

UrgoStart in Real Life



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INTRODUCTION

Chronic wounds are a challenge to clinicians involved in wound management and pose huge financial burdens on healthcare systems, while also having devastating effects on patients and their families.¹ Chronic wounds are classified by aetiology, specifically, diabetic foot ulcers (DFUs), venous and arterial lower limb ulcers (LUs), and pressure injuries (PIs), as a consequence of the underlying diseases such as diabetes, peripheral arterial disease or chronic venous insufficiency.² The cause of chronicity is the persistent inflammatory response created by common components within chronic wounds.³

A 2005 community-based epidemiological study identified the prevalence of chronic wounds in India to be 4.5 per 1000 of the population, with lower extremity wounds being the most common.⁴

Chronic wounds have been described as wounds that do not progress through a normal, orderly, and timely sequence of repair.⁵ Various publications try to estimate explicit timeframes of healing before a wound can be classified as longstanding chronic wounds, for instance 2 to 8 weeks for DFUs, and 4 weeks to 2 months for VLUs. Nonetheless a clear timeframe to define the chronicity of wounds and consensus on the timeline has never been provided or agreed upon.^{6,7} However, it is argued that such wounds may from the outset show chronic features, mainly due to excessive levels of matrix metalloproteinases (MMPs).⁷ The high levels of MMPs and decreased levels of tissue inhibitors (TIMPs) could be used as prognosis indicators, and, therefore, reducing the levels of the MMPs could optimise the healing outcomes of these challenging wounds.⁸

The UrgoStart treatment range, (TLC-NOSF - Nano-oligosaccharide factor, sucrose octasulfate dressing based on technology lipido-colloid) was discussed in a recent systematic review⁹ where it has been concluded that these dressings 'can provide clinicians with an evidence-based option for the management of chronic wounds which may be beneficial in reducing healing times, enhancing patients' health related quality of life and providing economic benefits.' The review identified a total of 21 publications of different levels, ranging from double-blind randomised control trials to case reports, involving over 12,000 patients (2021).

The various publications draw attention to the greater benefits that are achieved when the UrgoStart treatment range is used as the first-choice treatment, as an integral part of the standard of care, to be initiated as soon as a patient presents to a clinician. Also, consistent benefits

are achieved regardless of the characteristics of the wounds (such as wound aetiology, wound location, etc.) and provides a cost-effective solution that still offers the best healing outcomes in the management of chronic wounds, notwithstanding the age, size or location. There is a continuous growing recognition of the robustness of the evidence behind the UrgoStart treatment range amongst national authorities, payors and medical societies, as well as clinician endorsement, adoption and use of the UrgoStart treatment range for lower limb wounds, with these dressings being included in various guidelines and recommendations, including International Working Group on the Diabetic Foot (IWGDF 2019 & 2023)¹⁰, Diabetes Feet Australia (DFA)¹¹, Vietnamese Association of Diabetes and Endocrinology (VADE)¹¹, and the The National Institute for Health and Care Excellence of the UK (NICE 2019 & 2023).¹³

In contact with wound exudate, the TLC-NOSF wound contact layer or healing matrix forms a gel that soaks up wound exudate and decreases levels of MMPs.¹⁴ The TLC-NOSF decreases MMP levels on the wound surface, promoting wound repair and shortening time to wound healing.¹³ It has also been shown that, when treating neuroischaemic DFUs with a TLC-NOSF dressing, transcutaneous oxygen pressure is improved.¹⁵

This document showcases the outcomes of the implementation of the UrgoStart treatment range, as part of a holistic standard of care, in a real-world environment, demonstrating positive outcomes of the management of chronic wounds in India with improvement in wound conditions and, furthermore, enhancing the patients' quality of life and clinicians' satisfaction. This study encompasses the experience of senior wound care clinicians from various specialities including Plastic Surgeons, Podiatrists, Vascular surgeons, and General surgeons. This real-world experience with the UrgoStart treatment range shows its effectiveness in healing a wide range of wounds.

Clinicians and healthcare systems need to ensure that the most effective, evidence-based wound management interventions are implemented for improved outcomes in individuals living with chronic wounds.

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Dr. Rajesh Kesavan

Director, Dr. RK Diabetic Foot and Podiatry Institute, & Rakesh Jhunjhunwala Amputation Prevention Centre; Adjunct Professor, Saveetha Medical College, Chennai, India

In our practice, we tend to use the UrgoStart treatment range on wounds located in the foot and leg area which do not show any granulation tissue and are visibly free of active infection with or without ischaemia. We chose to use the UrgoStart treatment range because we were encountering wounds that were not showing signs of healing, despite addressing infection, offloading, and working on glucose control for a prolonged period. Typically, we start our patients on silver foam dressings to help reduce exudation and then move onto using UrgoStart once this is managed.

In my experience, I have found UrgoStart treatment range of dressings easy to use and effective in non-healing wounds with ischaemia, especially in the foot and leg. The UrgoStart treatment range of dressings act immediately and UrgoStart foam is effective in absorbing moderate exudate. It is also easily removed and atraumatic for patients.

“ I have found the UrgoStart treatment range easy to use and effective in non-healing wounds with ischaemia, especially in the foot and leg.

Dr. Kesavan's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Use the UrgoStart treatment range as soon as the wound becomes visibly clean and infection-free. The earlier you start, the better the results.
- If you are using the UrgoStart treatment range on a venous ulcer, do not forget to initiate compression therapy, if considered appropriate, to complement treatment with the dressing.

Following initiation, I observe the wound exudate levels decreasing very quickly, and granulation tissue formation picking up soon. There is also faster epithelialisation than with other treatments, and the wound quickly reduces in size. For this reason, I would say that the UrgoStart treatment range should form part of a structured pathway for the management of diabetic foot ulcers.

Case study 1

A 57-year-old male patient presented with a 5-month-old venous leg ulcer measuring 1x4cm [Figure 1]. The wound had 20% granulation tissue, mild exudation, and no signs of infection. The wound was initially treated with papain-urea debriding ointment. After cleansing the wound with saline, the wound was dressed with UrgoStart. The dressing was changed once a week. By day 7, the size of the wound had reduced to 1x3cm with healthy granulation tissue present [Figure 2]. After consecutive dressing changes, the wound size gradually reduced. At day 23, the wound had reduced to a size of 1x1cm [Figure 3].



Figure 1: Initial presentation
Size: 1x4cm



Figure 2: Day 7 of treatment
Size: 1x3cm



Figure 3: Day 23 - Final review
Size: 1x1cm

Case study 2

A 63-year-old female patient who had a history of hypertension for the last 10 years and diabetes mellitus for the last 20 years, presented with a 9-month-old wound measuring 3x3cm, with 20% granulation tissue, no exudate and no signs of infection [Figure 1]. The wound was initially treated with a debriding agent. The wound was cleansed with saline and then dressed with UrgoStart. The dressing was changed once a week. By day 25, the wound bed improved with healthy red granulation tissue and the wound size gradually reduced to 3x2cm [Figure 2]. After consecutive dressings the size of the wound had significantly reduced.



Figure 1: Initial presentation
Size: 3x3cm



Figure 2: Day 25 of treatment
Size: 3x2cm



Dr. Prem Chand Gupta

Clinical Director, Vascular and Endovascular Surgery, Care Hospitals, Hyderabad, India

“ When the UrgoStart treatment range was introduced, we saw much faster healing in these wounds.

I use the UrgoStart treatment range mainly on diabetic foot ulcers, but also venous ulcers. Venous ulcers are relatively healthy but often have a large surface area that I want to epithelialize as fast as possible. We start by cleaning wounds with surgical debridement, followed by UrgoClean Ag. Once the wound is clean, we then progress to using the UrgoStart treatment range.

Before we had the UrgoStart treatment range, we were using various dressings: silver dressings, alginate dressings and other absorbable sponges. A common problem was that once the wounds became clean (for example, with negative pressure wound therapy), the wounds would clear up gradually, but the epithelialisation was extremely slow and wounds greater than 5x6cm would need to be skin grafted. However, when the UrgoStart treatment range was introduced, we saw much faster healing in these wounds.

Dr. Gupta's top tips on introducing the UrgoStart treatment range into your clinical practice:

- The UrgoStart treatment range should be used on wounds that are clean, when they are granulating and when you want faster epithelialisation.
- The UrgoStart treatment range is not meant for wounds that are infected or have slough on them.

Patients' response to the UrgoStart treatment range has been very positive because the dressings are comfortable, easy to apply and remove and they do not need to be changed daily. Instead, the dressings can be left on for 3-4 days at a time. Our nurses teach the patients how to use the product and they seem to get on well with dressing the wounds at home and sending us photo updates. This means that as long as there are no negative signs presenting, the patients can keep managing the healing at home and visit us for a check-up every few weeks. In my opinion, it is the best product available for helping with epithelialisation and faster wound healing, and the reduction in hospital visits ultimately means cost savings for those patients and carers who have a long way to travel to a hospital.

Case study 1

A 74-year-old male patient with a history of diabetes for 20 years who underwent a great toe amputation 1 month ago, presented with a healthy, granulating wound of 6x2cm in size with mild exudation (previously treated with topical antibiotics) [Figure 1]. The wound was cleansed with saline and UrgoStart Contact was applied. After the application of UrgoStart Contact, there was a significant reduction in exudation, gradual improvement of granulation tissue, and complete removal of necrotic tissues. Reduction of the wound surface area was evident. The dressing was changed every 5 days. After 6 days of UrgoStart Contact use, the wound area had reduced to 4x1cm with no oozing [Figure 2] and the pain score had reduced from the initial 5 to 2 out of 10 (0=no pain, 10=extreme pain). The treatment protocol remained unchanged. 21 days after starting treatment, the wound had almost closed [Figure 3], the pain score was 0 and the dressing change frequency had reduced to every 7 days.



Figure 1: Initial presentation
Size: 6x2cm



Figure 2: Day 6 of treatment
Size: 4x1cm



Figure 3: Day 21 - Final review

Case study 2

A 54-year-old male patient, presented with a history of diabetes and hypertension for the past 13 and 8 years, respectively. Patient had previously sustained an injury to the medial plantar region of the left foot. The initial 3 months old wound was 3x2cm in size and was clean with moderate exudation and maceration of the surrounding skin [Figure 1]. The wound was cleansed with sterile water and UrgoStart Contact was applied. Dressing was changed every 3 days. After the application of UrgoStart Contact, there was a significant reduction in exudation, gradual improvement of granulation tissue and eventually, the complete removal of necrotic tissues. Reduction of the wound surface area was evident by reduction to 2x2cm after 5 days of initiating UrgoStart Contact [Figure 2]. After 12 days, the wound had filled with healthy tissue [Figure 3], the patient's pain had reduced from an initial score of 5 to 0 out of 10 (0=no pain, 10=extreme pain), and dressing change frequency was reduced to once weekly.



Figure 1: Initial presentation
Size: 3x2cm



Figure 2: Day 5 of treatment
Size: 2x2cm



Figure 3: Day 12 - Final review



Dr. Ravul Jindal

Director, Vascular Surgery, Fortis Hospital, Mohali, India

“ The UrgoStart treatment range is a very effective dressing, and I would certainly recommend it as part of a structured pathway.

In our practice, we use the UrgoStart treatment range on both diabetic foot wounds and venous ulcers. These tend to be about 1x5cm–2x5cm in size and located in the foot and ankle area. Before the introduction of the UrgoStart treatment range, we were using various products, including simple saline dressings, growth factors and occasionally silver or foam dressings. In some cases, the removal of these dressings was very painful, and some wounds showed no signs of improvement.

When we switched to using the UrgoStart treatment range, we saw improvements in cell migration and found that wounds were healing much faster than with previous treatments. Moreover, when the dressing was removed, it typically resulted in far less pain for the patients, as well as a reduction in bleeding and trauma to the healing wound with good granulation tissue underneath.

Dr. Jindal's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Be aware that there are different formats of the UrgoStart treatment range dressings, and some require a secondary dressing on the top of the original dressing.
- While UrgoStart shows good results in granulating wounds with mild to moderate exudation, healthcare professionals should bear in mind that while using UrgoStart Contact in wounds with high levels of discharge, an absorbent secondary dressing must be used.

In my experience, the UrgoStart treatment range of dressings is very effective, and I would certainly recommend it as part of a structured pathway. If the wound is infected, I would suggest using UrgoClean Ag, and once the wound becomes free from infection, initiate the UrgoStart treatment range to improve the healing of the wound.

Case study 1

A 45-year-old male patient, who had a history of diabetes for the past 6 years, presented with a 3-week-old venous leg ulcer. The patient was experiencing pain and itching. The wound size was 9x5cm. The wound bed was covered with granulation tissue and the periwound area appeared unhealthy. There was moderate exudation with no signs of infection [Figure 1]. After cleaning the wound with saline, it was dressed using UrgoStart, which was changed every 4 to 7 days. After 2 dressing changes, the exudate had reduced and healthy red granulation tissue had appeared. The wound size gradually reduced. By day 63, the wound surface area had reduced to 5x3cm, the wound bed was composed of healthy granulation tissue and the pain score had reduced from the initial 7 to 3 out of 10 (0=no pain, 10=extreme pain) [Figure 2]. By day 117, the wound had fully healed, and the patient was pain free [Figure 3].



Figure 1: Initial presentation
Size: 9x5cm



Figure 2: Day 63 of treatment
Size: 5x3cm



Figure 3: Day 117 - Final review

Case study 2

A 40-year-old male with a known history of varicose veins presented with a 2-week-old venous leg ulcer and associated pain and itching. The wound size was 5x5cm. The wound bed was covered with granulation tissue and an unhealthy periwound area [Figure 1]. The patient described the pain as 4 out of 10 (0=no pain, 10=extreme pain). After cleaning the wound with saline and povidone-iodine solution, it was dressed using UrgoStart. The dressing was changed every 4 to 7 days. By day 50, the wound surface area had reduced to 2x2cm with a healthy periwound area, and his pain score was 3 out of 10 [Figure 2]. By day 114, the wound had fully healed [Figure 3].



Figure 1: Initial presentation
Size: 5x5cm



Figure 2: Day 50 of treatment
Size: 2x2cm



Figure 3: Day 114 - Final review



Dr. Belehalli Pavan

Associate Professor and Head of Podiatry, Karnataka Institute of Endocrinology and Research;
Director, StrideAlde Private Limited, Bangalore, India

“ Patient feedback regarding the UrgoStart treatment range has been very good; the ease of dressing changes has been one of the major talking points.

The UrgoStart treatment range has been used primarily on chronic uninfected clean wounds and in continuum of use with UrgoClean Ag. I have a tertiary set-up and so I see a lot of chronic infected wounds which we start treating with UrgoClean Ag. Before the availability of the UrgoStart treatment range, we would continue to use UrgoClean Ag as we didn't have a better alternative, whereas now, as soon as the infection is clear, we move onto the UrgoStart treatment range of dressings. For all cases of residual infection, we apply UrgoClean Ag for at least the first 7 to 10 days. After we see that the wound is clean and no longer producing so much exudate, we then move over to the UrgoStart treatment range - it is used as the first intention dressing once the wound is clean.

Before the UrgoStart treatment range, we used a simple paraffin gauze, but when we compared it with the UrgoStart treatment range of dressings, the healing efficacy is nowhere near as good. Time to complete healing was much less with the use of the UrgoStart treatment range, especially for those 10-15% of uninfected chronic wounds which were not healing, even after applying all our treatments. In these cases, the UrgoStart treatment range of dressings showed very good results.

Dr. Pavan's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Use UrgoClean Ag initially on chronic/non-healing infected wounds. Even if there aren't signs of infection, aim to use UrgoClean Ag for the first 1-2 dressing changes before shifting to the UrgoStart treatment range.
- In venous leg ulcers that do not present with signs of infection, consider using the UrgoStart treatment range as the primary/first intention dressing when the patient first presents, as we have seen that venous leg ulcers heal superbly with the UrgoStart treatment range.

Patient feedback regarding the UrgoStart treatment range has been very good; the ease of dressing changes has been one of the major talking points. Paraffin gauze causes issues with removal, but with the UrgoStart treatment range, we can keep the dressings for 3 days. Before using the UrgoStart treatment range, we usually make sure that the wound is no longer exuding. Even with chronic uninfected wounds, we still have some amount of exudation, and in these cases, we tell the patients we may have to use secondary foam dressings to make sure the patient is able to maintain the dressing for 3 to 4 days. One of the biggest talking points for the UrgoStart treatment range was its efficacy in venous leg ulcers, especially when compared to using the product in non-venous leg ulcers.

I would recommend using the UrgoStart treatment range as part of a structured pathway, and it is already part of our standard operating procedure here. When dealing with infected wounds we would start treatment using UrgoClean Ag, followed by the UrgoStart treatment range once the infection has cleared. For uninfected wounds, we would start treatment using the UrgoStart treatment range. We have tried and tested them, and they have stood the test of time.



Case study 1

A 40 year-old male with a history of diabetes mellitus for the past 31 years presented with a non-healing wound on the right foot, which was 1.4x2.9cm in size [Figure 1]. The 20-day-old wound had minimal sloughing and little granulation tissue, with moderate exudation and periwound maceration. After cleansing the wound with saline, it was dressed with UrgoStart Contact. The dressing was changed every third day. After 7 days, the wound bed had improved with healthy red granulation tissue formation and was 0.9x1.8cm in size [Figure 2]. The wound size gradually reduced and with further dressing changes, healthy granulation tissue appeared after 2 weeks. By day 21, the wound size was significantly reduced and the patient's pain score had improved from an initial 6 to 0 out of 10 (0=no pain, 10=extreme pain). [Figure 3]. By day 36, the wound had completely closed [Figure 4].



Figure 1: Initial presentation
Size: 1.4x2.9cm

Figure 2: Day 7 of treatment
Size: 0.9x1.8cm

Figure 3: Day 21 of treatment
Size: 0.2x0.3cm

Figure 4: Day 36 - Final review

Case study 2

A 46-year-old male with a history of diabetes mellitus for the past 10 years, presented with a 3-week-old wound (0.9x0.8cm), post-trauma, with minimal sloughing and granulation tissue, moderate exudation, and a pain score of 4 out of 10 (0=no pain, 10=extreme pain). [Figure 1]. The wound was treated with papain-based cream. After cleaning the wound with povidone-iodine and saline, the wound was dressed with UrgoStart Contact the dressing was changed every 3 days. By day 3, the wound bed improved with healthy red granulation [Figure 2]. The wound size gradually reduced. After consecutive dressing changes, healthy granulation tissue appeared and after 21 days, the wound had fully healed, and the patient reported no pain [Figure 3].



Figure 1: Initial presentation
Size: 0.9x0.8cm

Figure 2: Day 3 of treatment
Size: 0.8x0.6cm

Figure 3: Day 21 - Final review



Dr. Venkateshwaran

Consultant Plastic Surgeon and Director, Wound Clinic, Jupiter Hospital, Thane, India

“ My patients have not been troubled at all by the UrgoStart treatment range and have experienced great comfort with this product as well as reduced healing times.

In my experience, I have used the UrgoStart treatment range mostly on chronic lower limb wounds, including diabetic foot wounds and venous ulcers. The sizes of these wounds vary from 6x8cm–10x8cm all the way down to 2x3cm, although typically, these are of a large or medium size. These are mainly healing wounds that don't have much slough or necrotic tissue, no sign of infection and a good periwound area.

I was introduced to the UrgoStart treatment range by the Urgo team. I was already using UrgoClean Ag at this point and this was introduced as the next step in the continuum of care pathway to help close the wound. I also use the UrgoStart treatment range of dressings as a standalone product, as most of the wounds I see are clean but with some form of stalled healing. I use it as a first intention dressing – the earlier you start, the better. The UrgoStart treatment range is a fantastic product that offers gentle healing to these wounds; the product is easy to apply and remove and is completely atraumatic.

Dr. Venkateshwaran's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Educate HCPs and patients on which wounds to use the UrgoStart treatment range.
- Use the UrgoStart treatment range in all chronic/non-healing, uninfected wounds and continue its use until the wound heals.

In my experience, my patients have not been troubled at all by the UrgoStart treatment range and have experienced great comfort with this product as well as reduced healing times. The UrgoStart treatment range is also cost-effective for patients. Faster healing, and the ability to increase the time between dressing changes, means reduced patient costs. The treatment range is also a product that caregivers can easily use. Venous ulcers can be painful and so this product is a great choice for those patients too.

I believe adding the UrgoStart treatment range into the wound continuum of care pathway is a very logical step; I would recommend that it be incorporated into any structured pathway looking to achieve this.

Case study 1

A 75-year-old male with a history of diabetes, and chronic kidney disease for the past 4 years, presented with a 4-month-old diabetic foot ulcer. The wound size was 6x2cm [Figure 1]. The wound bed was covered with granulation tissue and had a healthy periwound area. There was moderate exudation with no signs of infection. After cleansing the wound with an ionic silver nitrate solution, it was dressed using UrgoStart Contact. The dressing was changed every 3 days. By day 10, the wound had reduced to 5x2cm with mild exudation [Figure 2]. The wound size gradually reduced. After consecutive dressing changes, the slough had disappeared, and the size of the wound had reduced. By day 39, the wound had reduced to around 4x0.7cm with no exudation [Figure 3].



Figure 1: Initial presentation
Size: 6x2cm



Figure 2: Day 10 of treatment
Size: 5x2cm



Figure 3: Day 39 - Final review
Size: 4x0.7cm



Case study 2

A 60-year-old male with a history of diabetes for 10 years, presented with an 8-month-old, stage 4 pressure injury over the sacrum. The wound size was 2.7x3cm and no pain was reported. The wound bed was covered with granulation tissue, mild exudation and a healthy periwound area [Figure 1]. After cleansing the wound with silver stream solution, it was dressed using UrgoStart Contact. The dressing was changed weekly. After 2 dressing changes, the exudate level had reduced and the wound bed appeared healthy with red granulation tissue. At day 17, the wound size had reduced to 2x2cm [Figure 2]. After consecutive dressing changes, the slough had disappeared, and the size of the wound had reduced rapidly to 1.5x1.8cm by day 46 [Figure 3].



Figure 1: Initial presentation
Size: 2.7x3cm



Figure 2: Day 17 of treatment
Size: 2x2cm



Figure 3: Day 46 - Final review
Size: 1.5x1.8cm



Dr. Jessy Thomas

Consultant Diabetic Foot Specialist, Dr. L.H Hiranandani Hospital, Mumbai, India

“ The UrgoStart treatment range, when used on the right wound at the right time, helps accelerate healing when compared to other neutral dressings.

We have used the UrgoStart treatment range on a large variety of chronic wounds of varying sizes, including venous ulcers (3x3cm), sacral pressure injuries (15x10cm), leg ulcers (20x6cm) and diabetic foot ulcers (1x1cm–10x10cm). In my experience, use of the UrgoStart treatment range in these wounds tends to have great results with a reduction in healing time.

I use the UrgoStart treatment range as a first intention dressing and it is my primary choice for a non-silver dressing. In my wound care practice, I tend to use the UrgoStart treatment range in clean wounds with no infection or biofilm present. After thorough cleansing to prevent and clear the wound of biofilm and wound discharge, an appropriate antimicrobial dressing is used to achieve healthy granulation tissue formation within the wound bed. After this, we use the UrgoStart treatment range to reduce the matrix metalloproteinases (MMPs) and to promote epithelialisation and wound closure.

The treatment range, when used on the right wound at the right time, helps accelerate healing when compared to other neutral dressings. UrgoStart Contact and UrgoStart can be cut to the shape and size of the wound and are very easy to apply. These dressings are also highly atraumatic to granulation tissue upon removal. Dressing change frequency can be assessed according to the amount of exudate and size of the wound.

Jessy Thomas' top tips on introducing the UrgoStart treatment range into your clinical practice:

- Use the UrgoStart on clean wounds with healthy granulation and mild to moderate exudate.
- Apply a compression system when compression therapy is prescribed. All the UrgoStart treatment range dressings can be used under compression.
- Plan dressing changes according to the level of exudate, ideally anywhere between 2 to 7 days; select an appropriate version of the UrgoStart treatment range dressing.
- Avoid using the UrgoStart treatment range in ulcers with induration over granulation tissue and suspicious for malignancy.
- The UrgoStart Treatment Range dressings (excluding UrgoStart Border) can be cut to match the wound's shape and size, and then secured with a secondary dressing. UrgoStart Border does not need a secondary dressing; only the adhesive edges can be cut to fit the wound.
- For optimal results, protocols to ensure strict aseptic precautions to prevent contamination of wounds.
- In case of infection, discontinue the UrgoStart treatment range. Treat the infection and ensure its clearance before restarting the UrgoStart treatment range.

With the UrgoStart treatment range, healing time is significantly reduced. We often see wounds heal in half the time compared to alternative neutral dressings. The best results with the UrgoStart treatment range can only be achieved with strict aseptic techniques during dressing changes, because the UrgoStart treatment range doesn't possess antimicrobial properties. Patients with longstanding diabetic foot ulcers for months and years have described the way that the UrgoStart treatment range works as 'magical'.

In my experience, the UrgoStart treatment range is a comfortable and cost-effective treatment option that can be used as part of a continuum of care pathway following UrgoClean Ag. The dressing can be used once the wound bed is clean, with no biofilm present, granulating and has a low level of exudate.

Case study 1

A 75-year-old male with necrotising fasciitis and a history of diabetes for more than 11 years, with hypertension and chronic kidney disease presented with an 8-week-old abscess on left leg that was 26x6cm (previously treated with UrgoClean Ag) [Figure 1]. The wound was healthy, with granulating tissue and mild exudate. The wound was cleansed with silver stream and UrgoStart Contact was applied and the dressing was changed every 5 days. There was a significant reduction in exudate, gradual improvement of granulation tissue and complete removal of necrotic tissues. By day 30, the wound had reduced to 14x3cm in size with a healthy wound bed [Figure 2]. At day 49, the wound size had reduced to a remarkable size [Figure 3].



Figure 1: Initial presentation
Size: 26x6cm



Figure 2: Day 30 of treatment
Size: 14x3cm



Figure 3: Day 49 - Final review

Case study 2

A 54-year-old male who is diabetic for more than 10 years with hypertension presented with a non-healing ulcer on the MTP region of left foot. He developed the ulcer 3 years ago which was healing on and off with some treatments outside. The wound size was 3x3cm and was clean with moderate exudate. Surrounding skin was macerated [Figure 1]. The wound was cleansed with sterile water and dressed with UrgoStart Contact. The dressing was changed weekly. By day 21, there was a reduction in exudate, gradual improvement of granulation tissue, the wound size had reduced to 1.5x1cm [Figure 2]. By day 28, the wound had closed [Figure 3].



Figure 1: Initial presentation
Size: 3x3cm



Figure 2: Day 21 of treatment
Size: 1.5x1cm



Figure 3: Day 28 - Final review



Dr. Bharat Kotru

Podiatrist and Wound Care Specialist, Max and Amandeep Hospitals, Punjab, India

“ The UrgoStart treatment range should be used as part of a structured pathway wherever patients can benefit from it.

In our practice, we use the UrgoStart treatment range predominantly on diabetic foot ulcers. We chose the UrgoStart treatment range because it reduces wound healing time, and we ideally want to see wound closure as early as possible. If a wound shows signs of infection, we'll use UrgoClean Ag to clean the wound before moving onto the UrgoStart treatment range. In developing countries, infections are more common, so UrgoClean Ag is often the go-to first step for us. The UrgoStart treatment range is used as a first intention dressing as soon as the wound is clear from infection. We also assess the wounds on a case-by-case basis and use the product when it is appropriate to do so. I've found the UrgoStart treatment range of dressings to be a great product, especially for patients with ulcers of mixed aetiology and ischaemic ulcers.

I have received great feedback from patients on the UrgoStart treatment range, particularly around its application and removal, which they can do themselves at home. It doesn't take long to change the dressing, which is great for patients, and many have expressed satisfaction with being able to see a reduction in healing time.

Dr. Kotru's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Every wound has its own characteristics, and so every wound needs an individualised treatment plan.
- The UrgoStart treatment range should be used on an uninfected wound. If the wound is infected, I would recommend using UrgoClean Ag first to treat the infection and then switching to the UrgoStart treatment range.
- Keep track of the wound's healing. If wound healing is not progressing as expected, then you may need to reassess the treatment.

The main benefits that we see consistently with the UrgoStart treatment range are improvement in healing speed and improved cost-effectiveness of treatment. I think the UrgoStart treatment range should be used as part of a structured pathway wherever patients can benefit from it. However, I think the patients should still be assessed on a case-by-case basis and the most appropriate treatment for that patient should be used in each case.

Case study 1

A 56-year-old female presented with a 3-month-old diabetic foot ulcer on the right heel and plantar region which underwent surgical debridement earlier. She has had type 2 diabetes mellitus for 14 years, and hypertension and non-alcoholic fatty liver disease (NAFLD). The wound size was 2.4x3.2cm and the patient reported a pain score of 5 out of 10 (0=no pain, 10=extreme pain). The wound was healthy and granulating with mild exudation [Figure 1]. The wound was cleansed with saline and UrgoStart was applied. The dressing was changed every 5 days. After the application of UrgoStart, there was a significant reduction in exudation and gradual improvement of granulation tissue. Reduction of the wound surface area was evident. By day 22, the wound had completely healed, and the pain had reduced to 0 out of 10 [Figure 2].



Figure 1: Initial presentation
Size: 2.4x3.2cm



Figure 2: Day 22 - Final review

Case study 2

A 64-year-old male presented with a 6-month-old painful diabetic forefoot stump ulcer after multiple treatments outside. He has had a history of type 2 diabetes mellitus, hypertension and peripheral artery diseases. His pain score was 4 out of 10 (0=no pain, 10=extreme pain). The wound, which was 5x6cm in size, was cleansed with hypochlorous acid (0.0003%) and UrgoStart was applied [Figure 1]. The dressing was changed weekly. After the application of UrgoStart, there was a significant increase in granulation tissue. By day 20, the wound had reduced to a size of 3x3cm and the patient's pain score had reduced to 1 out of 10 [Figure 2]. By day 33, the wound had completely healed with no pain [Figure 3].



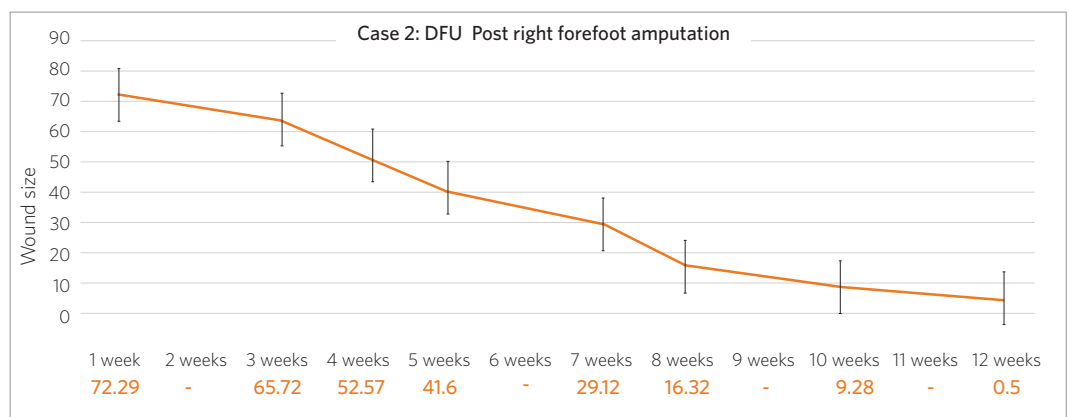
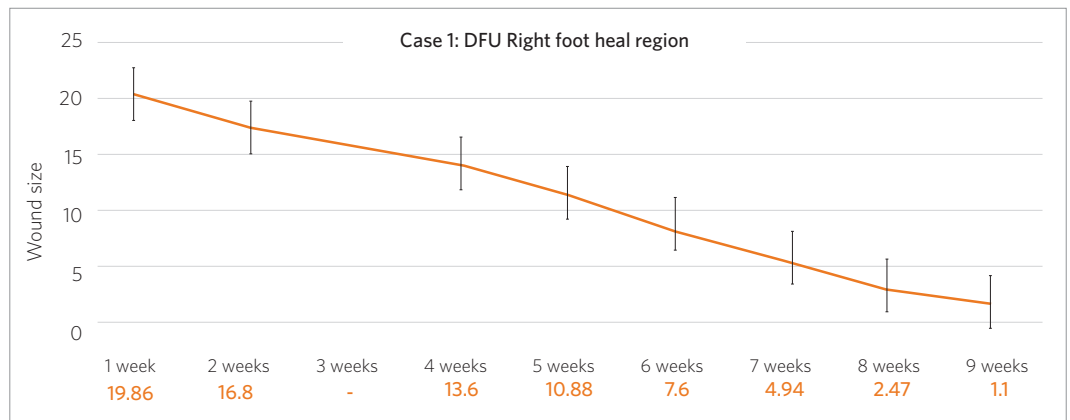
Figure 1: Initial presentation
Size: 5x6cm



Figure 2: Day 20 of treatment
Size: 3x3cm



Figure 3: Day 33 - Final review





Dr. Sanjay Sharma

Podiatric and Wound Care Specialist, Founder of FootSecure, Bengaluru, India

“ When using this product, we routinely see faster healing and reduced scarring.

My practice works mainly with diabetic foot ulcers and venous ulcers. Over the last 2 years, the use of the UrgoStart treatment range has become a part of routine treatment in these cases. Initially when it was launched, the UrgoStart treatment range would be introduced into the healing process if the patients had poor granulation tissue formation post-infection. Commonly, we would see ulcers in the plantar region of the foot that would cause thick hyperkeratosis. When using the UrgoStart treatment range, the hyperkeratosis formation was reduced when compared to the other standard dressings used at the time. Now, the UrgoStart treatment range is the norm to use immediately once infection has completely cleared and once we see a delay in granulation tissue formation or epithelialisation.

Before the UrgoStart treatment range, once the infection was treated, we were using placenta-based or platelet-based growth factors. If there was poor healing from these, we would perform some small scraping to promote fresh blood supply. Now that the UrgoStart treatment range is available, we have switched over to this product instead and always use this as the first intention dressing.

The speed of healing has been increased with the UrgoStart treatment range. We continue to use it because our primary goal is to close the wound as soon as possible, while reducing discomfort and trauma when applying and removing the dressing in both diabetic foot ulcers and venous ulcers. We have not seen any issues around it from the patient's perspective or any difficulty in applying or removing the dressing. The quality of the skin after the healing is much better - it is much more supple and there is a reduced incidence of hyperkeratosis.

Dr. Sharma's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Do start the UrgoStart treatment range only when healthy granulation tissue is present, and refrain from its use if there is still infection, slough, or biofilm present.

When using the UrgoStart treatment range, we routinely see faster healing and reduced scarring. The UrgoStart treatment range is already being used as part of a structured pathway in our clinic. As soon as the infection is taken care of and there remains a delay in healing, we introduce the UrgoStart treatment range as per protocol.

Case study 1

A 54-year-old male who had a history of diabetes mellitus presented with a 9-month-old non-healing ulcer of the left foot following amputation of the 3rd digit, and the 4th and 5th ray. The wound size was 6.5x4cm [Figure 1]. The wound bed was covered with granulation tissue with mild exudation and a healthy periwound area. There were no complaints of pain. The wound was initially treated with a dehydrated sterile human amnion/chorion membrane allograft. After cleansing the wound with polyhexamethylene biguanide, it was dressed with UrgoStart Contact, which was changed weekly. After 2 dressing changes, the exudate level had reduced, and the wound bed appeared healthy with red granulation tissue. After consecutive dressing changes, the size of the wound had reduced within a short period of time. By day 42, the wound had reduced to 2.5x2cm with healthy granulation tissue formation and the exudate was no longer present [Figure 2]. Treatment protocol remained unchanged.



Figure 1: Initial presentation
Size: 6.5x4cm



Figure 2: Day 42 of treatment
Size: 2.5x2cm



Figure 3: Day 56 - Final review

Case study 2

A 62-year-old male with a history of type 2 diabetes mellitus for more than 10 years, presented with 2 wounds in the right foot, following amputation of the fifth digit (wound A) and the hallux (wound B). Wound A was 2 weeks old and measured 3x2cm with no exudate, and had previous infection which subsided [Figures 1]. Wound B was 3 weeks old and measured 5x2cm with no signs of infection [Figure 2]. After cleansing the wounds with polyhexamethylene biguanide, they were dressed with UrgoStart Contact. The dressing were changed every 7 days. After 2 dressing changes, healthy red granulation tissue had formed in both wounds and they gradually reduced in size. By day 14, the size of wound A had reduced to 2x0.5cm [Figure 3], while wound B had reduced to 2x3cm [Figure 4]. After consecutive dressing changes, both the lateral and medial aspects of the right foot (wounds A and B) were completely healed by day 56 and day 42, respectively [Figures 5 and 6].



Figure 1: Wound A, initial presentation
Size: 3x2cm



Figure 2: Wound B, initial presentation
Size: 5x2cm



Figure 3: Wound A, day 14 of treatment
Size: 2x0.5cm



Figure 4: Wound B, day 14 of treatment
Size: 2x3cm



Figure 5: Wound A, day 56 - Final review



Figure 6: Wound B, day 42 - Final review



Dr. Pradeep Kumar

Plastic Surgeon, Rangadore Memorial Hospital, Bengaluru, India

“ I have seen many cases of improved healing time and faster epithelisation in inflamed wounds.

When using the UrgoStart treatment range, wounds should not be infected. We use the UrgoStart treatment range mainly on foot wounds that are less than 5cm in diameter because on bigger wounds, skin graft outweighs the benefits of the dressing. The UrgoStart treatment range is suitable for wounds of smaller size and wounds which are in preparation phase for skin grafting.

There were two qualities which made the UrgoStart treatment range stand out to me: the promotion of epithelisation and the relieving of pressure. We usually opt to use chlorhexidine paraffin gauzes before moving onto the UrgoStart treatment range and we always use the UrgoStart treatment range as a first intention dressing.

From my experience of using the UrgoStart treatment range, I have seen many cases of improved healing time and faster epithelisation in inflamed wounds. I have not seen a huge difference in the application and removal of this product when compared to the alternatives. Some common feedback points that we hear from the patients using the UrgoStart treatment range include reduced pain and faster recovery.

Dr. Pradeep Kumar's top tips on introducing the UrgoStart treatment range into your clinical practice:

- Use UrgoStart Contact dressing twice a week to reduce healing time.
- In areas where the new skin is breaking down due to pressure, UrgoStart which is a foam version will heal the wounds and protect the newly grown epithelial tissues.

Case study 1

An 82-year-old female presented with a 4-week-old necrotic foot infection who has had a history of diabetes for the past 22 years with hypertension. The periwound was macerated and unhealthy, and the wound bed was mildly sloughy, measuring 2.5x2.5cm and 1.5cm deep. Post debridement, the wound was cleansed with saline [Figure 1] and UrgoStart Contact was applied. The dressing was changed weekly. After the application of UrgoStart Contact, there was a significant reduction in exudation, and gradual improvement of granulation tissue. By day 16, the size of the wound had reduced to 1.2x0.5cm and 0.5cm deep [Figure 2]. Reduction of the wound surface area was evident. By day 24, the wound bed was healthy with no exudation and pain [Figure 3].



Figure 1: Initial presentation
Size: 2.5x2.5cm and 1.5cm deep

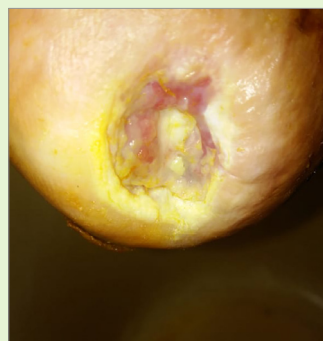


Figure 2: Day 16 of treatment
Size: 1.2x0.5cm and 0.5cm deep

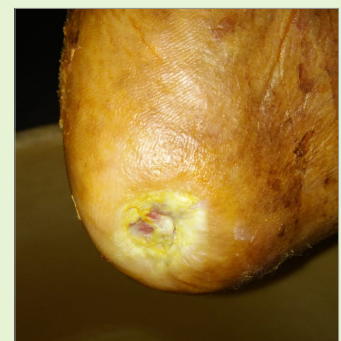


Figure 3: Day 24 - Final review

Case study 2

A 60-year-old female presented with a 4-week-old non-healing foot ulcer. She has had a history of diabetes for 7 years with hypertension. The periwound was 4x4cm in size, macerated and looked unhealthy with the previous traditional dressings [Figure 1]. The patient's pain score was 6 out of 10 (0=no pain, 10=extreme pain). The wound bed was mildly sloughy. The wound was cleansed with saline and UrgoStart Contact was applied. The dressing was changed weekly. After the application of UrgoStart Contact, there was a significant reduction in exudation, and gradual improvement of granulation tissue. Reduction of the wound surface area was evident. By day 14, the wound had reduced to 4x3cm in size, and the patient's pain had reduced to a score of 1 out of 10 [Figure 2]. By day 33, the wound was only 2x3cm in size, the patient was pain free, and treatment was ongoing with saline and UrgoStart Contact dressing changes weekly [Figure 3].



Figure 1: Initial presentation
Size: 4x4cm



Figure 2: Day 14 of treatment
Size: 4x3cm



Figure 3: Day 33 - Final review
Size: 2x3cm



Dr. Selva SeethaRaman

Senior Consultant Plastic Surgeon, Gleneagles Global Hospital, Chennai, India

“ We have consistently seen faster healing when using the UrgoStart treatment range of dressings.

I use the UrgoStart treatment range predominantly on diabetic foot wounds, but also on other wounds that are showing signs of delayed healing. I began using the UrgoStart treatment range by chance during the COVID-19 pandemic, as it provided the opportunity for patients to easily change their dressings at home, thereby reducing the risk of disease transmission. I have observed that the product reduces pain and results in much faster wound healing compared with other treatments.

I always initiate the UrgoStart treatment range once the wound is clear of infection and thoroughly debrided. If the patient is not fit for surgical treatment, then I would usually use UrgoClean Ag for infection management. If there is a lot of slough, then surgical debridement would be my choice, followed by UrgoClean Ag and then switching to the UrgoStart treatment range.

Most of the time I use the UrgoStart treatment range as a secondary intention dressing. The most common treatment I use is saline and other ointments to start with. If the wound showed signs of slow healing, I would then move straight to the UrgoStart treatment range. As I become more confident in using this product, I think it is likely to become the choice for first intention dressing.

Dr. SeethaRaman's top tips on introducing the UrgoStart treatment range into your clinical practice:

- The UrgoStart treatment range can be used on non-healing or slow-healing wounds.
- Use the UrgoStart treatment range in patients that are sensitive to alternative options that are currently being used in practice.

I have found the UrgoStart treatment range very easy to apply and remove. While patients experienced pain and burning sensations with other alginate dressings, the UrgoStart treatment range is very skin-friendly. We have consistently seen faster healing when using the UrgoStart treatment range.

Although the quality of the UrgoStart treatment range is well established, improving access to the product would be a great step forward. I would certainly recommend using the UrgoStart treatment range as part of a structured pathway.

Case study 1

A 60-year-old male, known to have diabetes mellitus for the past 5 years with peripheral vascular disease, presented with a 1-week-old wound of the great toe, which was discoloured and discharging. Debridement was performed with amputation of the great toe, leaving a wound of 9x5cm with mild sloughing and exudation [Figure 1]. After cleansing the wound, UrgoStart Contact was applied. Regular dressings were done with UrgoStart Contact every other day. After 2 dressing changes, the exudate had reduced, and healthy red granulation tissue had developed. The wound size gradually reduced. At day 145, the wound had reduced to 1x1cm in size [Figure 2] and the dressing change frequency was reduced to every 4 to 5 days. The small residual area was covered with a skin graft.



Figure 1: Initial presentation
Size: 9x5cm



Figure 2: Day 145 - Final review
Size: 1x1cm

Case study 2

A 65-year-old male with a history of diabetes mellitus for 15 years, presented with a 5-day-old acute paronychia of right thumb with necrosis of the pulp skin. Debridement of the wound was performed, along with the use of intravenous antibiotics. After cleansing the wound (4x3cm) [Figure 1], UrgoStart Contact was applied. Regular dressings were applied with UrgoStart Contact and the wound size gradually reduced. After 2 dressing changes, exudation had reduced with healthy red granulation development. By day 15, the wound had reduced to a size of 4x0.2cm [Figure 2]. After consecutive dressing changes, the wound size had reduced sooner than expected. By day 77, the wound had contracted and had completely healed [Figure 3].



Figure 1: Initial presentation
Size: 4x3cm



Figure 2: Day 15 of treatment
Size: 4x0.2cm

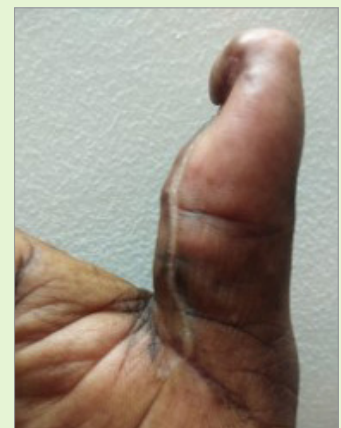


Figure 3: Day 77 - Final review



UrgoStart

Treatment Range



Take control of healing, close wounds sooner



Effective¹

Clinically proven to improve healing outcomes.



Simple²

Easy to use and implement.



Reliable^{2,3}

Recommended in international guidelines.

Recommended by
 | **NICE**

¹ Edmonds M, Lázaro-Martínez JL, Alfayate-García JM, Martini J, Petit JM, Rayman G, Lobmann R, Uccioli L, Sauvadet A, Bohbot S, Kerihuel JC, Piaggese A. Sucrose octasulfate dressing versus control dressing in patients with neuroischaemic diabetic foot ulcers (Explorer): an international, multicentre, double-blind, randomised, controlled trial. *Lancet Diabetes Endocrinol.* 2018 Mar;6(3):186-196.
² UrgoStart® for treating leg ulcers and diabetic foot ulcers. <https://www.nice.org.uk/guidance/mtg42>, April 2023
³ Chen P, VilorioNC, Dhatariya K, Jeffcoate W, LobmannR, McIntosh C, Piaggese A, Steinberg J, Vas, P., Viswanathan V, Wu S, & Game F. (2023). Guidelines on interventions to enhance healing of foot ulcers in people with diabetes (IWGDF 2023 update). *Diabetes/metabolism research and reviews*, e3644. Advance online publication. <https://doi.org/10.1002/dmrr.3644>.

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CONCLUSION

The clinical experiences which are presented in this supplement focus on UrgoStart in real life. The UrgoStart treatment range is a TLC-NOSF dressing recommended for use in non-infected chronic wounds and difficult to heal wounds or wounds at risk of becoming long-standing. Its use has been recommended in various guidelines including International Working Group on Diabetic Foot (IWGDF 2019 & 2023) guidelines and the NICE guidelines (2019 & 2023) and clinicians reported that it is cost effective and promotes wound healing at a faster pace. It can be used in diabetes related foot ulcers, venous leg ulcers, and pressure injuries.

The following is the summary of use of UrgoStart in clinical practice:

- The UrgoStart treatment range should be used on wounds which are non-infected and clean.
- The UrgoStart treatment range also heals the ischaemic wounds faster that are naturally difficult to heal.
- The earlier the UrgoStart treatment range is used, the better are the results.
- It can be used as a continuum of care after the levels of slough in an infected wound are brought down with dressings like UrgoClean Ag.
- When the UrgoStart treatment range is used in venous leg ulcers, combine with an appropriate compression therapy for better results.
- While using the UrgoStart treatment range on highly exuding wounds, make sure a super-absorbent secondary dressing is used.
- Plan dressing changes according to the level of exudate, ideally anywhere between 2 to 7 days; select an appropriate format of dressing from the UrgoStart treatment range.
- The UrgoStart treatment range is comfortable during wear time.
- The UrgoStart treatment range is pain-free during removal.

