level was lowered from the standard -125mmHg to ensure concordance. Pressure was set at -100mmHg on the continuous mode. Dressing changes were planned for every three days.

Dressing change 1: (9 July)The patient was given morphine sulphate 10mg to help with the pain at dressing change. Exudate levels were high but there were signs of healing and a positive response to treatment. The wound was estimated to be the same size as at presentation and granulation levels were between 0–25%. There were no signs of infection. The ADAPTIC TOUCH® had allowed exudate to pass through to the canister, had not adhered to the wound bed or the foam interface layer and was easy to remove. The patient rated her pain as 2 on a 10-point scale before the dressing change and 3 during it. The patient commented that the dressing had come away more easily than those previously used, and both nurse and patient were very satisfied with ADAPTIC TOUCH®. The regimen was continued.

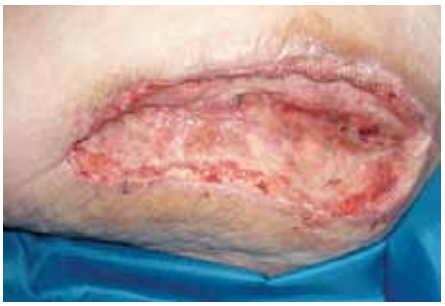
Dressing change 2: (11 July) The patient was again given 10mg morphine sulphate before the dressing was changed. Observations were largely the same as at the first dressing change and the wound size was estimated to be the same (95cm^2 with approximately 0-25% granulation tissue coverage). Granulation tissue was not seen growing through the mesh.

The patient experienced less pain at dressing change. She rated pain levels at 2 both before and during dressing change, and commented that the dressing was very comfortable. The nurse noted that the patient also appeared less anxious during the dressing change. The regimen was continued with the NPWT pressure increased to -125mmHg.

Dressing change 3: (13 July) The wound was estimated to have remained the same size (95cm^2) although it looked less deep. The level of exudate had reduced. The wound remained free from infection.

This time, no pain relief was required during the dressing change and the pain experienced by the patient had lessened: she rated the pain as 1 on a 10-point scale both before and during the change. The dressing was easy to remove and came away without adhering. The nurse found the ADAPTIC TOUCH® handled and cut well as a result of its backing paper, and could be laid on the wound in the presence of exudate without it moving.

As the patient experienced greater sensitivity at the wound margins, it was decided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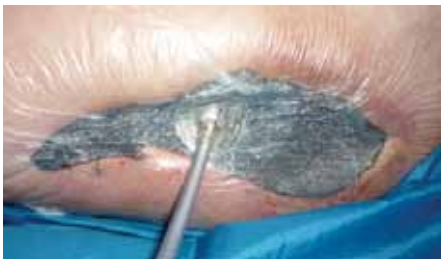
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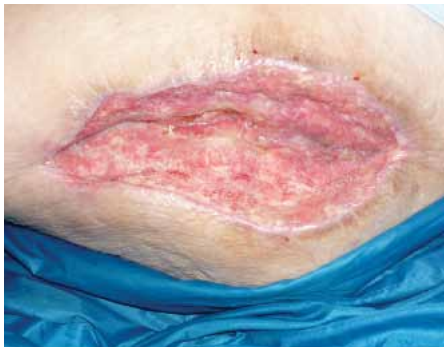
Figures 1-3: (Top) The wound at presentation. (Middle and bottom) Application of NPWT.

to slowly reduce the extent of the contact layer. The patient was anxious that when ADAPTIC TOUCH® was no longer used, she would experience severe pain again. As a result, application of ADAPTIC TOUCH® was limited to the sides of the wound bed.

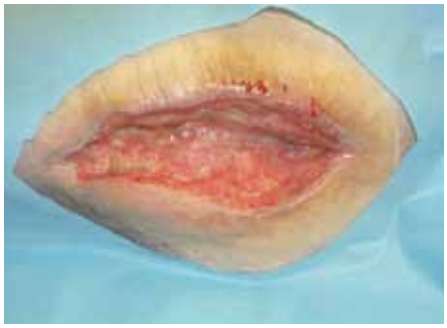
Dressing change 4: (16 July) Ten days after the ADAPTIC TOUCH® was introduced as a wound contact layer, signs of healing continued to be seen. Granulation was estimated as 25–50% of the wound bed but the wound was not measured. Exudate levels were low. The wound contact layer had not adhered to the wound bed or the foam interface layer and it was easily removed. There were no signs of infection and a WOUNDCHEK™ Protease Status test indicated protease activity was not elevated. The patient rated pain as a 1 on the 10-point scale. The regimen was continued.

Dressing change 5: (19 July) Exudate levels remained low and there were continued signs of healing. The wound continued to granulate (0–25% granulation tissue). The wound had reduced in size, as a result of its decreased depth (Figure 5). There were no signs of infection.

The dressing was easy to remove and the patient reported being pain-free during dressing removal. As the patient was not experiencing pain she was more relaxed at dressing changes, anxiety levels were reduced and the nurse observed an increase in trust during their interactions. The patient was discharged and the plan was to continue the current treatment regimen with regular weekly reviews. However, she was lost to follow-up when she moved out of the area to be with her family.



Dressing change 4



Dressing change 5

Figures 4-5: The patient reported decreased pain as the wound showed signs of healing.

Outcome

Both nurse and patient remained very satisfied with the dressing throughout the treatment period. The nurse found ADAPTIC TOUCH® very easy to use, since it could be cut to shape before removing the backing paper. ADAPTIC TOUCH® was easy to handle and place on the wound, and there were no problems with the passage of exudate into the canister. On presentation, the patient had been in considerable pain but agreed to further NPWT treatment with a reduced negative pressure and a change in the wound contact layer. The nurse believed that the alternative to using ADAPTIC TOUCH® and NPWT would have resulted in twice daily dressing changes, which would have negatively impacted the patient's wellbeing and increased the risk of the wound becoming infected. Using ADAPTIC TOUCH® with NPWT improved the patient's quality of life (fewer dressing changes) and enabled early discharge.

By: Janet McGowan, Lead Research Nurse, Bradford Wound Healing Unit|Bradford Institute for Health Research Clinical Research Facility, Bradford, UK

Assessment	1	2	3	4	5
Patient pain scores before and during dressing changes (VAS 1-10)	2, 3	2, 2	1, 1	1, 1	1, 0
Protease activity	Low	n/a	n/a	Low	n/a
Wound size	–	–	–	n/a	↓

Case 3

Background

Mr A, a 57-year-old man, underwent revision of a femoral popliteal bypass graft (lateral aspect of the left calf) on the 8th May, 2012. A thrombus developed in the graft resulting in compartment syndrome on the evening of surgery and, consequently, Mr A returned to theatre for an emergency fasciotomy. In addition to arterial disease, Mr A had type 2 diabetes, which was treated with sulphonylurea (Glimepiride) 60mg daily and other medications including: aspirin 75mg daily; Dalteparin sodium injection 15 IU daily; Atorvastatin 40mg daily; Loperamide 2mg daily; Lansoprazole 30mg daily and Tramadol 100mg (maximum dosage 400mg in 24 hours). The surgical wound was treated with negative pressure wound therapy (NPWT) set at -125mmHg of continuous negative pressure. A soft silicone primary wound dressing (Mepitel®; Mölnlycke Healthcare) had been applied under the NPWT foam interface layer. Contact layers are used under foam with NPWT when increased pain is experienced at dressing changes. Two weeks after surgery, Mr A was seen in clinic. The wound measured 29cm^2.

Treatment

In the two weeks prior to attending the clinic the patient had experienced some pain during dressing changes. As a result, ADAPTIC TOUCH® was introduced as an alternative wound contact layer. It was decided to continue with NPWT at -125mmHg continuous negative pressure.

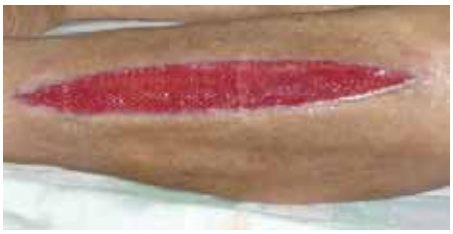
Dressing change 1: The dressing was changed after three days and the wound was cleansed with normal saline. The ADAPTIC TOUCH® was removed with no adherence to the wound bed or the foam interface layer. The wound size remained the same (29cm^2) and exudate levels were moderate. A WOUNDCHEK™ Protease Status test indicated protease activity was low. The patient rated his pain as a 1 on a 10-point scale before dressing change, and a 2 during. The patient commented that the dressing change had produced less discomfort than the previous regimen. The NPWT/ADAPTIC TOUCH® regimen was continued.

Dressing change 2: Four days later, Mr A returned to clinic. The wound had continued to improve. The wound edges were continuing to show good signs of epithelialisation and exudate levels were low. The wound had decreased in size and now measured 25cm^2. The patient rated his pain as a 1 before dressing change, and a 2 during it.

Outcome

In this short evaluation, the wound responded positively to the treatment regimen. Clinicians noted that ADAPTIC TOUCH® had performed well, allowing exudate to pass through the dressing to the canister. Additionally, there was no evidence of granulation tissue growing through the mesh. The clinical staff rated the dressings as highly satisfactory in terms of ease of application and removal. The double-sided cover made cutting ADAPTIC TOUCH® to the size of the wound simple and prevented it sticking to gloves. Although Mr A's pain scores remained the same during the evaluation, he reported that the dressing was more comfortable when applied and removed than the original wound contact layer/NPWT regimen. He thought this was because the wound bed was touched less during dressing changes as a result of better handling by the nurse, and because the ADAPTIC TOUCH® could be easily removed from the wound bed.

By: Wendy Jepson, Wound Care Research Nurse/Janet McGowan, Lead Research Nurse, Bradford Royal Infirmary, Bradford, UK



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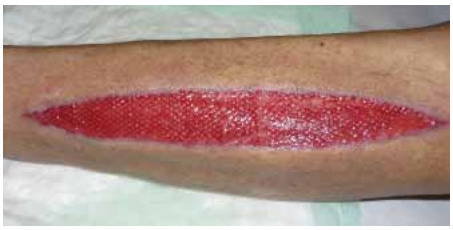


Dressing change 1

Dressing change 2

Figures 1-3: The wound size decreased between dressing changes and the patient reported that ADAPTIC TOUCH® was more comfortable during application and removal.

Assessment	Dressing change 1	Dressing change 2
Patient pain scores before and during dressing changes (VAS 1-10)	1, 2	1, 2
Protease activity	Low	n/a
Wound size	–	↓

Case 4

Background
A 69-year-old lady presented with a wound on the left lower abdomen which measured 18cm x 6cm x 2.3cm deep. She had been admitted with a small bowel infarction and had had stoma surgery about a month before. She had had three subsequent surgical procedures including reversal of the stoma. This area had not healed and necrotic tissue had to be debrided from the site twice. The patient had hypertension and atrial fibrillation, and had experienced extreme pain at dressing changes. A WOUNDCHEK™ Protease Status test showed that protease activity was elevated.

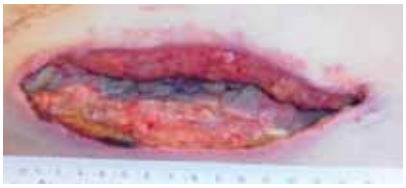
Treatment
The last surgical procedure had been 10 days before. The wound was exuding heavily and required daily dressing changes. It was decided to use NPWT (V.A.C.® Therapy; KCI) to reduce the frequency of the dressing changes to twice weekly, thus reducing the pain experienced by the patient, and to manage exudate. ADAPTIC TOUCH® was chosen as a wound contact layer with the aim of reducing trauma to the wound and pain at dressing changes. The pressure was set at -100mmHg. The dressing was changed every three days and reviewed weekly for the purposes of the evaluation.

Week 1: (Dressing change 2) Exudate levels were reported to be medium but there were signs of healing. The exudate had passed into the canister and there was no evidence of granulation tissue growing through the mesh. ADAPTIC TOUCH® was easy to remove and did not adhere to the wound bed or the foam interface layer. The patient was in unbearable pain during dressing change (rated 9 on a 10-point scale) despite being supplemented with gas and air (Entonox), although she reported that it was not more painful than the previous dressing. The frequency of dressing changes had been reduced and this would reduce the amount of times she had to experience the pain of the change.

Granulation tissue was 0–25% and the wound measured 15cm x 4.5cm x 2cm. The wound bed was covered in surgical mesh. The wound remained free of infection and protease activity was not elevated. The nurse and patient were highly satisfied with the performance of ADAPTIC TOUCH®.

Week 2: (Dressing change 4) After two weeks of treatment exudate levels remained moderate. There were signs of healing and the wound was estimated to consist of 25–50% granulation tissue. The wound contact layer had allowed the exudate to pass to the canister and it did not adhere to the wound bed or the foam interface layer.

The patient still experienced distressing pain (rated 6 on the 10-point scale) at dressing change, but this was less than the pain experienced at previous dressing ▶


Baseline


Week 1


Week 2

Figures 1-3: Granulation tissue increased during the evaluation period and pain at dressing changes was reported to be less.

Cases 4 and 5

ADAPTIC TOUCH® was evaluated under NPWT for only two weeks of treatment. In both cases the patient's co-morbidities meant that it was not possible to continue with formal evaluations. Although the patients' conditions deteriorated, the wound contact layer performed well and as expected.

changes. There was some soft necrosis to the wound edges, but overall the wound size had reduced to 13cm x 3cm x 2cm. It was expected that the slough would lift with further use of NPWT. A WOUNDCHEK™ Protease Status test indicated that protease activity was not elevated. The nurse was highly satisfied and the patient reported satisfaction.

Outcome

Although the clinician would usually have used a primary wound dressing such as Atrauman® (Hartmann) if a contact layer with NPWT and foam was felt necessary, for the purposes of this evaluation the decision was made to use ADAPTIC TOUCH® as the wound contact layer because of the patient's pain levels. The treatment worked as expected. The patient reported a reduction in pain at the second dressing change, probably due to increased time since surgery and because ADAPTIC TOUCH® did not adhere to the wound bed. Using ADAPTIC TOUCH® enabled dressing changes to be performed twice weekly instead of daily. This reduced the number of times the patient had to undergo the pain associated with dressing change, and increased her quality of life. There was also a definite reduction in the size of the wound. While there was some deterioration at the edges of the wound, this coincided with general deterioriation of the patient's health. The patient was systemically unwell. The treatment was discontinued as a result of the patient's care pathway.

By: Sue Edwards, Wound Care Nurse, Southend University Hospital

Assessment	Week 1	Week 2
Patient pain scores before and during dressing changes (VAS1-10)	2, 9	2, 6
Protease activity	Low	Low
Wound size	↓	↓

Case 5

Background
The patient was a 65-year-old man who presented with a large sacral pressure ulcer, which measured approximately 49cm^2. He suffered from a long-term chronic illness and had been nursed at home. He was nutritionally depleted as a result of a poor appetite and had been admitted for intravenous therapy. He also had a chest infection. The pressure ulcer was present on admission.

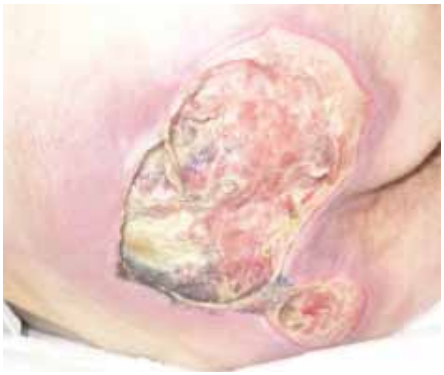
Treatment
It was decided to treat the ulcer with negative pressure wound therapy (V.A.C.® Therapy; KCI) to contain exudate and to ensure the dressing remained intact while encouraging granulation tissue formation. The pressure was set at -125mmHg continuous pressure. Dressing changes were planned for every three days. The decision to use a contact layer was made because the patient reported having experienced pain at dressing changes, and ADAPTIC TOUCH® was a suitable low-adherent dressing.

Dressing change 1: (19 July) There was a positive response to treatment (slough was estimated to have decreased by 10%) although the wound had not reduced in size. ADAPTIC TOUCH® had allowed the exudate to pass through the canister. There was no adherence to wound bed or foam interface layer and it was easy to remove. The nurse and patient were both satisfied. The wound remained free from infection.

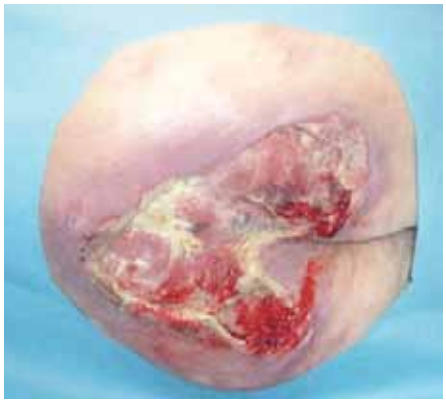
Dressing change 2: (22 July) At the next dressing change three days later the level of exudate was medium. The wound remained free from infection. The patient reported satisfaction with the comfort of the treatment and experienced no pain before or during the dressing change. The dressing had allowed the exudate to pass through to the canister and it was easy to remove.

Dressing change 3: (25 July) There was a medium level of exudate and although this was a positive response to the treatment there were no other signs of healing. The dressing was again easy to remove with no adherence to the foam or wound bed. The patient was not experiencing pain but the wound had increased in size (no measurements taken). The wound was free from infection. The nurse was satisfied with the dressing. The patient reported being highly satisfied.

Dressing change 4: (27 July) The dressing was changed two days later. There had not been a positive response to the treatment. Pain levels had increased with the patient rating pain as 2 on a 10-point scale before the dressing change and 3 during the change. The wound was deteriorating and had increased in size. The ▶



Week 1



Week 4

Figures 1-2: The wound deteriorated over the evaluation period, as a result of the patient's general ill health, but quality of life was improved by the dressing regimen chosen.

Cases 4 and 5

ADAPTIC TOUCH® was evaluated under NPWT for only two weeks of treatment. In both cases the patient's co-morbidities meant that it was not possible to continue with formal evaluations. Although the patients' conditions deteriorated, the wound contact layer performed well and as expected.

patient was very unwell and had not been eating or drinking sufficiently. It was decided not to continue with the treatment. The patient was discharged into the community and the relatives requested for him not to be followed up further.

Outcome

The nurse commented that ADAPTIC TOUCH® was easy to cut and place onto the wound bed. The benefit of using this treatment had been that the dressing had stayed intact, wound exudate had been allowed to drain away, and the wound had been protected from contamination of urine and faeces. The patient's quality of life had been increased by only undergoing dressing change twice weekly, instead of twice daily, resulting in a reduction of pain and discomfort. NPWT allowed the patient to be discharged early so that he could be nursed at home. However, the wound failed to heal due to the co-morbidities and general health of the patient.

By: Janet McGowan, Lead Research Nurse, Bradford Wound Healing Unit/Bradford Institute for Health Research Clinical Research Facility, Bradford, UK

Assessment	1	2	3	4
Patient pain score before and during dressing change (VAS 1-10)	n/a	1, 1	1, 1	2, 3

Case 6

Background

The patient was a 46-year-old man with a large pretibial soft tissue defect that had been caused by trauma. He underwent split skin grafts to treat the pretibial tissue defect. The grafts were taken from donor sites on the thigh. This case focuses on ADAPTIC TOUCH® as a treatment for wounds of this kind.

Treatment

The femoral donor site wounds A (10cm x 5cm) and B (15cm x 4cm) were positioned mid-thigh. The wounds were cleansed using Ringer's solution. Adrenalin-soaked gauze was used initially to stop bleeding at the donor sites. ADAPTIC TOUCH® was placed on the donor site wounds using sterile gloves in the operating theatre. The wounds were then covered by superabsorbent dressings (Sorbion®; Sorbion GMBH). The wound contact layer was left on wound A for 14 days, although the secondary dressing was changed every 2–4 days. On Wound B, the contact layer was left in place undisturbed for 16 days. ADAPTIC TOUCH® was chosen for its non-adherent properties, to encourage epithelialisation without the need to disturb the wound bed.

Donor site wound A: ADAPTIC TOUCH® was removed 14 days after application. The superabsorbent dressing was slightly moistened to facilitate dressing removal. There had been a positive response to the treatment and the donor site had healed well. The ADAPTIC TOUCH® was easy to remove and came away with minimal adherence to the wound bed. The patient experienced no pain before and minimal pain (rated 2 on a 10-point scale) during removal of the ADAPTIC TOUCH®.

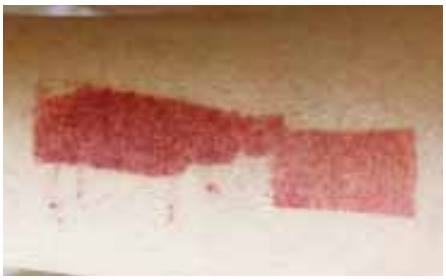
Donor site wound B: ADAPTIC TOUCH®was left in place for 16 days although the superabsorbent dressing was changed after the first 24 hours and then after 3–4 days due to high levels of exudate. The dressing was moistened to facilitate removal. The ADAPTIC TOUCH® dressing came away easily with minimal adherence to the wound bed. The patient reported no pain before removal and minimal pain during dressing change (rated 2 on a 10-point scale). The wound had healed well at 16 days.

Outcome

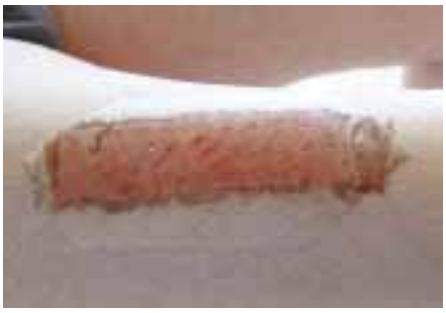
In both these skin graft donor site wounds, ADAPTIC TOUCH® proved an effective wound contact layer, with the wounds progressing well towards healing over 14/16 days and after only one application. Removing the dressing caused minimal pain because the product did not adhere to the wound bed or disturb it on removal. The clinician and patient were highly satisfied with the overall performance of the dressing. The clinician commented that it was an innovative and successful wound management solution as it enabled the wound to be left undisturbed for extended periods of time. It was a straightforward and easy procedure resulting in uncomplicated wound healing, with potential cost benefits, although a full cost analysis would need to be conducted in the future to evaluate this.

By: Dr Andreas Bruhin, Consultant, Kantonsspital Lucern, Switzerland

Wound A, Day 1



Wound A, Day 14



Wound B, Day 4, showing ADAPTIC TOUCH in place during a dressing change

Wound B, Day 16

Figures 1-4: ADAPTIC TOUCH® was effective in the healing of donor site skin graft wounds.

Assessment	Wound A	Wound B
Patient pain score before and during dressing change (VAS 1-10)	0, 2	None, 2
Wound progress	Healed in 14 days	Healed in 16 days

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