

WOUND MANAGEMENT FOR AN AGEING PATIENT

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PRINCIPLES OF WOUND MANAGEMENT

- Assess the patient
- Assess the wound
- Manage the patient
- Manage the wound
- Review patient and wound
- Prevent wound recurrence

WOUND MANAGEMENT IS MULTIDISCIPLINARY

- Medical
- Nursing
- Dietetic
- Pharmacy
- Podiatry
- Orthotics
- Others
- AND the patient



WOUND MANAGEMENT CLINIC HEIDELBERG REPATRIATION HOSPITAL

- Strong referral system
 - In adjacent corridor (on same day)
 - plastic surgery
 - general surgery
 - dermatology
 - Other close relationships with
 - high risk foot clinic
 - vascular surgery
 - infectious diseases

OUR POPULATION IS AGEING

- 13% older than 65
- Most rapidly increasing proportion is those over age 80

WOUND MANAGEMENT IS INCREASINGLY BECOMING CARE OF THE OLDER PATIENT WITH A WOUND

- Multidisciplinary model well-suited
- Geriatric medicine skills of doctor are important
- All clinic staff need skills in managing older patient

AGEING IS NOT DISEASE

- Normal ageing does affect wound healing
- Skin changes
 - reduced inflammatory response
 - reduced dermal immune function
 - thinner dermis
and weakened dermal/epidermal junction
 - less elastin
 - reduced sweat and sebum
 - less water/more fat
 - reduced capillary epithelial migration
 - small blood vessels more fragile

NORMAL AGEING

Systemic changes

- Reduced cardiac output
- Reduced haemoglobin
- Reduced lung capacity
- Reduced liver protein synthesis
- Reduced renal functions
- Impaired cerebral “reserve”
- Reduced hearing and vision
- Impaired muscle and joint function
- Impaired gait/balance
- General immunoparesis

NORMAL AGEING, FRAILITY & DISEASE

FRAILITY = combined effects of multiple diagnoses

- Reduced homeostasis
- Impaired capacity to vary function
- Increases mortality

DISEASE = pathological ageing

- Increases frailty
- But, unlike frailty, probably reversible

WOUNDS AND AGEING

More common in frail or sick elderly

- Probably also more common in healthy elderly
 - eg skin tears
 - need more research

Slower healing in older people

Need to be even more careful to look beyond the wound

MRS H G, Age 73

- Referred from hyperbaric clinic, with left medial malleolar ulcers, 4 x 3.5 cm
- Present 3 years
- Numerous treatments to date
 - pretty much everything!
 - Surgical debridement
 - Iodosorb
 - Kaltostat
 - SSDC
 - Comfeel paste
 - Polymem
 - Acticoat
 - zinc dressing
 - Hyperbaric oxygen
 - Manuka honey
 - Rye grass spray (!)
 - etc

MRS H G, Age 73

- Diabetic
 - on insulin
 - peripheral neuropathy
- Hypertension
- TIA's
- Peptic ulcer
- Osteoarthritis

MRS H G, Age 73

– Medications

- Insulin
 - Naproxen
 - Caltrate
 - Irbesartan
 - Spironolactone
 - Paracetamol
 - Omeprazole
 - Dothiopen
 - Diltiazem
 - Numerous vitamins
- Non smoker
 - No alcohol

MRS H G, Age 73

– Examination

- Obese
- Poor hygiene
 - Strong smell of incontinence
- BP 160/90
- Lungs clear
- Heart unremarkable
- Abdo normal
- Severe sensory peripheral neuropathy
- Pedal pulses present
 - ABI 1.0 on right; 2.0 on left



MRS H G, Age 73

Initial management

1. Whole Patient

- podiatry assessment
- dietitian advice
- continence clinic
- check renal function (was normal)

2. Hole in the Patient

- Contreet foam
- Tubigrip

MRS H G, Age 73

–Progress

- ulcer macerated
 - strong smell of urine
- increased dressing changes
- extra layer Tubigrip

MRS H G, Age 73

Week 16

- largely continent
- better nutrition
- ulcer healing

DOMAINS TO ATTEND TO IN THE AGEING PATIENT WITH A WOUND

- Nutrition
- Hydration
- Cognition
- Sensory
- Mobility
- Comorbidity
- Incontinence
- Medications
- Socio economic

NUTRITION

- Overall appraisal
- BMI
- Consider using formal tool
- Review usual diet
- Bloods
 - albumin
 - FBC
 - 25-Hydroxy Vitamin D
 - iron studies if anaemic
 - little value – Zn, Vit C
 - intervene
 - supplements, including Arginaid
 - improve basic diet
 - improve access to food

NUTRITION AND WOUND HEALING DOCUMENT

- Produced by wound specialists with funding support from Nestle`
- Particularly useful for non-specialists assisting in wound healing

HYDRATION

- Dehydration common in older people
 - impaired thirst
 - impaired access to fluids
 - diuretics
 - illness
- Common in residential care
- Best sign is reduced axillary sweating
- Preventable and treatable
- Increases risk of wounds and probably delays wound healing

HYDRATION GUIDELINES

Mainly for residential care but
useful elsewhere

COGNITION

- 10% over age 60 have dementia
- 20% of inpatients delirious
- Mild cognitive impairment affects up to an additional 20%
- Effects
 - reduced compliance with dressings and other management
 - increased risk of wounding falls, trauma

SENSORY

- Impaired vision
 - glaucoma
 - cataracts
 - macular degeneration
- Impaired hearing
 - presbycusis
 - wax
- Loss of peripheral sensation
- Effects
 - don't hear instructions
 - slightly increased risk of trauma
 - neuropathic ulcers

MOBILITY

- Falls, fractures, trauma
- Reduced calf pump
- Less able to get dressings/attend clinics
- Less able to apply dressings
 - eg compression

COMORBIDITY (NOT NORMAL AGEING!)

Diabetes

Cardiac failure

Renal failure

Arthritis

COAD

Cancer

Stroke

ALL IMPACT ON WOUND RISK, HEALING
& ABILITY TO APPLY DRESSINGS

INCONTINENCE

URINARY

- usually stress or overactive bladder
- causes
 - . moisture lesions
 - . maceration of leg ulcers

FAECAL

- usually due to constipation
- also diarrhoea, dementia
- risk factor for
 - . pressure ulcers
 - . infections
 - . and admission to RCF!

MEDICATIONS & WOUNDS

- Medications can cause wounds
- Medications can delay wound healing
- Medications can promote wound healing
- and treat periulcer skin
- Medications can treat systematic disorders that are associated with wounds
- Anaesthesia important in wound management

MEDICATIONS & OLDER PEOPLE

- Older people consume more medications
 - Community: 4 drugs daily¹
 - Nursing Home: 7 drugs daily²
 - Hospital: 10 drugs daily³
- Extreme polypharmacy common
 - 6.7% of veterans take more than 15 drugs daily⁴

1. Cohen, J Clin Pharm Ther 1998
2. Roberts, Age Ageing 1998
3. J Clin Pharmacol 2001; 58:231-8
4. Parker, ANZ J Pub Health 1997

MEDICATIONS & OLDER PEOPLE

Consequences of Polypharmacy

- Reduced adherence (compliance)
- Adverse drug reactions
 - Including ulcers and other skin reactions
- Drug-drug and drug-disease interactions
- Medication wastage and lack of medication effectiveness

PRESCRIBER AWARENESS OF MEDICATION

- Prescribers often unaware of medications taken
 - In one study GPs unaware of a median of 2 drugs taken by each patient (range 0-10)¹
- Especially a problem at community/hospital interface
 - Only 38% of GPs provide medication information to hospitals²
 - 73% of discharge summaries contain medication errors³
 - And often GPs do not receive any summary

1. Atkin 1998, MJA

2. Stowasser 1997, Aust J Hosp Pharm

3. Mant 2002, MJA

REDUCED COMPLIANCE

- Non-compliance contributes to 50% of drug-related admissions¹
- Overall, prescription adherence is about 50%
 - ie taking >85% and <115% of prescribed doses
- Most is undercompliance
 - 20% completely omit one or more drugs²
- 40% of undercompliance not reported to the doctor³

1. Roughead 1998, MJA
2. Stewart 1999, ANZ J Med
3. Thompson 2001, Int J Pharm Pract

ADVERSE DRUG REACTIONS (ADRs)

- Review of Australian studies by Libby Roughead¹:
 - 2.4 – 3.0% of all hospital admissions drug-related
 - The number of medications used is a consistent contributor to the risk of a medication-related admission
- The risk of an ADR increases as the number of medications increases²

RISK OF ADVERSE DRUG REACTIONS

- Estimates of the potential for ADR are
 - 65% if 2 drugs taken
 - 50% if 5 drugs taken
 - 100% if > 8 drugs taken
- Estimates of risk of serious ADR
 - 55-64 years 18.5%
 - 75-84 years 30%
 - > 85 years 41.9%

DO OLDER HOSPITAL PATIENTS RECOGNISE ADVERSE DRUG REACTIONS?

- 106 patients over age 70 in a UK general medical ward
 - 36 believed they were experiencing side effects
 - Correct opinion (true positive or true negative) in 79%
 - Asking patients about side effects had sensitivity 0.70 and specificity 0.85
 - of 21 with severe adverse drug reactions, 14 did NOT recognise this

COMBATING POLYPHARMACY

- Regular review of medications
 - Formal medication reviews by pharmacist and doctor annually if in residential care or high-risk
- Target high-risk drugs
 - Alerts, audits
 - Prescriber feedback programs

COMBATING POLYPHARMACY

- Only commence a new drug if:
 - Risk less than benefit
 - Prescriber aware of all other medications
 - Patient education material provided
 - Duration pre-determined
- Always aim to DEprescribe
 - Can be safely achieved

MEDICATIONS THAT CAN CAUSE WOUNDS

- Several mechanisms
 - General skin reaction with ulceration
 - Vasculitic
 - other
 - Local ulceration
 - Localised skin necrosis

MEDICATIONS CAUSING WOUNDS

– Rare!

Causes of leg ulceration¹

	%
• Venous and mixed venous/arterial	70
• Arterial	20
• Diabetes	5
• Trauma	3-4
• Vasculitis	1
• Other	1

UNCOMMON LEG ULCERS

- Prevalence survey on 799 Limbs in 710 patients with leg ulcers
- attending various leg ulcer clinics
- 17 patients with 21 involved limbs did not have venous or arterial ulcers
- All had full examination, ABI, duplex ultrasonography and skin biopsies
- Mean duration 5.5 years, mean age 65.6

UNCOMMON LEG ULCERS

<u>● PATHOLOGY</u>	<u>LIMBS</u>	<u>No. OF PATIENTS</u>
● Undetermined	5	3
● Chronic inflammation	3	3
● SCC	2	2
● Kaposi Sarcoma	1	1
● Carcinoma	1	1
● BCC	1	1
● Sickle cell anaemia	2	1
● Vasculitis	2	1
● Pyoderma gangrenosum	1	1
● Hydroxyurea	1	1
● Rheumatoid arthritis	1	1
● No histology (lost!)	1	1
● TOTAL	21	17
● % of all ulcers	1.3%	2.1%

PYODERMA GANGRENOSUM

- A “sterile inflammatory neutrophilic dermatosis”
- Often a destructive, necrotizing, non-infective ulceration of any part of the skin.



Pyoderma gangrenosum--
wound and then area once
healed revealing characteristic
severe scarring



Pyoderma Gangrenosum



Pyoderma Gangrenosum



Pyoderma Gangrenosum



PG – TREATMENT

- Systemic
 - Steroids
 - continuous or pulse
 - Immunosuppressants
 - cyclosporin
 - mycophenolate
 - Immunoglobulin
 - Methotrexate
 - Azathioprine
 - Cytokine blockers
 - eg infliximab
 - Other monoclonal antibodies
 - adalimumab

PG – TREATMENT

- Local
 - topical steroids
 - pimecrolimus
- Surgical
 - contraindicated : can worsen PG dramatically
 - But consider SSG for pain relief
 - rarely taken
- Analgesia
 - vital

VASCULITIS

Inflammation and necrosis of blood vessels

- Immunological or inflammatory mechanisms
- Categorised on vessel size affected

Symptoms and Signs

- Systemic
- Local
 - including skin ulceration
 - frequently legs

CUTANEOUS VASCULITIS: AETIOLOGY

	%
Idiopathic	45-55
Infection	15-20
Inflammatory	15-20
Drugs	10-15
Malignancies	< 5

CUTANEOUS VASCULITIS: PATHOLOGY

- Mediated by immune complexes
 - Usually locally deposited
 - Activate complement
 - Attract neutrophils
 - Tissue damage results

CUTANEOUS VASCULITIS: CLINICAL PRESENTATION

- Classically red papules (lumps) that do not blanch
- Frequently associated with / become ulcerated
 - more so in dependent areas (eg legs)
- Usually painful
- May be accompanied by fever, arthralgia, myalgia

CUTANEOUS VASCULITIS: PRECIPITANTS

- Infections
 - Group A Strep
 - Staph aureus
 - Mycobacteria
 - Hepatitis B & C
- Drugs
 - penicillin
 - sulphonamide
 - Including thiazide diuretics
 - Other antibiotics
 - Suspect any drug patients taking

Purpuric Vasculitis



Vasculitis



Vasculitis



Vasculitis





29.09.2005

Vasculitic ulcers--superficial
necrotic tissue, purple/red
edge, severe pain



29.09.2005

Necrotising Vasculitis



Allergic Vasculitis



VASCULITIS - TREATMENT

- Systemic
 - steroids, high dose
 - other immunosuppressants, eg
 - cyclosporin
 - methotrexate
 - azathioprine
 - mycophenolate
- Topical
 - Occasionally topical steroids or pimecrolimus effective
- Topical
 - Skin grafting
 - often fail but can reduce pain

CALCIPHYLAXIS - THIOSULPHATE

- Sodium thiosulphate used to treat nephrocalcinosis
- Case reports of response to sodium thiosulphate (IV) in calciphylaxis¹
 - Reduced pain in 2 weeks
 - Healing in 6 weeks
- Recommended: 10g IV 3 times a week for 12 weeks
 - With dialysis

OTHER MECHANISMS OF DRUG-INDUCED ULCERATION

- Erythema multiforme
 - If severe: Stevens-Johnson syndrome
- Erythema nodosum
- Toxic epidermal necrolysis

DRUG-INDUCED ULCERATION (non vasculitic)

- Common Drugs
 - sulphonamides
 - antibiotics
 - allopurinol
 - phenytoin
 - warfarin
 - hydroxyurea



Warfarin necrosis --superficial skin necrosis --when therapy ceased --with careful management the necrotic area separates and healthy tissue is revealed

DRUGS WITH A NEGATIVE EFFECT ON WOUND HEALING

- Corticosteroids
- Cytotoxic drugs
- Antibiotics (some)
- Colchicine
- NSAIDs
- Anti-RA Drugs

MEDICATIONS & DELAYED WOUND HEALING

MECHANISMS

- Attenuate inflammation
 - Acute inflammation necessary for wound healing
 - Immunosuppressives, anti-inflammatories
 - Steroids
 - Cyclosporin
 - Mycophenolate
 - Cyclophosphamide
 - Azathioprine
 - NSAIDs

MEDICATIONS & DELAYED WOUND HEALING

OTHER MECHANISMS

- Antimetabolic
 - Cytotoxic / antineoplastic
 - numerous
 - Reduce folate metabolism
 - Methotrexate
 - Vasoconstricting drugs
 - Other
 - Some monoclonal antibodies
 - Eg anti-VEGF

CORTICOSTEROIDS

- Includes:
 - Prednisolone
 - Hydrocortisone
 - Dexamethazone
- Inhibit acute wound healing only when given prior to or immediately after injury
 - Inhibit inflammatory phase

CORTICOSTEROIDS

- In chronic wounds, inhibit healing as
 - Reduce inflammation
 - Reduce wound contraction
 - Inhibit epithelial migration
 - Reduce tensile strength in maturation phase
- Also increase risk of infection

MEDICATIONS TO PROMOTE WOUND HEALING

- Specifically target mechanism of wound
 - eg treatment of pyoderma gangrenosum
- Generally promote wound healing
 - eg micronutrients
- Specifically promote wound healing
 - Developed as treatment for wounds/ulcers

TREATMENT OF WOUND INFECTIONS

- Contamination/Colonisation/Critical Colonisation/
- Infection

- Drug Therapies
 - Local antiseptics
 - Iodine
 - Silver
 - others

 - Systematic antimicrobials

DOES IODINE WORK?

- Over 50 studies recently reviewed¹
 - Conclusion: does have a place, in presence of infection
 - eg 13 human studies of cadexomer – iodine
 - One RCT of 93 with venous leg ulcers showed 34% decrease in ulcer size with cadexomer iodine compared to 5% with other standard therapies²

1. Angel et al. Wound Prac Res 2008; 16: 6-22

2. Skog et al. Br J Dermatol 1983; 109: 77-83

DOES SILVER WORK?

- Recently 2 review articles^{1,2}
- Conclusions
 - Useful if critical colonisation/infection
 - But need systemic antibiotics for more severe infection/cellulitis
 - Useful in some “stalled” wounds

1. Templeton, Primary Intention 2006; 13: 170-9

2. Woodward, Primary Intention 2006; 13: 153-60

SYSTEMATIC ANTIMICROBIALS

- Use only if evidence of infection
 - Clinical
 - Culture
 - Radiological (osteomyelitis)
- Risk of
 - Adverse reactions
 - Resistance

TREATMENT OF ARTERIAL INSUFFICIENCY (WITH MEDICATIONS)

- Limited evidence
 - Pentoxifylline (“Trental”)
 - Antiplatelet agents / anticoagulants

PENTOXIFYLLINE ("TRENTAL")

- Changes flow characteristics of blood and oxygenation of ischaemic tissue
- Exact mechanisms uncertain
 - Increase red and white cell deformability (flexibility)
 - RBC 8-9 μ m and capillary 4-5 μ m
 - Decreases whole blood viscosity
 - Decreases platelet aggregation
 - Decreases fibrinogen levels

PENTOXIFYLLINE

- Used to treat PVD
- Increases blood flow to ischaemic tissues
- Vasodilator effects
- Reduces effects of build up of anaerobic metabolites in ischaemic times
- Other methylxanthines were used for PVD
 - Caffeine, theophylline
 - Minor efficacy

PENTOXIFYLLINE

- Cochrane review 2007¹ – for venous leg ulcers
- 11 trials (841 participants) compared pentoxifylline with placebo or not treatment
 - 7 trials (659 participants) compared with compression
 - 4 trials (182 participants) compared with no compression
- Conclusion
 - Effective either as adjunct to compression or above where compression cannot be used
- Most adverse effects gastrointestinal
- BUT not on PBS (veterans can get it)

TREATMENT OF VENOUS INSUFFICIENCY (with medications)

- Drugs to prevent (further) thrombosis
 - Warfarin
 - Other anticoagulants
- Specific agents for venous insufficiency

AGENTS FOR CHRONIC VENOUS INSUFFICIENCY

- Oxerutins (Rutosides)
- Horse chestnut extract
- Both agents reduce leg volume in chronic venous insufficiency
 - May have a role if compression not tolerated or impractical
- Little evidence for benefits in venous ulcers

DRUGS THAT GENERALLY PROMOTE WOUND HEALING

- Micronutrients
 - Zinc
 - Vitamin C
 - Little evidence for efficacy unless clear deficiency
 - Difficult to demonstrate for zinc
- Other nutritional agents
 - Arginine
- Others
 - Phenytoin

PHENYTOIN – evidence of efficacy

1939	Patients on phenytoin observed to develop gingival hyperplasia
1958	Phenytoin used to accelerate gingival healing
1965	DBRPCT in leg ulcers showed phenytoin promoted wound healing

Subsequently trialed in diabetic ulcers, pressure ulcers and burns

PHENYTOIN – evidence for efficacy

- Systematic review supported possible role of phenytoin in promoting wound healing¹
- 2 recent case studies in Wound Practice and Research² showed healing of severe pressure ulcers in 10-14 weeks²
- However, need more evidence to use routinely

1. Shaw. Br J Dermatol 2007; 157: 997-1004

2. Sinha. Wound Prac Res 2007; 16 37-41

MEDICATIONS DEVELOPED SPECIFICALLY TO PROMOTE (CHRONIC) WOUND HEALING

- ACUTE WOUNDS

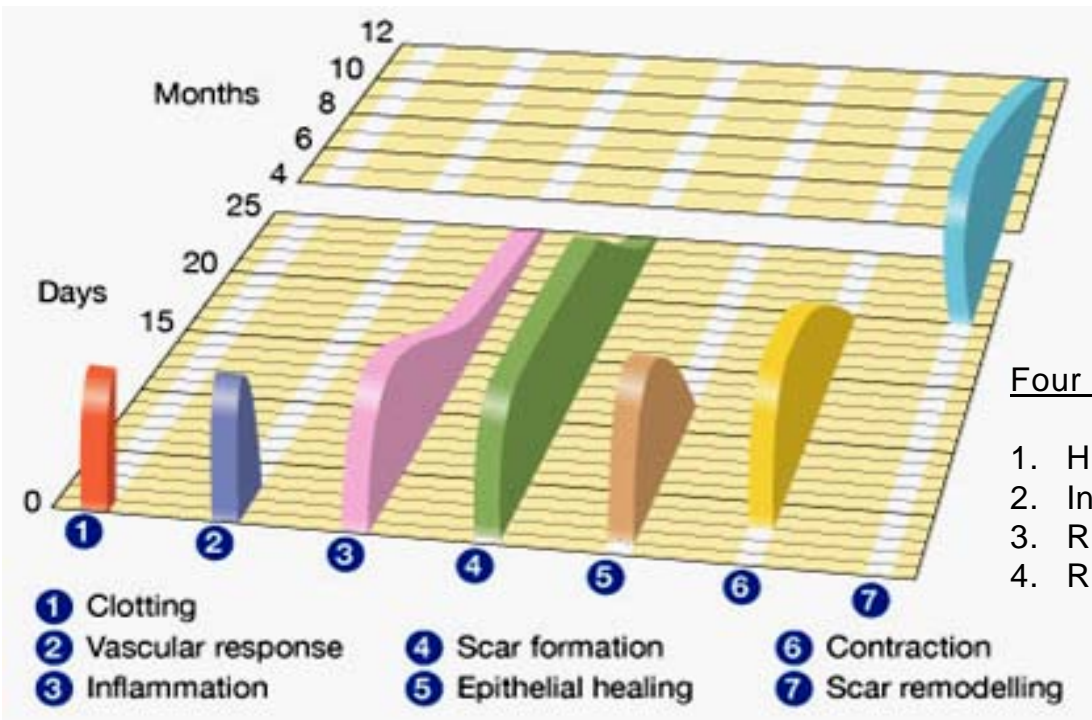
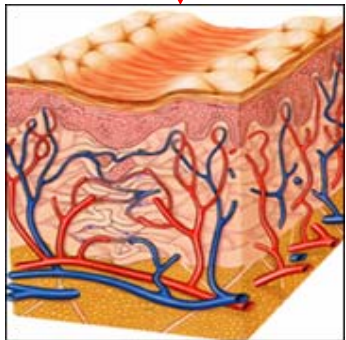
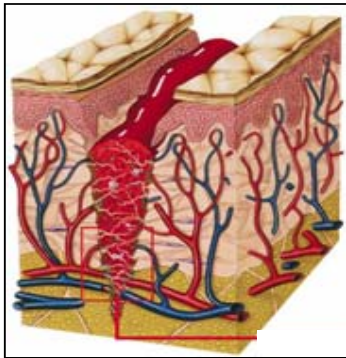
- Not a great need for medications APART from
 - Reducing infection
 - Reducing scar formation

- CHRONIC WOUNDS

- Need to target the stages of wound healing
 - Especially growth factors and proteases

WOUND HEALING STAGES

Sequence of Molecular and Cellular Events in Skin Wound Healing



1

Clotting



2

Vascular Response



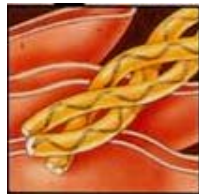
3

Inflammation



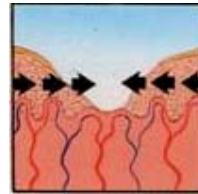
4

Scar Formation



5

Epithelial Healing



6

Contraction



7

Scar Remodeling



DRUGS TO PROMOTE WOUND HEALING

- Growth factors
 - Platelet-derived growth factor
 - “REGRANEX”
 - Only marketed agent
 - Other single growth factors
 - Multiple growth factors
 - Some skin substitutes/matrix-derived products
 - Whey-derived product
 - ❖ Trial here: failed (GROPEP)
- OTHERS
 - Agents to increase NO
 - Giberillic acid
 - Trial commencing here
 - Alkalised fruit extract
 - Results to be presented at this conference

BECAPLERMIN ("REGRANEX")

- Recombinant human platelet-derived growth factor
- 4 studies in diabetic lower extremity ulcers¹
 - 922 participants
 - 8 – 20 weeks duration
 - Comparator: good ulcer care with or without placebo gel
- Results: becaplermin significantly increased probability of complete healing in the 95% of ulcers $\leq 10\text{cm}^2$ ($p=0.007$)
 - 39% more healed
 - 305 more rapidly

BECAPLERMIN FOR PRESSURE ULCERS

- One phase II DBRPCT¹
- N = 124
- 16-week trial
- Once daily treatment with becaplermin
 - Significantly increased complete healing
 - Significantly increased $\geq 90\%$ healing
- Higher dose (300 $\mu\text{g/g}$) not more effective than lower dose (100 $\mu\text{g/g}$)

BECAPLERMIN – role in wound management

- Not available in Australia
- Poor sales in USA
- BUT shows that growth factor therapy may have a role
 - Many other trials have failed
 - eg whey-derived growth factor (GROPEP)
 - One system uses 5-30 ml of patients' own blood
 - Centrifuged to concentrate platelets
 - Then applied onto wound
 - Needs more evidence of efficacy

TISSUE MATRIX PRODUCTS AND BIO-ENGINEER TISSUE REPLACEMENTS

- Alternative to growth factor application
- These products either contain growth factors or stimulate their production
 - eg OASIS
 - Wound matrix product produced from pig small intestine
 - One 12-week RCT in 73 patients with diabetic ulcers showed efficacy similar to becaplermin¹
 - 49% of OASIS-treated healed
 - 28% of becaplermin-treated healed

OTHER TISSUE MATRIX PRODUCTS

- PROMOGRAN
- XELMA
- Expensive!

CONCLUSIONS

- Take a full medication history when assessing a person with a wound
- Working with doctor/pharmacist, aim to reduce polypharmacy in older people
- Medications are needed to treat some wounds
 - Target wound mechanisms
- Medications may be useful to promote healing of some chronic wounds
- We are a long way from a magic bullet that will heal (all) chronic wounds

SOCIOECONOMIC FACTORS IN OLDER PEOPLE

Less income

- unable to purchase dressings
- unable to afford community nursing

Isolation

- less assistance with dressing

Impaired community mobility

- unable to attend clinics, GP

Residential issues

- poor hygiene (squalor sometimes)
- falls, trauma
- home visit can be invaluable

WOUND DRESSINGS IN OLDER PEOPLE

No need to modify for age alone

But consider comorbidity

- eg arterial disease – may tolerate less compression
- eg CCF - avoid too much compression initially
- eg thyrotoxicosis – caution with iodine

and other factors above

- can they afford?
- can they apply?
- can they comply?
- can they return to clinic or get to practice?

PROGNOSIS FOR WOUNDS IN OLDER PEOPLE

Not necessarily affected by
age alone

- comorbidity more important

Never too old to heal

WHAT IS AWMA DOING TO HELP OLDER PEOPLE WITH WOUNDS?

- Wound Product Access
 - Part of Wound Awareness Campaign/Week
- Standards
 - Will be adopted for residential care facilities
- Guidelines
 - Pressure ulcers
 - Venous leg ulcers
- Position statements
 - Infections
 - Skin tears



Bryce Courtenay
supporter of
The Elephant In
The Room campaign



Australian Wound Management Association

Over 270,000 people in Australia suffer from wounds. It is the elephant in the room that no one is talking about!

In the majority of cases patients receive no funding for treatment in the community and have to pay for it out of their own pocket.

This means that in a lot of cases people go without best possible care because they can't afford it.

The Australian Wound Management Association (AWMA) is calling upon Federal Government to take action on this major problem.

You can help by visiting
www.elephantintheroom.com.au

You can also help by signing the online petition and telling your friends and colleagues about the website.

Every signature is important and it really does make a difference!



Australian Wound Management Association

WHAT IS AWMA DOING FOR OLDER PEOPLE?

- List of basic products for RCFs
 - See www.awma.com.au
- Improved health professional training
 - Accreditation of educational courses
- Improved awareness of wounds
 - Out of closet
 - Part of WAC

RECOMMENDED INVENTORY STOCK ITEMS FOR AGED CARE FACILITIES

Recommended inventory stock items

Films – eg Opsite, Tegaderm

Low-adherent absorbent pad – eg Melolin, Cutilin

Hydrogels – eg Intrasite gel, Solugel, Purilon gel, Solosite

Hydrocolloids – eg Duoderm, Comfeel

Alginates – eg Algisite M, Kaltostat

Foams – eg Allevyn, Biatain, Lyofoam, Mepilex

Hydrofibre – eg Aquacel

Impregnated mesh dressing/contact layer – eg
Adaptic, Mepitel, Urgotul

Secondary absorbent pad – eg Combine Zetuvit plus,
Mesorb, Adsorb Plus

RECOMMENDED INVENTORY STOCK ITEMS FOR AGED CARE FACILITIES – (cont)

Retention tapes/products

Tubular retention bandage – eg Tubifast

Tubular support bandage – eg Tubigrip

Tubular protection – Tubular Plus

Paper tapes – eg Micropore

Polyacrylate tape – eg Mefix, Hypafix, Fixomull

RECOMMENDED INVENTORY STOCK ITEMS FOR AGED CARE FACILITIES – (cont) Skin Care

Barrier cream – eg zinc & castor oil, Critic Barrier cream,
Sudocrem, Calmaseptine

Barrier ointment – eg Ungvita A

Moisturizer – eg Dermaveen QV, Hamilton, Cavioln,
Durable Barrier cream

Protective barrier wipes – eg No Sting Barrier Wipe,
ConvaCare wipes, Adhesive remover wipes, eg
ConvaCare barrier wipes

Skin barrier removers – eg Convacare Adhesive
removers

RECOMMENDED INVENTORY STOCK ITEMS FOR AGED CARE FACILITIES – (cont)

Miscellaneous items

Dressing pack

Normal saline

Sterile instruments

Hand hygiene products eg rapid dry alcohol moisturisers

Plastic aprons

Gloves

Wound tracing equipment

Wound resource folder

CONCLUSIONS

- Aging is everywhere
 - we can't ignore it!
 - neither can we poorly manage older people with wounds
- Consider the whole patient
 - but ageing is not a disease
- We should heal wounds in older people (almost) as well as in younger folks